



**CONFRONTING THE HUMAN
RESOURCES FOR HEALTH
CRISIS IN TANZANIA**

**TANZANIA HUMAN RESOURCE
CAPACITY PROJECT (2009–2013)**

End of Project Report

December 2013

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LIST OF ACRONYMS

AIHA	American International Health Alliance
AKF	Aga Khan Foundation
AMREF	African Medical and Research Foundation
APHFTA	Association of Private Health Facilities in Tanzania
BAKWATA	National Muslim Council of Tanzania
BMAF	Benjamin William Mkapa HIV/AIDS Foundation
CBO	Community-based organization
CCHP	Comprehensive Council Health Plan
CDC	Centers for Disease Control and Prevention
CHMT	Council health management team
CHW	Community health worker
CIDA	Canadian International Development Agency
CSO	Civil society organization
CSSC	Christian Social Services Commission
DAT	District advocacy team
DHIS	District Health Information Software
DICT	Division of Information, Communication, and Technology
DMO	District medical officer
DQA	Data quality assessment
DSW	Department of Social Welfare
ECSA-HC	East, Central and Southern African Health Community
ELRA	Employment and Labor Relations Act
FBO	Faith-based organization
FHI360	Family Health International 360
FY	Fiscal year
GIS	Geographic information system
GOT	Government of Tanzania
GTZ	German Organization for Technical Cooperation
HCD	Human capacity development
HCMIS	Human Capital Management Information System
HR	Human resources
HRH	Human resources for health
HRHIS	Human resources for health information system
HRIS	Human resources information system
HRM	Human resources management
HSS	Health system strengthening
HSSP III	Health Sector Strategic Plan III
HW	Health worker
ICT	Information and communications technology
ISW	Institute of Social Work

IT	Information technology
JACSW	Jane Addams College of Social Work
JICA	Japan International Cooperation Agency
LGA	Local government authority
LGHRIS	Local government human resources information system
M&E	Monitoring and evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOST	Management and Organizational Sustainability Tool
MSH	Management Sciences for Health
MVC	Most vulnerable children
MVCC	Most vulnerable children committee
NCPA	National Costed Plan of Action
NIMR	National Institute for Medical Research
OC	Other charges
OPRAS	Open performance review and appraisal system
PASONET	Para-social Workers' Network
PEPFAR	President's Emergency Plan for AIDS Relief
PMO-RALG	Prime Minister's Office-Regional Administration and Local Government
PMP	Performance management plan
POPSM	President's Office, Public Service Management
PSW	Para-social worker
RAS	Regional administrative secretary
RHMT	Regional health management team
SO	Strategic objective
SWA	Social welfare assistant
TASWO	Tanzania Association of Social Workers
THRP	Tanzania Human Resource Capacity Project
TRG	Training Resources Group
TWG	Technical working group
UDSM	University of Dar es Salaam
UDSM-DCS	University of Dar es Salaam, Department of Computer Sciences
USAID	United States Agency for International Development
USG	US government
VPN	Virtual private network
WCI	Workplace climate improvement
WEI	World Education Inc.
WISN	Workload Indicators of Staffing Need
WHO	World Health Organization
ZHRC	Zonal health resource center

EXECUTIVE SUMMARY

This report documents results of over four years (2009–2013) of implementing activities under the Tanzania Human Resource Capacity Project (THRP), a USAID/Tanzania-funded initiative that strengthened the systems and structures of the central government and local district authorities working with human resources for health (HRH) in Tanzania. In the spirit of USAID Forward and PEPFAR II, the THRP coalition was designed with the intent for the prime partner, IntraHealth International, to “lead from the sidelines.” IntraHealth and the Benjamin William Mkapa HIV/AIDS Foundation (BMAF) co-led the project, with additional direct implementation by a coalition of local partners, namely the Christian Social Services Commission, Aga Khan Foundation, and the Department of Computer Sciences at the University of Dar es Salaam. International partners included Management Sciences for Health, IMA World Health, and Training Resources Group. The coalition worked in collaboration throughout the life of the project with several departments within the Ministry of Health and Social Welfare (MOHSW) and within the Prime Minister’s Office for Regional Administration and Local Government (PMO-RALG).

The THRP was conceived to introduce strategic HRH innovations as prioritized by the MOHSW and other national stakeholders in the national Human Resources for Health Strategic Plan 2008–2013. The national plan provided the guidance for multisectoral efforts to strengthen the planning, deployment, management, and efficient utilization of human resources and was thus the blueprint for THRP contributions to the realization of its goals. In 2011, USAID released its Tanzania Global Health Initiative (GHI) Strategy 2010–2015, highlighting US government commitment to strengthening health systems across all World Health Organization (WHO) building blocks and specifically reinforcing existing efforts to improve human resources for health for efficient, quality service delivery.

The THRP initiative was a critical undertaking in Tanzania, a sub-Saharan country facing the burden of a high maternal mortality rate (454 deaths per 100,000 live births) (Ministry of Finance 2011) and a high incidence of malaria, HIV/AIDS, and a host of other curable and preventable diseases. Morbidity and mortality rates are high, in part, because the systems and structures that manage health workers are not responsive to the deficit and low productivity of health workers. The health system in Tanzania operates with 36% of the optimum workforce and in rural areas the vacancy rates reach up to 70%, threatening to negate national efforts to attain universal health coverage and health development goals.

THRP had four strategic objectives (intermediate results):

1. Assist the MOHSW and the PMO-RALG in implementation of the HRH strategy and human resources components of the Health Sector Strategic Plan III, as requested by the MOHSW
2. Strengthen the capacity of national and local government authorities to predict, plan for, and recruit the health and social welfare (H&SW) workforce

3. Improve the deployment, utilization, management, and retention of the health and social welfare workforce
4. Increase the productivity of the health and social welfare workforce.

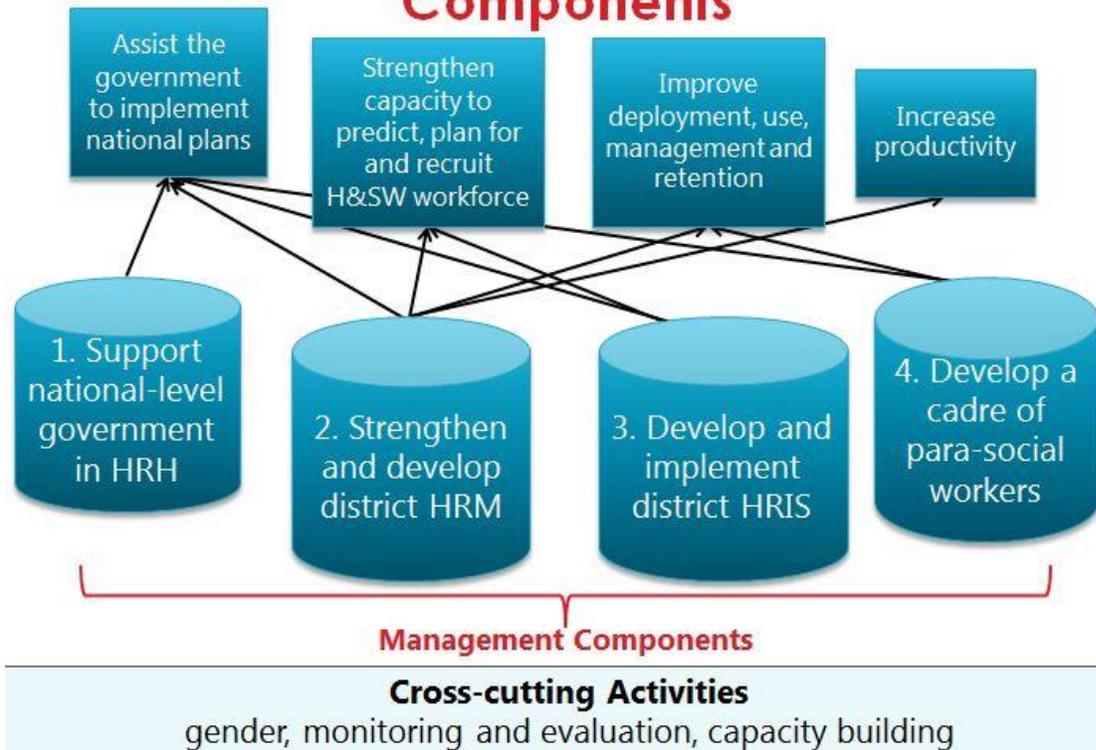
The project strategies contributing to each of the project objectives focused on:

- Developing a comprehensive human resources management (HRM) program to strengthen district managers' competencies and provide them with tools to identify and tackle HRH problems (Chapter One)
- Collaborating with the MOHSW in implementing key components of the national HRH strategic plan (Chapter Two)
- Establishing a comprehensive human resources information system (HRIS) to provide routine health worker data for decision-makers in both the public and private sectors (Chapter Three)
- Building the capacity of the social welfare workforce to provide services to address the needs of the most vulnerable children (Chapter Four).

This report highlights achievements, challenges, and recommendations associated with each of the project's strategic components and describes how the four strategies contributed to the four intermediate results, as shown in the conceptual framework on the next page.

THRP adopted a comprehensive program approach with an emphasis on building the competencies of the core team of local project partners; the aim was to reduce the complexities of Tanzania's human resources system to manageable elements. This approach ensured growing availability of strategic leadership on human resources issues and increased the potential sustainability of program accomplishments through integration with existing government systems and structures from the national, regional, and district levels.

Management/Implementation Components



District Level

At the district level, THRP built the capacity of decision-makers to make decisions using the best data available and strengthened their leadership and management roles. THRP worked with district authorities—within their span of control and influence—to implement strategies to strengthen district manager competencies and improve human resources management practices. THRP activities across the mainland and on Zanzibar included:

- Customizing and deploying a **comprehensive open source human resources information system** to enable efficient human resources planning decisions based on complete and accurate data (nationwide, Zanzibar)
- Influencing the **prioritization of health worker-related activities** in district budgeting and planning (54 districts in Iringa, Mtwara, Lindi, Ruvuma, and lake zone regions)
- Training, **coaching, and mentoring district managers** and improving their use of standardized health worker management guidelines such as Comprehensive Council Health Plan guidelines, orientation packages, and supportive supervision guidelines (54 districts in Iringa, Mtwara, Lindi, Ruvuma, and lake zone regions)
- Assisting with the **formation of district advocacy teams** to advocate for the needs of vulnerable children in district planning (27 districts in Dodoma, Mwanza, Iringa, and Mtwara)

- Developing a volunteer **cadre of village-based para-social workers** to address the psychosocial needs of vulnerable children (27 districts in Dodoma, Mwanza, Iringa, and Mtwara)
- Strengthening the **linkage between social welfare offices within local governments** and village-based para-social workers (27 districts in Dodoma, Mwanza, Iringa, and Mtwara)
- Facilitating an **independent professional network** for para-social workers.

The project's priority focus at the district level was to strengthen local human resource management practices. THRP's comprehensive approach included reviewing multiple policies and HR guidance documents; operationalizing national guidelines; developing a team of local HRH management experts; and strengthening the capacity of district-level health managers. As a result of these activities, THRP contributed to reducing staff vacancy rates in the 54 project districts between 2009 and 2012, with an average decrease from 45% to 36% in the 54 districts. Moreover, by 2012, 17% of project districts had dedicated resources to HR activities other than training (such as orientation of new staff and local incentives). Additionally, the project supported 32 enrolled rural nurses to upgrade to registered nurses in a pilot retention program, and 530 nurses who received basic skills training to improve their productivity and safety at work.

Central Level

THRP enhanced central-level stakeholders' knowledge in using HRH data and evidence to improve HRH-related policy formulation and successful implementation. Working with several ministries with HR responsibilities, THRP:

- Supported national efforts to prioritize the HRH agenda. In collaboration with other stakeholders, THRP developed the structure, roles, and responsibilities of the national HRH Technical Working Group (TWG) and—following senior-level endorsement of the structure—facilitated representation from different MOHSW departments and other ministries. The **HRH TWG is operating** on a regular basis, although there is room for improvement to become fully functional. THRP engaged consistently with the HRH TWG, providing technical advice and direction on a number of technical initiatives.
- Strengthened HR leadership through building the **capacity of senior officials** from across several departments within the MOHSW responsible for implementing the national HRH strategic plan.
- Provided **evidence to advocate for systems change** through a number of studies, including a tracking study, a study examining multisectoral criteria for defining underserved areas, a recruitment bottlenecks study, and a social welfare workforce assessment.
- Facilitated **engagement with district leadership** to include “real practice” in national-level dialogue through knowledge forums, policy forums, and a national HRH conference.

- Facilitated **coordination across ministries** to address recruitment bottlenecks, confront HR deployment issues, and determine the direction for the national HRIS.
- Reviewed national policy and **developed guidance documents**, including supportive supervision guidelines and new staff orientation guidance; augmented the Comprehensive Council Health Planning guide and the pay and incentive policy strategy.
- Played a leadership role along with the MOHSW's Department of Social Welfare in developing a **national social welfare workforce strategy**.

Human Resources Information Systems

THRP worked closely with the PMO-RALG, the Zanzibar Ministry of Health, and the private faith-based health sector to strengthen access and use of critical human resources data. The Computer Sciences Department at the University of Dar es Salaam customized dedicated open source HRIS to the specific needs of all three organizations. The project helped establish a local government HRIS (LGHRIS), a computer-based system of collecting and storing personal and professional staff information and producing reports that inform management decisions in areas such as recruitment and deployment. The LGHRIS is now deployed nationwide in all 156 districts and 22 regional offices on the Tanzanian mainland. The LGHRIS has records of 99% (323,663) of civil service employees, including 24,671 health workers. The HRIS has also been deployed in Zanzibar's 10 districts and in 46 out of 48 hospitals managed by faith-based institutions. Zanzibar's Ministry of Health increased its health workforce by 25% between 2009 and 2013 as a result of internal advocacy based on data produced by the functioning HRIS. High levels of confidence in the data have propelled even further use and analysis of the information.

Social Welfare

To introduce and enhance social work competencies among workers addressing the psychosocial needs of vulnerable children, THRP trained almost 4,700 village-level para-social workers and more than 700 supervisors, who in turn have served 100,807 children defined as most vulnerable children. The para-social worker program component also spearheaded the development of the country's first social welfare workforce strategy in 2012. The strategy will guide the development of appropriate structures and systems required for effective provision of social services across Tanzania. The project raised the visibility of the critical role that social work plays in the health and well-being of Tanzania's vulnerable populations and highlighted the need for a competent social welfare workforce deployed where it is most needed. It facilitated engagement on social welfare workforce issues within the HRH TWG and vice versa. THRP also advocated for representatives of the Department of Social Welfare to participate on a regular basis in the development of the next national HRH strategic plan.

Moving Forward

The many partnerships developed throughout project implementation culminated in a truly collaborative effort to organize the country's **first national HRH conference**, which took place in Dar es Salaam from September 3-5, 2013. The conference brought together the key ministries essential for HRH planning, recruitment, and deployment (MOHSW, PMO-RALG, the President's

Office for Public Service Management [POPSM], and the Ministry of Finance [MOF]) with representatives from academia, the professional councils, private and faith-based organizations, and health training institutions. The theme of the meeting—HRH is crucial for reaching development goals—underlined the need to focus on existing inefficiencies in HR production, recruitment, retention, and performance management processes to ensure that health workers are truly in the right place with the right skills to meet community needs.

The national HRH conference produced a series of specific recommendations. The highest-priority recommendation was a call for stronger coordination among government ministries on key HRH policies and strategies, and enforcement of existing regulations. The conference recommendations also served as a launching pad for the government to articulate three macro-level national commitments during the Third Global Forum on Human Resources for Health held in Recife, Brazil in November 2013. The end of THRP coincided with Tanzania's participation in the Global Forum.

Top Project Achievements

The project's top achievements can be summarized as follows:

- THRP maintained HRH on the **national agenda** through consistent visibility in the media, leading HRH technical discussion with the MOHSW and coordinating the first national HRH conference
- THRP contributed to decreased health staff **vacancy rates** (from 45% to 36% across 54 districts)
- Seventeen percent of project districts dedicated **resources to HR activities** other than training (such as staff orientation and local incentives)
- Eighteen enrolled rural nurses successfully upgraded to registered nurses through a pilot **retention program** (blended learning)
- **HRIS data** were used to successfully advocate for increased health workers on Zanzibar
- A **local government human resources information system** was deployed in 154 districts and data were recorded for more than 81% of civil service staff (all cadres and not only health workers)
- **Human resources management practices** improved across several measures as a result of review of health worker management guidelines (central level) and their application at local government level (for example, new staff oriented, supportive supervision practiced)
- National orientation guidelines for new health workers were created and disseminated
- National guidelines for health staff developed and approved (*Staffing Levels for Ministry of Health and Social Welfare Departments, Health Service Facilities and Health Training Institutions, 2013*)
- More than 4,600 **para-social workers** were trained and deployed in their villages to provide psychosocial support to most vulnerable children

- A para-social worker professional **network** was established
- An increased number of **social welfare officers** were deployed to local government authorities in the regions of Dodoma, Mwanza, and Iringa/Njombe (from 22 in 2009 to 52 in 2013)
- THRP facilitated a formal **career path for PSWs**, taking advantage of the newly established social welfare assistant cadre
- PSWs provided support and referrals to nearly 36,000 **most vulnerable children**
- A **national social welfare workforce strategy** was developed
- BMAF is increasingly seen as a **leader in HRH** and a key development partner for the government of Tanzania and donors
- The Department of Computer Sciences at the University of Dar es Salaam is recognized regionally as a **technical resource** for open source human resources information systems and has the institutional capacity and entrepreneurial leadership to sustain national investments in these systems.

Key Challenges

- The lack of strong operational linkages across ministries responsible for health worker planning and recruitment (MOHSW, PMO-RALG, POPSM, and MOF) frequently impeded the implementation of HR policies for recruitment and deployment.
- District capacity for institutionalizing and formalizing best HRM practices (such as the ability to hire retired health workers) is limited.
- Health systems and service delivery interventions, focused on vertical disease programming, often work at cross-purposes, impeding collaboration on systems innovations.
- Weak health facility infrastructure and work environments (such as limited water supply, electric power, and staff housing) demotivate staff. In addition, weak logistics systems have contributed to erratic supply of drugs, medical supplies, and equipment for health services and laboratory diagnosis including HIV testing and provision of medical care.
- Data management systems are weak at all levels, but this is more pronounced at the district level. In turn, these weaknesses are accentuated by the limited functionality of the health management information system and the multiple monitoring and reporting expectations of different funding partners.
- There is a weak culture of data use upon which to make decisions and inform policy development.
- Limited budgets and competing priorities within districts frequently forced leaders to prioritize immediate tasks first, hindering effective systems initiatives.
- There are inadequate human resources in the health sector with planning, analytical, management and administrative skills.

Recommendations

The following key project recommendations reflect the THRP span of effort for strengthening Tanzania's HRH and social welfare workforce system. Many of the following recommendations are consistent with those developed during the national HRH conference. The themes of the conference mirrored THRP's scope and thus the recommendations coalesce. See Appendix 3 for a more in-depth list of HRH recommendations.

Cross-cutting priorities

- Coordinate and align HRH priorities across four key ministries: MOHSW, PMO-RALG, POPSM, and the MOF; for example, the MOHSW needs to rationalize the effort and resources used to produce more health graduates with the resources available to hire more staff (MOF), the determination of the number of new staff (POPSM), and the capacity to recruit, deploy, and employ new staff (MOHSW)
- Engage with the Ministry of Education to harmonize public resources dedicated to accredited universities (with medical and allied health schools) with public sector ability to absorb new graduates
- Identify accountability and operationalize, under the direction of the HRH Technical Working Group, the recommendations from the national HRH conference held in September 2013
- Develop an implementation plan with identified accountability for the national commitments declared at the Third Global Forum on Human Resources for Health in Recife, Brazil in November 2013
- Provide the HRH TWG with dedicated technical HRH expertise that brings a multisectoral approach to Tanzania's national HRH agenda and deliberations; this could be through a secondment position with the MOHSW
- Apply a systems approach when rolling out a new cadre of community health workers consistent with national policy; that is, engage a broad consultative process including perspectives from different sectors (finance, social welfare) to determine the financing, remuneration, scope, training, and performance expectations of community health workers and their integration into the existing system of health services
- Clarify how community-based social workers and justice volunteers are to be engaged in the national discussion of the community health worker cadre
- Strengthen social welfare as a priority for the MOHSW, fostering leadership in the Department of Social Welfare, maintaining social welfare on the agenda for health advocates, and including social welfare in the national discourse on community care
- Continue to strengthen local capacity in monitoring and evaluation, critical analytical skills, research and evaluation skills, and use of evidence to substantiate policy recommendations.
- Generate broad media campaign(s) for the general public to improve the image of health workers and potentially increase demand for facility-based services

- Test and apply appropriate technologies to strengthen consumer and client efforts to hold health professionals accountable for their presence in facilities and professional conduct

HR planning and recruitment

- Decentralize select recruitment processes to the local government authority level; strengthen the relationship and communications between local government authorities and local health training institutions to encourage graduates to remain in the area
- Strengthen competencies of staff in the MOHSW Department of Administration and Personnel for the recruitment and deployment of health staff
- Identify ways to acculturate managers at all levels in the health sector to use available evidence and data for planning purposes
- Standardize procedures and data entry responsibilities and institutionalize a quality improvement approach to strengthen the quality of HR data at the local government authority level
- Develop and implement a data quality assurance process that outlines standards and procedures for entering and verifying HR data across multiple HR information databases
- Empower POPSM to provide a concrete vision on utilizing an HRIS to minimize inefficiencies and enhance effective data use in making HR decisions; facilitate the necessary interministerial discussions that will result in alignment of the multiple HRIS
- Building on Tanzania's eHealth strategy, coordinate efforts to capture HR information across the lifespan of health workers as they come into contact with the health system; along with harmonization and coordination, develop a master provider registry, creating a master list of all health providers across Tanzania
- Conduct district-level censuses of health staff to verify and validate data in existing national HRIS
- Facilitate and/or streamline access by national and local decision-makers to HR information and related financial and service delivery information systems
- Align priorities to be outlined in the national production plan (under development) with the minimum staff complement proposed in the newly approved national staffing norms
- Expand current efforts to increase the annual recruitment of graduates from mid-level cadres and specialized professions
- Expand current efforts to prepare and deploy professional social workers within the local government authorities
- Advocate for filling social welfare assistant posts; local government authorities need to budget for and request the positions, PMO-RALG needs to coordinate requests with POPSM and the MOHSW, and POPSM has to approve the positions

- Continue to support the MOH of Zanzibar HRIS through upgrading the ministry's technical capacity (server) and expanding staff capabilities to take on even more sophisticated analyses such as monitoring progress of its production plan (through an electronic dashboard), engaging a fledgling private sector in health training, and tracking outmigration of health workers.

HR management and retention

- Expand implementation of Tanzania's national public service pay and incentive policy beyond 29 initial districts
- Recognize and support local government authority efforts to use their own resources to retain staff (local incentives mostly related to housing); institutionalize efforts to create an enabling environment for staff
- Strengthen local government authority initiatives to meet HRH needs in underserved communities
- Develop flexible arrangements to upgrade the skills of and develop career paths for lower-level staff (e.g., medical attendants), particularly those based in underserved areas; the MOHSW needs to engage the professional councils to recognize skills gained through experience rather than only through academic qualifications
- Scale up efforts to formalize task shifting efforts
- Focus on ways to blend learning for mid-level and lower-level cadres; assess current efforts to expand distance learning with health staff, particularly with lower-level cadres.

Performance management and productivity

- Align recognition, salary increments, and professional development opportunities with performance assessments, implementing OPRAS policy true to its stated purpose
- Reinforce supportive supervision practices with emphasis on individual performance expectations and facility performance
- Strengthen clients as consumers with media campaigns that outline the professional conduct expected of health professionals
- Institutionalize HR management training through expanded preservice curricula of health administration programs and through in-service continuing education opportunities for those in positions of HR decision-making and supervision
- Expand upon partnerships with local organizations—public, private, and civil society organizations—to increase the impetus for supporting district efforts in using HRM approaches.

INTRODUCTION: BACKGROUND TO THE TANZANIA HUMAN RESOURCE CAPACITY PROJECT

Tanzania is among the sub-Saharan African countries that the World Health Organization (WHO) classifies as struggling with an acute shortage of human resources for health (HRH). As of 2013, the health system in Tanzania was operating with 36% of the optimum workforce, with vacancy rates in rural areas up to 70% (MOHSW 2013a). The Tanzania Human Resource Capacity Project (THRP) was conceived in the face of this and myriad other HRH challenges, including:

- Inadequate numbers of qualified health workers and social welfare workers, particularly in rural areas
- Mismatches between needed health worker competencies and the skill sets available
- Inaccurate or incomplete data about the health workforce, hampering workforce planning and decision-making
- Retention problems, including outmigration of trained providers and shifts of managers between sectors
- Slow and inefficient recruitment, hiring, and deployment processes
- Weak human resources management (HRM) systems for the health workforce.

Collectively, these challenges leave health facilities understaffed and/or staffed with unmotivated workers or health workers lacking the needed skills. These factors in turn compound the struggle to reduce the burdens of a high maternal mortality rate, malaria, and HIV as well as social consequences related to HIV/AIDS. In this context, children without parental support are particularly vulnerable.

Capacity Project

The USAID-funded global Capacity Project led by IntraHealth International began working with the Government of Tanzania (GOT), including Zanzibar, in 2006 to strengthen its response to the HRH shortage and related challenges. Major project components focused on strengthening national HRH capacity and leadership; conducting studies on health worker retention with the National Institute for Medical Research (NIMR) and on productivity in Zanzibar; complementing Tanzania's emergency hiring program (implemented by BMAF, the Benjamin William Mkapa HIV/AIDS Foundation) with the development of an HRM toolkit and strengthening HR

Workplace Climate

Tanzania's Ulanga District faced shortages of health workers at every service delivery level. The district implemented a workplace climate improvement (WCI) initiative in 14 public sector facilities with support from the global Capacity Project to improve morale and performance. The aspects targeted for improvement included management practices for facility managers and the work environment for health workers in frontline facilities. Health workers confirmed that facility functioning improved in the 12 months of WCI implementation (2008). The initiative documented increases in the proportion of health workers reporting availability of workplans (51% to 80%), constructive feedback (77% to 92%), and provision of an expanded scope of outreach services (55% to 96%).

management efforts in 20 districts; piloting a continuing education and distance learning program for nurses in Masasi; and piloting a program to address the most pressing challenges of delivering social welfare services to most vulnerable children (MVC) at the village level.

Capacity worked with the Zanzibar Ministry of Health (MOH) to improve health service delivery, efficiency, and system performance. Following a health worker time utilization study, which found that less than half of health workers' time was spent on direct patient care and nearly a quarter waiting for clients, in-country partners decided to focus on improving productivity at the primary health care level. The project worked with key stakeholders on the agreed set of productivity improvement interventions, which included simple facility-driven interventions such as improving signage, posting facility hours, completing daily workplans, instituting weekly meetings, and completing community outreach forms to monitor the balance of health worker activities. Capacity designed additional interventions to strengthen the technical working groups at the MOH and facilitate ownership for the interventions implemented at the facility and district levels within Zanzibar's health system.

Capacity also provided technical assistance to the Christian Social Services Commission (CSSC) and its network of dioceses, hospitals, health centers, and dispensaries beginning in 2006 in an effort to improve data collection and analysis of all faith-based organization (FBO) health facilities, health care staff, and programs. Using geographic information system (GIS) mapping and data on over 15,000 health care providers and 850 facilities, senior CSSC staff were able to more effectively advocate for additional resources with Tanzania's Ministry of Health and Social Welfare (MOHSW). This activity laid the groundwork for integrating compatible human resources information systems (HRIS) to assist with national health assets planning and policy development.

Finally, building on an assessment of staffing needs for the provision of care for MVC, IntraHealth and Capacity entered into a partnership with the Institute of Social Welfare to pilot a program to develop a new cadre of para-professional social workers.

Tanzania Human Resource Capacity Project

These Capacity Project initiatives built a foundation for the THRP to strengthen and scale up central and district-level interventions, shifting from an emphasis on HRM toolkit training to a more comprehensive focus on competencies. The aims of the THRP (2009–2013) were to apply tested approaches (with correspondingly less emphasis on research), engage the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG) in efforts to revise recruitment and deployment processes, and build the capacity of local organizations to lead these efforts.

Solely funded by USAID, THRP worked within the scope of Tanzania's national HRH strategic plan, focusing on five of the plan's seven strategic objectives. Appendix 1 maps how THRP strategies contributed to each HRH plan strategic objective. Specifically, USAID charged the THRP to confront the systemic challenges of Tanzania's HR crisis by:

1. Assisting the MOHSW and PMO-RALG to orchestrate implementation of the national HRH strategy and HR components of the Health Sector Strategic Plan III (HSSP III)
2. Strengthening the capacity of national and local government authorities to predict, plan for, and recruit the health and social welfare workforce
3. Improving the deployment, utilization, management, and retention of the health and social welfare workforce
4. Increasing productivity of the health and social welfare workforce.

IntraHealth created an innovative partnership whereby leading Tanzanian organizations came together under a local partner coalition to play key technical and implementation roles on the project, with international partners offering strategic technical and operational support. This was a new model for USAID/Tanzania and one that holds potential for future efforts to transition to greater direct funding of local organizations. The local partnership included BMAF, CSSC, the University of Dar es Salaam (UDSM), and the locally-registered branch of the Aga Khan Foundation (AKF), with critical technical assistance provided by Training Resources Group (TRG), IMA World Health, and Management Sciences for Health (MSH). The success of the project also resulted from close collaboration across several ministries including the MOHSW, the PMO-RALG, and the President's Office Public Service Management (POPSM).

CHAPTER ONE: STRENGTHENING TANZANIA'S CAPACITY TO RECRUIT, MANAGE, AND RETAIN ITS HEALTH CARE WORKFORCE

Background

Many governments, including Tanzania's, are deficient in their ability to plan, develop, and support their health and social welfare workforce. Many also lack reliable and up-to-date human resource information to make strategic decisions about meeting current and future workforce needs. Factors accounting for these shortcomings in Tanzania include insufficient planning capacity to predict HRH needs, uncoordinated decision-making at central levels, and government financial constraints (THRP 2011a).

Effective HRM systems and practices are essential for attracting, retaining, and increasing the productivity of a health care workforce. The importance of an improved HRH management system is fundamental in Tanzania, where citizens endure less than optimal quality health care due to the absence of appropriately skilled health workers. According to the HSSP III (2009–2015), 2009 staffing levels for the health sector were at 35% of the actual need. Tanzania has particularly high health and social welfare worker shortages in rural areas, with deficits of 70% or more for some cadres. Reasons include limited production of clinical cadres, internal migration away from unattractive areas, imbalanced staff deployment, high attrition compounded by the HIV epidemic, and the absence of systemic policies and best practices to influence staff retention in remote areas. Tanzania struggles 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, malaria, maternal and child morbidity and mortality, and other diseases that severely curtail life expectancy in Tanzania (THRP 2010a).

THRP and Human Resources Management

The THRP worked under the auspices of the HSSP III, which identifies health workers as one of 12 priorities, and the national HRH strategic plan, which focuses on planning, production, management, and financing of health sector staffing needs. Over the four years (2009–2013), BMAF (as the lead implementing partner) collaborated with the GOT to institute and sharpen



HRM systems and practices among district authorities. THRP interventions were two-fold, involving both central-level advocacy and district-level intervention in 54 project districts in eight regions.¹

Central level: THRP identified and removed policy barriers and strengthened coordination and communications among and within central government entities with HRH responsibilities.

¹ Ruvuma, Mtwara, Iringa, Kagera, Mara, Mwanza, Shinyanga and Lindi.

District level: THRP challenged district health managers within the local government authorities (LGAs) to introduce HRM practices that attracted new employees and improved staff productivity and retention.

THRP's comprehensive approach took into account central-level inefficiencies and their practical implications at the LGA level, recognizing that policies formulated at higher levels cascade down to lower levels. THRP influenced modification of key central guidelines documents that directly affect HRH recruitment, retention, and deployment in LGAs but also brought local feedback on the realities of implementing HRM policies back to the attention of the MOHSW HRH Technical Working Group, the entity with oversight responsibility for the national HRH strategic plan. Other central-level THRP initiatives (discussed more comprehensively in Chapter Two) included influencing the addition of HRH targets and indicators in the annual Comprehensive Council Health Plan (CCHP) guidance, providing input into the revision of health sector staffing norms, supporting the review process for supportive supervision guidelines, and developing an orientation package for newly deployed health workers.

Baseline Study: HRH Management Systems at District Level

In order to design and implement appropriate interventions to address current and emerging HRH challenges, the THRP collaborated with the MOHSW on a baseline assessment examining current HRM systems and practices. The assessment findings were used as a benchmark but also to guide which interventions would best improve staff retention, work climate, and HRM information systems in project districts. The baseline assessment was conducted in 13 districts of Mtwara, Lindi, and Iringa regions from April–May 2010, with key findings summarized in Table 1.

Table 1: Key Findings from Human Resources Management Baseline Assessment in 13 Districts

Area	Key Findings
Hiring	<ul style="list-style-type: none"> The system of hiring both highly skilled and less-skilled health workers was highly centralized, which contradicts Tanzania's policy of "decentralization by devolution" giving authority to LGAs.
HRM planning and budgeting	<ul style="list-style-type: none"> None of the districts had stand-alone HRM annual operational plans or sustainable budgets to support HRM activities. Each district's CCHP included an HRM section, but it lacked detail and was used for simple budgeting rather than for planning purposes.
HR data updates	<ul style="list-style-type: none"> Although all 13 districts maintained employee data, data updates occurred irregularly and primarily at the initiative of individual employees. The main source of staff data was the seniority list (Tange list), updated annually during annual planning and budgeting.
HRIS	<ul style="list-style-type: none"> None of the districts had computerized human resources information systems, making it difficult to retrieve information for decision-making.
Health worker positions	<ul style="list-style-type: none"> There was a severe shortage of skilled health workers in the assessed districts (overall vacancy rate of 45% in the 2009–2010 fiscal year). Shortages were observed more for professional cadres (i.e., doctors, nurses, and pharmacists) than nonprofessional cadres (i.e., medical attendants).
Salaries	<ul style="list-style-type: none"> Eight out of 13 district councils (62%) reported that new staff members received their salaries between two and three months after joining the district.
Contract employees	<ul style="list-style-type: none"> Council health management teams were not familiar with national policy for hiring retired health professionals nor with guidelines for recruiting retirees on contract terms. As a result, the teams were not recruiting available retirees looking for contract employment to fill staffing gaps.

Area	Key Findings
In-service training plans	<ul style="list-style-type: none"> All districts provided training opportunities for staff, and 88% of health workers interviewed reported availability of training opportunities. However, no district had conducted training needs assessments to guide their training plans. In-service training was limited to MOHSW generic courses and nongovernmental organizations supporting districts in health care service delivery.
Job descriptions	<ul style="list-style-type: none"> Half (49%) of health workers did not have a job description, and 36% reported having a generic job description that did not reflect the tasks the health workers were actually doing.
Performance review	<ul style="list-style-type: none"> The Open Performance Review and Appraisal System was not implemented appropriately in the districts, although many staff members were aware of it. Seventy percent of health workers interviewed reported they had not done performance reviews with their supervisors in 2009. There were no formal established mechanisms for rewarding or sanctioning staff based on performance. The only mechanisms for rewarding staff, common to all districts, were best worker and hard worker awards.
Incentives	<ul style="list-style-type: none"> Districts lacked formal incentive packages for health workers. Commonly mentioned incentives provided on an ad hoc basis (depending on fund availability) included night duty allowances, responsibility allowances, and housing allowances.

District Strengthening Approach

THRP interventions at the district level focused on fortifying HRM capacities in leadership and management and strengthening health management systems. THRP developed a comprehensive training and coaching approach (including development of an HRM training manual) that it used to cultivate local HR experts, train senior district officials, and facilitate supportive supervision dedicated to HR planning and management. The project developed a cohort of 37 individuals from council health management teams (CHMTs), regional health management teams (RHMTs), zonal health resource centers (ZHRCs), and the private sector to become HR experts and strengthen HR management efforts within regions and districts. The initiative aimed to develop and support HRH champions with the skills, attitude, and authority to articulate HR issues and build, advocate for, and provide guidance on appropriate strategies. Trained as trainers, these experts then facilitated HRM training at the district level, providing the MOHSW and PMO-RALG with a pool of local HRH/M experts. The local HR experts also coached and mentored district staff on HR management.

Through this process, the CHMTs set up plans that increased HRM activities in the annual district budgets, applied the revised supportive supervision tool to conduct supervision at health facilities, and developed local incentive packages to attract and retain health workers in their respective districts.

By carrying out interventions with the LGAs, the THRP's district strengthening initiative embedded itself into the PMO-RALG's operational structure. To complement its district-level interventions, THRP helped develop central-level HRH systems to enhance coordination among key ministries (particularly MOHSW, PMO-RALG, and POPSM), develop capacity of HRH champions, and develop HR leadership skills. THRP fostered interministerial coordination through its participation in the HRH Technical Working Group that also had representation from many partners, including USAID, the US Centers for Disease Control and Prevention (CDC), the Canadian International Development Agency (CIDA), Japan International Cooperation Agency (JICA), German Organization for Technical Cooperation (GTZ), and civil society organizations

(CSOs). This high-level coordination evolved into joint preparations for Tanzania's first national HRH conference, national commitments that evolved from the conference, and an official interministerial delegation that attended the Third Global Forum on HRH in Recife, Brazil in November 2013.

District-level HRH assessments

Under BMAF's leadership and with IntraHealth technical assistance, THRP identified knowledge gaps and addressed technical and operational challenges to strengthen the capacity of HRH management at the district and central levels.

The project undertook several assessments to expand central and district-level officials' understanding of local HRH management issues. The assessments included the baseline HR assessment in 13 districts, a recruitment bottlenecks study, and an assessment of the GOT's open performance review and appraisal system (OPRAS) (a public-sector staff appraisal system introduced in 2004). Recommendations from these studies informed the improvement of national HRH policies and guidelines. As detailed above, the baseline assessment identified several areas—including staff planning, staff information management, orientation, and supportive supervision—where district-level HRM systems could be improved (THRP 2011a). THRP designed its HRM or district strengthening approach accordingly, focusing on building the capacity of LGA decision-makers to use HR data for staff planning and introducing guidelines for orienting new health workers and for HR-specific supportive supervision.

The recruitment bottlenecks study (THRP 2010b) found that—in addition to poor infrastructure—institutional and organizational arrangements, poor follow-up, and limited accountability hindered the successful deployment of competent health workers to rural districts. The study recommended a review of policies and guidelines to foster increased efficiencies in recruitment and retention. The OPRAS assessment (THRP 2010c) reported that the official appraisal system was not effective in instituting and encouraging employee performance, largely due to an underdeveloped performance culture in Tanzania. The assessment also found that the OPRAS form was complicated and lacked a systematic linkage between employee productivity and merit-based rewards. Prior to THRP intervention, a four-country study conducted by the African Medical and Research Foundation (AMREF) and MSH found that 78% of respondents with HRM-related responsibilities in Tanzania expressed the need for sharper skills in areas of HR policy, performance management, management of staff training, HR data systems, and general leadership and management (AMREF 2009).

District Policies and Planning

The annual Comprehensive Council Health Plans (CCHPs) are the districts' annual policy and planning guidelines for monitoring and evaluating the district-level performance of the health sector. After THRP carried out interventions in 54 LGAs in eight regions (Lindi, Mtwara, Iringa, Ruvuma, Mwanza, Kagera, Shinyanga and Mara), the CCHPs in the 54 districts began including deliberate and detailed employee orientation plans, retention tactics, workspace improvements, and initiatives to increase supervision of professional conduct.



Human resources management and HR toolkit

THRP developed a comprehensive program to address management issues within the span of LGA control. During the early project years and in close collaboration with the MOHSW, THRP developed a toolkit of user-friendly tools specific to Tanzania for carrying out interventions to address HRM challenges. MSH provided critical technical assistance during this phase. The foundation of the HR toolkit is a

comprehensive HRM training manual (THRP 2013a) with 13 modules to guide and improve HR management practices. The training manual focuses on specific components of HRM systems such as workforce planning, HRIS, recruitment, deployment, performance management, and health worker retention.

THRP trained 37 local HRM experts working with the ZHRCs in Iringa, Mwanza, and Mtwara regions to conduct HRM trainings in the 54 project districts. The team of local HRM experts in turn trained members of the CHMTs. During the CHMT trainings, participants developed action plans to apply improved HRM practices to their respective districts and formally committed to deliver 50% on their plan targets within 18 months following the training (THRP 2013b). Through subsequent coaching and mentoring visits, the local experts provided continuous support to members of the CHMTs and followed each CHMT's progress toward achieving its commitments to implement HRM norms.

Separate THRP-sponsored training events, also with the CHMTs, focused on key HRM elements such as strengthening the implementation of OPRAS and the HRH component of the national supportive supervision guidelines. Knowledge-sharing workshops were another mechanism to provide continuous support to CHMT efforts. The workshops brought together CHMT members from districts that shared nearly similar HRH management challenges to allow decision-makers to learn from each other, exchange achievements, and share best practices and challenges in their application of improved HRM.

Results

THRP supported efforts in 54 districts to contend with specific HRM challenges through a comprehensive approach involving the HRM toolkit of guidelines and manuals (HRM district strengthening manual, orientation package, HRM supportive supervision); training, coaching, and mentoring; job fairs (to encourage health graduates to apply for available posts in the public sector); OPRAS reinforcement; and advocacy to implement local incentives. The complementary interventions resulted in central adoption of HRM guidelines applied to the district level. The following discussion provides evidence of districts' improved capacity to attract, recruit, retain, and improve the productivity of HRH.

HRM RESULTS AT A GLANCE

- ❖ **Districts have prioritized HRH within district budgets.**
- ❖ **Improved recruitment processes have reduced vacancy rates.**
- ❖ **New employees receive a structured orientation in accordance with the newly developed orientation guide.**
- ❖ **LGAs now create incentive packages to attract and retain new staff.**
- ❖ **CHMTs have begun conducting designated HRH supportive supervision.**
- ❖ **Mid-term and annual performance reviews are conducted more frequently.**

District budgets

Through engagement with the MOHSW, THRP successfully advocated for inclusion of clear HRH actions in the national CCHP guidance that was under review as an early action in the MOHSW's National Human Resources for Health Strategic Plan (2008–2012). THRP assisted the MOHSW to incorporate HRH priority areas, targets, and indicators into the revised national guidelines for development of the annual CCHP. The revised CCHP guidelines were completed in June 2010. The HRH targets and indicators require districts to budget to fill at least 30% of the HRH gap; prioritize specific cadre gaps and forward requests to POPSM;

increase the number of skilled staff in the district by at least by 10%; ensure that 70% of health facilities have at least 30% of the required mix of skilled staff; and orient all new and promoted staff on their roles and responsibilities.

The targeted LGAs used the CCHP guidelines to develop a chapter in their annual plans dedicated to staffing. The HRM training included activities for participants to create clear HR targets and management actions in their respective district plans, project their staffing needs, and advocate with central government for staff deployment to their districts. CHMTs from the 54 project districts made measurable commitments that reflected health worker management targets and indicators in the CCHP guidelines. Through subsequent coaching and mentoring visits, THRP tracked the progress made on each agreed-upon indicator and worked with district leadership to devise solutions to operational difficulties.

Reflecting improved health management skills, CHMTs in all 54 project districts achieved 50% of their action targets within 18 months of completing the HRM training (THRP 2012a). Additionally, by the end of the project, 39 out of 54 intervention districts had increased the number of HRH priority activities, including offering new employee orientation, completing OPRAS forms, performing HRH supportive supervision, and establishing retention incentives (THRP 2013a) (discussed further below). As numerous coaching and mentoring reports note, however, districts are still challenged by delayed information about their budgets (if approved, when funds will arrive) and lower budget ceilings than originally planned for.

Recruitment processes

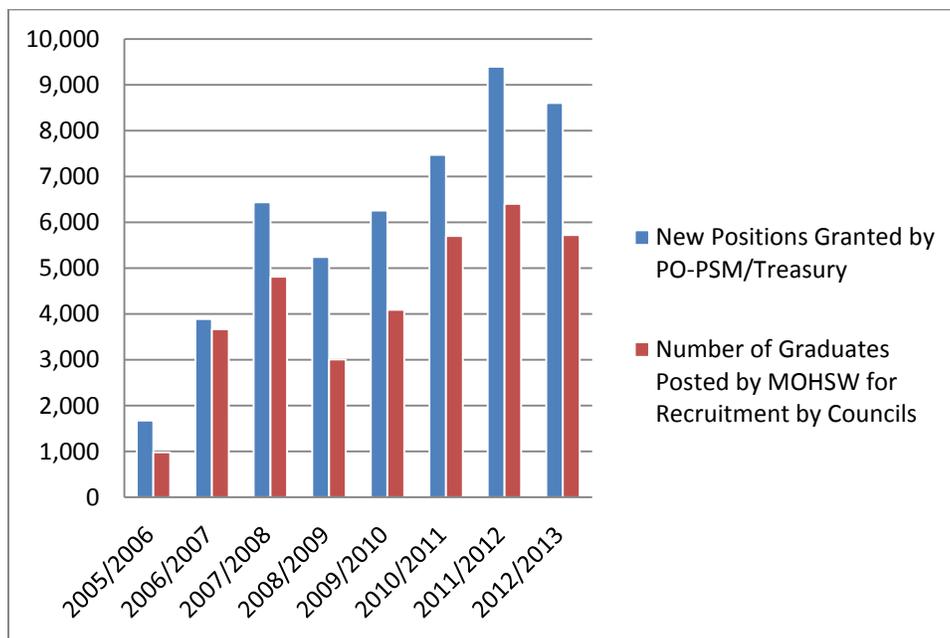
Several ministries share responsibility for recruiting health workers in Tanzania. Initiating the process, the PMO-RALG oversees district planning and advocacy for health staff. The POPSM reviews district staffing projections and fiscal alignment and sets annual work permit limits. The

MOHSW manages staff recruitment and postings. THRP worked with senior-level stakeholders—particularly within POPSM and the Department of Administration and Personnel of the MOHSW—and the LGAs to address bottlenecks and inefficiencies as identified in the recruitment bottlenecks study (THRP 2010b).

With the experience of developing detailed HR plans as part of the annual CCHP, senior district leaders have become better able to advocate with central authorities responsible for staff allocation and recruitment. LGAs now specify which cadre of health personnel is a priority for recruitment; they also can provide a profile of their district, highlighting what incentives are available locally to attract staff candidates. Moreover, LGAs can support their requests for more staff permits with data from the local government human resource information systems (LGHRIS) installed in each district. By the end of the project, 48 out of 54 districts had installed HRIS hardware and software and had HR managers making routine use of the data. This stands in contrast to the situation observed during the baseline assessment, where staffing data were rarely used to make HRM decisions. LGAs have implemented another simple but effective change to improve the recruitment process, asking job applicants to provide mobile numbers and email addresses to facilitate communication and timely reporting.

The cumulative result of these improvements has been to lower vacancy rates in the 54 THRP-supported project districts (THRP 2013c). Figure 1 shows health worker recruitment trends in the country as a whole (2005–2012), and Figure 2 shows trends in the THRP project districts over the project period (2009–2013). It should be noted that slight decreases or steadiness of vacancy rates in the 54 rural districts actually reflect improvements in recruitment and/or retention in light of the alarming attrition of health workers previously experienced by these districts.

Figure 1: Health Worker Recruitment Trends, 2005/2006–2011/2012



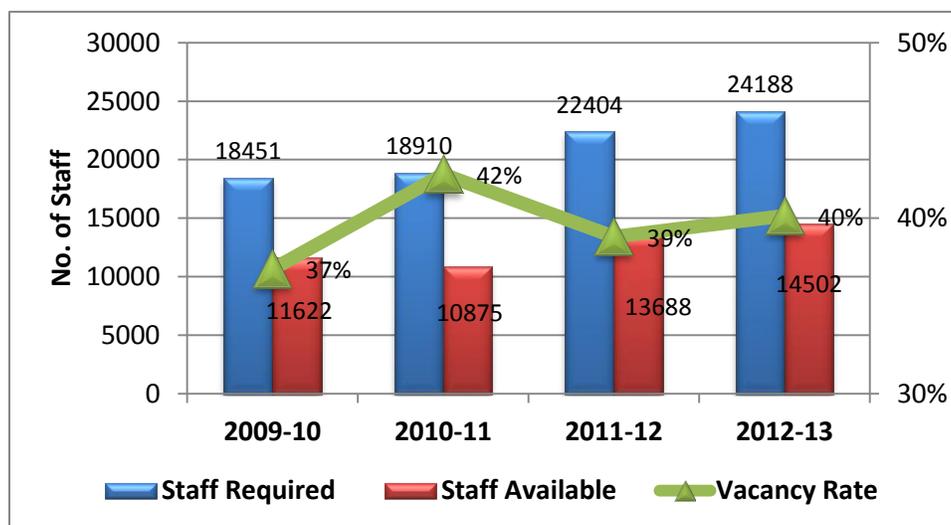
Source: MOHSW 2013a. Human resources for health country profile 2012/2013, p. 36.

Vacancy rates

An analysis of the CCHPs that compared data for 2009/2010 and 2012/2013 by facility level showed a slight fluctuation in vacancy rates but an increase in overall staff availability. Vacancy rates remained essentially constant in hospitals and health centers but went down in dispensaries, from 52% to 49% (not shown).

During the project period Tanzania increased the number of health centers and dispensaries across all districts. Although the absolute number of health staff increased, the government could not keep up with the need. Tanzania now has to confront the challenge of meeting expectations stated in the new staffing norms (discussed in the next chapter), which increase the staff requirements for each facility. Even as Tanzania successfully deploys increased numbers of health staff to LGAs, vacancy rates will not be substantially impacted.

Figure 2: Staff Shortage Trends 2009/2010 through 2012/2013, THRP Project Districts



During the project period, the district CHMTs were consistently short a member. In 2012/2013, however, the average vacancy rate for the eight-member CHMTs in the project regions was 11%, an improvement from the average CHMT vacancy rate of 28% in 2009/2010.

The average vacancy rate for all health cadres in the eight regions increased from 37% in 2009/2010 to 40% in 2012/2013. The analysis indicates that this is due to the increased number of health facilities and services without concordant increases in staff. The highest vacancy rate was recorded in Mtwara (52%), followed by Mara (44%) and Ruvuma (41%).

In 2012/2013, mid-level cadres were in shortest supply, with increased vacancy rates over the 2009 levels. Vacancy rates were highest for occupational therapists (82%), followed by assistant dental officers (65%), opticians (61%), laboratory technicians (57%), pharmacists (49%), and nursing officers (48%). Medical attendants had the lowest vacancy rate (5%).

New employee orientation

The MOHSW has a policy requiring a formal orientation for all posted staff. The ministry understands that unclear job expectations and weak or uncoordinated induction contribute to

"If it was not for a very hospitable human resource officer, I would have gone back. If that system went on, many more people would have quitted their government jobs even before starting them."

– Sezaria Andrew, member of CHMT in Iringa Municipal, discussing the importance of proper orientation for new staff.

low health worker reporting and retention rates. Previously, however, the policy had not been operational due in part to a lack of standardized guidance (including checklists) on how to orient staff. The THRP baseline study found that only one district had a new staff orientation guidance document.

In close coordination with the MOHSW, PMO-RALG, select LGAs, and the Tanzania Public Service College, THRP developed standardized guidelines for orienting new staff. The *Orientation Package of*

New Employees of the Local Government Authorities in the Health Sector in Tanzania provides step-by-step guidelines to familiarize new staff with their work environment, from the point of central-level recruitment to the district level and eventually to the specific health facility level (MOHSW 2013b). Applying these structured guidelines not only adds clarity and consistency in settling in new staff but establishes expectations for ethical conduct and performance excellence. By the end of the project, 49 out of 54 targeted districts had introduced stronger and more consistent orientation practices for new employees (THRP 2013b). The MOHSW endorsed the orientation package in 2013.

Local incentive packages

THRP engaged different stakeholders to identify what qualifies a locality to be defined as *disadvantaged* or *underserved*. The discussion is politically sensitive and far from conclusive. THRP synthesized experiences from the field with previous research and different multisectoral perspectives to produce the publication, *Multisectoral Criteria for Defining Underserved Areas* (THRP 2012b). The



publication describes LGA innovations to encourage health workers to stay on the job in rural areas, provides a critical analysis of existing contextual incentives with reference to WHO guidelines (WHO 2010) and lessons learnt from other countries, and concludes with recommendations on criteria to define underserved areas. The document also includes guidance for designing locally appropriate and affordable monetary and nonmonetary incentives for health workers.

During HRM district strengthening trainings led by THRP, districts committed to developing an incentive package to attract and retain skilled staff. During follow-up coaching and mentoring visits, the HRM experts encouraged CHMTs to initiate their own incentives to complement the

primary central government incentive (funding for construction of staff houses to improve working conditions). Commitment from district leadership was the common trend in all districts with retention program success. By June 2013, 16 out of 54 districts had implemented some type of local incentive strategy (see Appendix 2). For example:

- Makete District provides mattresses and blankets for new staff
- Ukerewe District houses new staff in a local hostel or provides six months' rent
- The Iringa municipality provides a month's salary advance and facilitates timely entry into the government payroll system.

HR supportive supervision

Bringing attention to the need for HRH supportive supervision was a key component of THRP's comprehensive district strengthening efforts. The THRP baseline study (THRP 2011a) noted a lack of depth and clarity in reporting HR management issues at health facilities and within LGAs, suggesting that HR management urgently needed CHMT attention. Through engagement with CHMTs, THRP advocated for clear management actions and indicators to focus CHMT decisions and actions. All 54 project districts were introduced to the revised national supportive supervision guidelines, which emphasize the HR component of supportive supervision in LGAs. As a result, Iringa municipality implemented a requirement that HR meeting minutes be reviewed during CHMT supervision visits; the Health Secretary subsequently reported fewer HR-related grievances because many are now dealt with at facility meetings. Iringa municipality, appreciating the importance of detailed HR supervision, has designed a specific HR supportive supervision process, scheduled quarterly. According to a special assessment by BMAF, by the end of the project, 43 (75%) of the district health management teams had implemented an HRH supportive supervision system.

OPRAS

OPRAS, introduced in 2004, fosters openness through feedback and frequent communication between supervisors and supervisees. However, rollout to individual employees previously had stalled due to a lack of understanding of the purpose of an appraisal system and the links between performance, merit, and remuneration (THRP 2010c). In 2009, the THRP baseline study (THRP 2011a) reported that 70% of health workers interviewed did not engage in performance reviews with their supervisors. With such low adoption of the OPRAS, PMO-RALG requested that THRP include operationalization of OPRAS among its activities.

During the first national HRH conference, participants described some of the challenges associated with OPRAS, including the lack of punitive action for noncompliance and a lack of appraisal by peers. Among the conference recommendations was the need to further improve accountability for performance management. Conference participants also recommended that OPRAS become something more than just completing forms, for example, by making salary increments and career progression truly contingent on performance assessments.

THRP's OPRAS-related activities involved advocating for and facilitating compliance with the system. THRP and key stakeholders designed and implemented several remedial interventions,

including clarifying the roles of supervisory and managerial staff and employees. POPSM also centrally instituted a policy to enforce compliance. Under the new policy, no recommendations for promotion of civil servants can be considered unless they are accompanied by three consecutive years of comprehensive OPRAS assessment forms. Consequently, half of the project districts (27) now use OPRAS and 87% of employees in these districts have completed their annual performance review (THRP 2013d).

Work environment

Work climate improvement strategies were among the actions and indicators included in the revised CCHP guidelines. In turn, CHMTs in project districts were encouraged to include work climate activities and indicators in their supportive supervision checklists. THRP conducted a baseline assessment to examine HRM practices and working environments in all 27 health facilities in two districts to identify potential interventions for improving health worker productivity as well as the quality and efficiency of health care services (THRP 2013e). In the area of productivity, the assessment found that clients spent more time waiting for than receiving services from health workers, and up to 23% of staff time was used unproductively. Describing the work environment, staff reported a lack of recognition or appreciation of their work and insufficient working tools. THRP subsequently worked with the CHMTs to review specific work environment issues in more depth and identify potential actions to remedy inefficiencies that contribute to low retention rates of priority cadres. A BMAF analysis helped define criteria for identifying hard-to-reach areas and documenting incentive strategies to retain health workers. The study provided a reference for criteria to use in determining locally appropriate and affordable incentives to attract health workers in areas categorized as hard to reach (THRP 2012b).

Summary

Table 2 summarizes the key achievements resulting from THRP's district strengthening approach over the project period.

Table 2: Key Achievements in 54 Project Districts, by Type of Intervention, 2009–2013

Intervention Focus	Key Achievements
District budgets	<ul style="list-style-type: none"> - Chapter dedicated to staffing in annual LGA budget plans - 50% of CHMT action targets achieved within 18 months of HRM training (all 54 districts) - Increased number of HRH priority activities in most districts (39/54)
Recruitment	<ul style="list-style-type: none"> - LGHRIS installed in 48/54 districts - Growth in health workforce in project districts, from 18,451 to 24,188 (2009–2013), although vacancy rates decreased slightly - Up to 50% of health workforce positions filled in 32/54 districts
Orientation	<ul style="list-style-type: none"> - More focused new employee orientation practices introduced in 49/54 districts
Local incentives	<ul style="list-style-type: none"> - Local incentive strategy implemented in 16/54 districts
Supportive supervision	<ul style="list-style-type: none"> - Orientation on revised supportive supervision guidelines provided to CHMTs (all districts) - HRH supportive supervision systems implemented (43/54 district health management teams)
OPRAS	<ul style="list-style-type: none"> - OPRAS regularly used in half of project districts (27/54) - Annual performance reviews completed by most (87%) employees in the 27 districts using OPRAS

Sustainability

From the beginning of the project, THRP implemented activities within the existing structures of its government partners—PMO-RALG, MOHSW, and the implementing LGAs. Local organizations in the consortium carried out the activities, developing their own skills as well as those of their government counterparts. By working with and within the government structure and within Tanzania’s existing policy framework, the project influenced policy change and made technical contributions to revise HRH management processes both at the central level (MOHSW, POPSM, PMO-RALG) and in LGA CHMTs. In addition to contributing to the short-term achievements summarized in Table 2, the technical assistance provided by THRP at the macro policy and LGA levels is likely to continue to bear fruit in the long run.

Under THRP, 54 districts tested the new staff orientation package. The MOHSW subsequently reviewed, published, and adopted the package and will soon disseminate it to all LGAs nationwide. Following earlier efforts of the USAID-funded global Capacity Project in HRM training and assessment of recruitment bottlenecks, the THRP contributed to and facilitated implementation of several key components of the national HRH strategy and the HR elements of the HSSP III. Through THRP’s technical contributions and review of the national CCHP guidance, HRH visibility has increased. HRH considerations now need to be planned for and reported against by each district in its annual CCHP (BMAF 2013). In the same vein, THRP’s gains on OPRAS compliance have been strengthened by the POPSM directive stipulating that three consecutive years of comprehensive OPRAS assessments need to precede all recommendations for promotion. This requirement will intensify interest among managers, supervisors, and staff to implement OPRAS.

Lessons Learned: District Strengthening

THRP set out to strengthen LGAs’ capacity to plan, budget for, and recruit health and social welfare staff while improving the HR management practices needed to retain this workforce and improve its productivity. Many lessons learned relate to efforts to sustain the interventions, share knowledge gained, and strengthen partnerships. The overarching operational approach of the project involved complementary interventions at both the central and district levels. There are four key lessons learned:

1. LGA involvement in recruitment can increase new staff reporting and retention.

Specific forms of LGA involvement included preparation of district profiles, follow-up with posted staff through mobile phones, and involvement of districts in local recruitment initiatives (e.g., lobbying students attending medical colleges in LGAs to stay and work in the area, taking part in job fairs).

2. Capacity building is a continuous process that requires targeted training to address key skills and process gaps, and focused coaching and mentoring on operational gaps.

The HRM training process involved identifying skill gaps, developing a task-oriented methodology, reviewing guidelines, and developing action plans. Engaging local resources and stakeholders to manage implementation as “change champions” was effective. Coaching and mentoring enabled timely identification of challenges to implementing plans for

improvement and facilitated collectively-owned solutions. This process promotes accountability, continuous capacity building, local ownership, and sustainability.

3. To decrease staff shortages, training institutions and LGAs need to share HR information.

Regular sharing of information about LGA needs (vacancy rates) and planned health worker production from local health training institutions can assist in aligning workforce supply and demand at the local level. Proactive district authorities and job fairs, for example, can counter myths and incorrect assumptions among health workers about working in underserved areas.

4. It takes a comprehensive set of HRH interventions to facilitate change.

THRP successfully deployed multiple methodologies such as job fairs, knowledge sharing, and coaching and mentoring to strengthen different aspects of Tanzania's HR system. While none of these interventions are new per se, they had not been comprehensively used in HRM interventions in the country previously. Consequently, the overall approach has been adopted and applied by the MOHSW in rolling out its HR systems-strengthening effort nationwide through the Global Fund.

Orientation of New Employees Boosts Job Satisfaction in Iringa Municipal Health Facilities

There is a world of difference between how Sezaria Andrew was oriented and how she welcomes and guides new employees to settle into their new jobs in her current role as Iringa Municipal Reproductive Health Coordinator and member of the Council Health Management Team (CHMT). "In the old days, orientation was not done systematically," she says.

When she arrived in Iringa, fresh from college, Sezaria was immediately assigned as "in-charge" at Ipagala health center. At the time, she did not know where Ipagala was or what the expected role of an in-charge of a rural health center was. Luckily, Ipagala turned out to be just on the outskirts of Iringa town. Other rural health workers have been equally stymied by the impersonal instructions they receive before finding their way to rural duty stations in an area of the country with which they are unfamiliar. Sezaria says, "If it was not for individual efforts of the human resource officer, I would have gone back (home)."

Under the Tanzania Human Resource Capacity Project, the Benjamin William Mkapa HIV/AIDS Foundation (BMAF) and IntraHealth carried out district strengthening interventions that helped health management teams improve their practices in recruiting, managing, and retaining health workers. Under the project, BMAF and the Government Employee Training College jointly developed an orientation package that was ultimately endorsed by the MOHSW.

Now, new staff members are oriented by a team of people who are prepared to welcome them. Upon arrival they meet the district medical officer (DMO), who takes them to the human resource office. Then they receive a letter, with a job description attached. The same job description is sent to the in-charge of the health center where the new staff member is posted. In the Iringa municipality, the Health Secretary orients new staff on their work, general work rules, how to channel their grievances, and who to come to see at the municipal office when they need support.

"We assign new staff in centers closer to the town. When they have stayed for at least a year and get to know how to get around and appreciate the region, then we can transfer them to remote health facilities," says Sezaria.

Three health centers in Iringa are designated for orienting college graduates to their likely working environment. Besides standard requirements stipulated in the orientation package, Iringa municipality created its own initiatives to eliminate inconveniences of reporting to a new work station. Consequently, new staff may find reasons to remain at their facility for a long time. The initiatives include giving salary advances to new staff to sustain them as they settle into a new environment, paying subsistence allowances, and prioritizing them in on-the-job trainings to increase their skill levels so they are on par with experienced staff.

One of the beneficiaries of the revitalized HRH management systems in Iringa municipality is Rebecca Maganga, a clinical officer at the Nduli health center. According to the Health Secretary, it was during health facility steering committee meetings—encouraged with use of the supportive supervision checklist—that the ideas of building a house for the clinical officer and setting aside land for staff to grow crops came up. The village community is represented on the facility steering committee. The new clinical officer, Rebecca Maganga, is happy to stay in the farming village 15 kilometers from the municipal health center, though her prospective house has yet to be completed. The brick-walled house has three bedrooms and stands in the middle of her thriving maize crop less than 20 meters from the maroon structure that is the village's health center.

"I am comfortable working here, especially now that soon I will move in a decent house near my work station," says Rebecca. To the villagers, her stay saves them the 15-kilometer trip uphill on a bicycle to Iringa Municipal whenever they need medical attention.

CHAPTER TWO: INITIATIVES AT THE CENTRAL GOVERNMENT LEVEL

Throughout the project, THRP worked to maintain a strong level of political commitment and improve the HRH knowledge base at senior government levels in order to bring about systemic change. The project worked with the three key government ministries instrumental in the nation's HR system—the MOHSW, PMO-RALG, and POPSM—and focused on workforce management and utilization, policy and planning, and leadership.

National HRH Strategic Plan

THRP worked within the scope of the national HRH strategic plan 2008–2013. THRP strategies at the central and district levels contributed to five of the seven national HRH strategic plan strategic objectives (SO). THRP was also an instrumental partner with the government on the MOHSW's HRH Technical Working Group (TWG), the entity responsible for guiding and monitoring the HRH strategic plan. Appendix 1 outlines how each of the THRP partners contributed to the goals of the plan. Partner representatives worked with each of the strategic objective teams (subunits of the TWG aligned by SO) as follows:

SO 1—Improve human resource planning and policy development capacity

- THRP partners led by IntraHealth, the UDSM, and CSSC customized open source HRIS software and supported its implementation in the public sector with PMO-RALG—the ministry responsible for local administration (156 districts and 22 regional administrative secretaries)—in FBOs and the private sector, and in all 10 of Zanzibar's districts.
- BMAF built the capacity of district staff in HR planning through HRM training and addressed HR policy for the delivery of health services.

SO 2—Strengthen HR leadership and stewardship

- With technical assistance from MSH and IntraHealth, BMAF developed the HRM package to strengthen local leadership and supportive supervision specific to HR in the 54 project districts.

SO 3—Improve HR education, training, and development

- THRP contributed through AKF's efforts to upgrade enrolled nurses to qualify as registered nurses as well as providing refresher training for 530 nurses in Iringa, Mtwara, and Lindi regions.

SO 4—Improve workforce management and utilization

- THRP developed local experts or HRH champions based at district or regional levels to implement the HRM package in 54 districts and coach and mentor district managers.
- THRP rolled out a program to develop a cadre of para-social workers (PSWs) and supervisors in four regions and supported development of a scheme of service for a ward-level social welfare assistant position in LGAs.

- THRP, through BMAF, contributed to strengthening the rollout of OPRAS nationally and coordinated districts' efforts to develop local incentive packages to attract and retain staff.

SO 5—Build and strengthen HRH partnerships

- THRP was involved in building and strengthening partnerships across government, private, and donor institutions engaged in HRH activities.

Results

THRP worked in a number of specific areas to strengthen HRH capacity at the highest levels. Project activities included developing HRH leadership and engaging with the HRH TWG; training national HRH experts; incorporating a focus on HR in the CCHP; revising national staffing norms; developing a tool to track posted health workers; improving centralized recruitment processes; promoting policy discussions; generating an HRH evidence base; contributing to efforts to define and develop a formal community health worker cadre; assessing the social welfare workforce; incorporating HR considerations into the national MVC plan of action; and playing the lead role in organizing Tanzania’s first national HRH conference.

CENTRAL-LEVEL RESULTS AT A GLANCE

- ❖ **The HRH TWG has become increasingly active, and HRH is a growing priority across several ministries.**
- ❖ **National HRH champions are training a pool of local HRM experts.**
- ❖ **Revised national staffing norms and a staff tracking system are in place.**
- ❖ **Information sharing between employers and new hires has improved.**
- ❖ **The HRH evidence base has expanded.**
- ❖ **Efforts are underway to standardize a community health worker cadre.**
- ❖ **A social welfare workforce strategy has been finalized, and the HR focus of the second National Costed Plan of Action for MVC has been strengthened.**
- ❖ **Tanzania held its first national HRH conference.**

HRH technical working group and health system strengthening

In collaboration with other stakeholders, THRP engaged in clarifying the structure, roles, and responsibilities of the HRH TWG. After senior-level officials endorsed the group’s structure, THRP facilitated representation from different departments of the MOHSW and PMO-RALG. A training needs assessment of designated SO team leaders (THRP 2011b) indicated the need for stronger meeting management and enhanced coordination across SO teams, which prompted the project to strengthen these skills for MOHSW members of the HRH TWG. Although the HRH TWG meets regularly, it is not providing the leadership to drive the national HRH agenda across multiple ministries. Over the project period, THRP (through IntraHealth technical assistance and BMAF) was actively engaged in HRH

TWG activities, providing technical feedback on numerous documents and policies, engaging in multiple coordination efforts across ministries and across departments, and taking on specific activities under the TWG’s purview, such as the revision of national staffing norms (discussed

below). THRP also supported a technical “theme day” in 2011, bringing together stakeholders from multiple ministries, parliamentary representatives, and representatives from academia or the private sector.

For one year, THRP also seconded two HRH experts to work at the MOHSW to assist with operationalizing the Health System Strengthening (HSS) Unit at the ministry, reflecting the importance of HRH in HSS planning and direction. The unit, now functional, oversees and coordinates HSS activities across many departments internally.

HRH expertise

A major gap identified early in the project and further reinforced by the baseline assessment (THRP 2011a) was the lack of HRH technical professionals to influence change and build capacity in the field. At the national level, HRH champions are few and far between. Many of the local experts, developed under the district strengthening approach, contributed to national activities as well. At the request of the MOHSW Permanent Secretary, THRP conducted an HRH short course for senior staff and key internal stakeholders from across several MOHSW departments, MOH/Zanzibar, and PMO-RALG. The purpose was to build skills in key areas of HR planning and management, including the analytical skills necessary for workforce projections. THRP contracted Tim Martineau, a Senior Lecturer at the Liverpool School of Tropical Medicine (LSTM), to deliver the course. An important focus of the course was on developing HR strategies based on problem analyses; this focus was timely because the MOH/Zanzibar was about to start the process of developing its own HRH strategic plan and the MOHSW’s Department of Social Welfare (DSW) was undertaking a similar exercise for the social welfare workforce.

Comprehensive Council Health Plan

The CCHP provides annual policy and planning guidelines for monitoring and evaluating health sector performance at the district level. In 2009/2010, when the MOHSW reviewed the CCHP guidance, THRP gathered feedback and consolidated input to improve the HRH component of the guidance, which previously represented a gap in the plan’s content. As an outcome of the review process, the MOHSW included HRH as a priority area to enable districts to plan and budget for HRH issues and added specific HR targets and indicators. Targets included increasing skilled staff by at least 10%, orienting all new staff, and developing incentive packages to attract and retain staff. One indicator was the presence in the district of a functioning computerized HRH information system (HRHIS).

National staffing norms

THRP supported a long-overdue revision of the national norms for staffing health facilities. Previously, districts had been using the last official version dated 1999 for all HRH planning. The process of revising the norms involved assessing approaches for determining staffing levels, recommending the most effective approaches for estimating HRH needs, defining roles at all facility levels (i.e., national hospitals, consultant hospitals, special hospitals, agencies and MOHSW departments, district hospitals, health centers, and dispensaries), and setting criteria for staffing levels for each facility type. The final step in early 2013 was to develop an operational tool to assure an *optimal equitable distribution* of available human resources with the objective

that all functioning health facilities are staffed with the minimally appropriate number of health workers with the appropriate skills before considering increased staffing in any facility. The MOHSW endorsed the document in early 2013. The staffing norms present ambitious figures for the number of staff expected at each facility level. In the short term, facility-level vacancy rates will increase quite dramatically as the denominator of expected staff increases.

Tracking posted health workers

THRP supported the MOHSW in an exercise to analyze the rates at which newly posted staff actually reported to their local duty station or left soon after arrival. UDSM, a THRP partner, developed a tracking tool to observe these trends between the 2007/2008 and 2009/2010 fiscal years. Findings indicated that the MOHSW was unable to fill between a quarter to almost half of the available positions (budgeted work permits) and an average of 37% of the posted staff did not report to their duty stations. In contrast, only 13% of those who did report to the districts had left their posts. The analysis paved the way for simple procedural interventions to improve efficiencies in MOHSW hiring procedures (discussed below), strengthen positive communication with applicants, and attract health staff to underserved areas and retain them (MOHSW 2011).

Centralized recruitment processes

As noted in the first chapter, HRH recruitment in Tanzania spans three ministries. The PMO-RALG oversees district planning and advocacy for health staff. POPSM reviews district staffing projections and fiscal alignment and sets annual work permit limits. The MOHSW manages staff recruitment and postings. THRP supported MOHSW efforts to improve information-sharing between recent health graduates and their new district employers, with the goal of increasing the number of staff reporting for duty. The focus was to minimize fear stemming from graduates' lack of knowledge about or familiarity with specific districts, clarify the work environment in those districts, and attract new employees with an understanding of the financial incentives awaiting them. The simple steps of adding new employee contact information to job applications and facilitating sharing of this information with districts enabled direct tracking of posted staff. In addition, the straightforward measure of personalizing posting letters to address new staff by name increased the likelihood of staff reporting to their postings. THRP piloted these basic improvements and showed that they were useful to both job applicants and recruiters. Beginning in 2012/2013, the government committed to scaling up the changes in posting letter format.

Policy forum

To influence changes in health sector policies and guidelines that have an impact on HRH initiatives, THRP organized a policy forum in September 2012. As lead local coalition partner, BMAF has important political and contextual understanding that informs program design and facilitates convening of key stakeholders. BMAF's relationships at the national level support legitimacy in its work with local government authorities, and increased exposure and understanding of local government challenges add to the organization's legitimacy at the national level. BMAF used its increasing reputation as an HRH leader to convene the most influential decision-makers from POPSM, PMO-RALG, MOHSW, the Employment Secretariat of the Public Service, select regional administrative secretaries, district executive directors, and

health secretaries. These decision-makers deliberated on the initial results gathered from selected THRP-tested interventions in the districts and discussed recommendations to address HRH policy implications. The forum provided an opportunity for focused discussion of three themes:

1. Recruitment and deployment of health workers in LGAs
2. OPRAS implementation at the district level
3. Implementation of integrated supportive supervision guidelines.

One key resolution that emerged was to improve the information shared between job applicants and recruiting authorities in order to fast-track posted staff. The Permanent Secretary of the MOHSW also directed LGAs to conduct HRH supportive supervision.

HRH evidence base

THRP conducted a number of studies and assessments to systematically deepen knowledge of existing HRH management practices, observe gaps, and recommend solutions. The studies focused on a variety of different areas summarized in Table 3.

Table 3: THRP Assessments, 2010–2013

Topics/Descriptions	Reference
Planning - District-level human resources information needs	(THRP 2009)
Human resource management - Human resources for health management systems at the district level	(THRP 2011a)
Underserved districts - Temporary and permanent health workers, with a focus on underserved districts - Multisectoral definition of underserved districts and use of localized incentives	(THRP 2010a) (THRP 2012b)
Recruitment, retention, and performance - Recruitment bottlenecks - Assessment and strengthening of the open performance review and appraisal system - Orientation processes and practices	(THRP 2010b) (THRP 2010c) (THRP 2010d)

Community health worker cadre

In a country facing an acute shortage of skilled human resources for health in rural areas, community health workers (CHWs) can make a difference. CHWs can be available to provide preventive care and initial support to communities that may otherwise lack access to timely attention from a skilled health worker. Tanzania’s vision is that community-based health workers can bridge the gap between communities and health facilities. Toward the end of the project, THRP contributed to ongoing efforts to apply a systems approach to develop a standardized CHW cadre. IntraHealth participated in the first planning meeting sponsored by the One Million Community Health Workers Campaign (www.1millionhealthworkers.org) in Ifakara in 2013 and contributed lessons learned from THRP experience in developing a cadre of village-based para-social workers to the discourse. THRP supported the MOHSW request to convene regional and district authorities and provide technical assistance for a technical review of national guidelines for community-based health services.

Social welfare workforce

In 2009, Tanzania had an estimated 800,000 MVC (MOHSW 2013c). MVC live in environments without parental support, lack basic needs, and/or may be prone to abuse. Tanzania's fledgling social welfare system previously lacked a strategy to provide guidance for engaging, utilizing, and managing professionals who respond to the needs of MVC. Working in close collaboration with the DSW, THRP provided technical support to conduct an assessment of the social welfare workforce (THRP 2012c). The findings indicated that local government is an increasingly important employer of social workers in Tanzania. Additionally, not only does Tanzania have a general shortage of professionally-trained social workers, but current social workers do not have the necessary competencies to meet increasing expectations and responsibilities.

The assessment findings and analysis provided critical background for the development, in collaboration with the DSW, of a draft national social welfare workforce strategy, which has been finalized for adoption by the MOHSW. Once adopted, the strategy will provide stakeholders in both the public and private sectors with social welfare workforce guidance.

In addition to supporting DSW in creating a social welfare workforce strategy, THRP advocated for interministerial coordination between the DSW and the LGA Department of PMO-RALG. Whereas the DSW oversees the technical systems that produce and manage the ethical and professional conduct of social welfare workers, PMO-RALG (the central government sponsor of LGAs in the decentralized environment) oversees public service provision at the district level where social welfare professionals are actually employed. Therefore, a properly functioning strategy and system to manage the social welfare workforce hinges on smooth coordination between these two entities. The successful implementation of the social welfare workforce strategy (and implementation of envisioned national guidelines on CHWs) depends on the strategy's proper conceptualization and prioritization at the LGA level.

In collaboration with UNICEF, FHI360, and PMO-RALG, THRP analyzed the fitness of the PMO-RALG organizational structure—from headquarters to the LGA level—to support implementation of the emerging strategies for the social welfare workforce and CHWs. As a result of these efforts, PMO-RALG recognized the need to employ social welfare technical personnel at headquarters to influence high-level decision-making. An MOHSW position at PMO-RALG was posted and filled by a secondment supported by FHI360. At the district level, PMO-RALG resolved to create a designated cost center for social welfare issues.

National Costed Plan of Action for MVC II

Tanzania developed its second National Costed Plan of Action (NCPA) for MVC in 2012. THRP leveraged the process to advocate for including a chapter dedicated to HR and specifically the social welfare workforce that is so critical to successfully reaching vulnerable children. THRP was able to take advantage of its experience developing a community-level cadre of para-professionals who provide psychosocial support to MVC in rural areas as well as efforts to strengthen district-level HRM, marshaling this expertise to fortify the second NCPA with

strategic input related to systematically strengthening human resources. The effort further reinforced the need for a strategy for developing Tanzania’s social welfare workforce.

First national HRH conference

More than 280 participants, representing central and local government entities, development partners, civil society, academia, FBOs, and the private sector gathered in Dar es Salaam in September 2013 for Tanzania’s first national HRH conference, entitled “Health Workforce: Crucial to Meeting the Development Goals.” THRP facilitated broad collaboration and engagement in the design of the conference to provide a platform to accelerate implementation of existing policies along four key themes: planning and recruitment; retention; performance management and productivity; and production of the health workforce. Another conference objective was to identify and advocate for key priorities and increased national and international resources to be incorporated into the next national HRH strategic plan (2014–2019). Over three days of intense deliberations, more than 50 speakers and over 200 participants explored the complexities of HRH challenges, exchanged ideas, reviewed strengths and weaknesses, debated critical issues, and called for specific actions to resolve the human resource crisis that continues to threaten Tanzania’s progress toward achievement of Millennium Development Goals.

Key issues considered at the conference included staffing projections; equitable distribution of staff by cadre and location; data for decision-making; centralized versus decentralized planning; systems, processes, and procedures for effective retention; pay policies for underserved areas; task shifting; pay for performance; OPRAS; health worker productivity at all facility levels; quality of health worker education; performance of recent graduates; decentralization of health education; and cadre skill mix.

The national HRH conference produced a series of specific recommendations (see Appendix 3). The highest-priority recommendation was a call for stronger coordination among government ministries on key HRH policies, strategies, and enforcement of existing regulations. Important actors in the HRH arena include the MOHSW; the PMO-RALG; the President’s Office, Public Service Management; and the Ministry of Finance (MOF).

The conference recommendations also served as a launching pad for the government to articulate three macro-level national commitments during the Third Global Forum on HRH held in Recife,



First National HRH Conference

“I’m so happy, I’m so delighted, that this initiative is being undertaken.” [Thousands of health workers] “have dedicated their time and energy to save the lives of their fellow human beings in our dear country. We have achieved what has been achieved so far due to their dedication and commitment.”

– His Excellency, Dr. Jakaya Kikwete, President of the United Republic of Tanzania

“I want to assure you that the Government of Tanzania is committed to act upon the recommendations generated from the three days of intense work. We can all be proud of the achievements in the health sector, especially when we take a hard look at the many obstacles we encounter. All Tanzanians, 45 million people, they are all counting on us.”

– Dr. Donan Mmbando, Chief Medical Officer, MOHSW



Brazil in November 2013 (see Appendix 4). The end of THRP coincided with Tanzania's participation in the Global Forum. The project supported eight participants, including public-sector staff from PMO-RALG, POPSM, and the MOF—all key ministries working in coordination with the MOHSW in HRH strategic planning and priority setting as future HRH leaders in Tanzania.

Summary

Table 4 summarizes key achievements resulting from THRP's central-level initiatives.

Table 4: Key Achievements at the Central Level, by Type of Intervention, 2009–2013

Intervention Focus	Key Achievements
Technical working group	- Increased functionality in terms of regular meetings, focused agenda, and accountability toward the national HR strategic plan
HRH expertise	- Cohort of 37 HRH champions developed
CCHP	- National CCHP guidance revised to require specific HRH targets and indicators as part of staff planning and rationalization
National staffing norms	- National staffing norms developed and approved by MOHSW, including an operational guide to assist districts in meeting minimal staffing levels
Health worker tracking	- System in place to track health workers posted by the government
Centralized recruitment	- Strengthened advertisement and recruitment processes; increased number of districts with incentives to attract staff to underserved areas
Policy forum	- Key milestones achieved in staff recruitment processes, including adjustments to posting letters and dissemination of district information to attract staff - Orientation package for new health sector employees of LGAs developed and endorsed by MOHSW - HRH supportive supervision checklist included in the National Supportive Supervision Guideline
HRH evidence base	- Findings from initial assessments used to improve district strengthening interventions; inform development of orientation package and supportive supervision checklist; develop simplified OPRAS training; and identify generic indicators for defining underserved areas
Social welfare workforce	- National workforce strategy developed
Select media campaigns and highly visible events dedicated to HRH	- First technical HRH theme day held as part of Joint Annual Health Sector Review; national HRH conference and Tanzania participation in Third Global Forum on HRH led to increased visibility of HRH on national agenda across key ministries responsible for public-sector HR planning and recruitment

CHAPTER THREE: MAKING HUMAN RESOURCES DATA AVAILABLE FOR LOCAL DECISION-MAKING

Background

HRH data are crucial for predicting, recruiting, and deploying health workers. Access to this type of data through HRIS is crucial for ensuring that an appropriate number and mix of health and social welfare professionals are available to serve citizens. IntraHealth had been introducing iHRIS—IntraHealth’s open source HRIS, during the Capacity Project, nearly two years before the start of THRP. iHRIS is designed to flexibly gather staff information and can be easily adapted to support local health workforce management. The system is capable of addressing information needs at the national, regional, and district (LGA) levels. Moreover, its information flow follows a bottom-up approach.

At the start of THRP, the one national HRIS that existed on the mainland—the Human Capital Management Information System (HCMIS)—was a proprietary payroll system utilized by POPSM, designed to manage remuneration to all government employees. With limited information on employee duty stations or other district-level data, the HCMIS was not sufficient for local government HR management, nor did it capture the broad spectrum of health workers outside of the public sector. At about the same time period, the MOHSW embarked on development of a central HRHIS with JICA support that would cater to macro-level data needs in the areas of recruitment, planning, and posting of health workers to districts. Development of the MOHSW-based HRHIS was a commitment specified in the national HRH strategic plan; however, like the HCMIS, the MOHSW HRHIS did not contain needed information for managing local health services and lacked any information on health workers outside the public sector. In addition, neither MOHSW nor PMO-RALG staff had access to HCMIS. Both systems had the technical capacities to meet their respective organizations’ needs, but neither was designed to provide health-worker-specific information at the local government level or pertaining to the FBO and private sectors.

The decision to focus on a system for PMO-RALG was taken at the project design phase for THRP. PMO-RALG requested assistance in building a system that would meet the multisectoral HR management needs of the LGAs. The risk of creating a new, potentially duplicative system became clear at the start of THRP implementation, and USAID and IntraHealth held multiple meetings with key government and development stakeholders to attempt to align the proposed new system with the existing POPSM system and the newly introduced MoHSW HRHIS. POPSM, which had originally acquired HCMIS in 2000 followed by a system upgrade in 2011 for web-based implementation, was clearly invested in the HCMIS and felt that the other systems failed to address its specific payroll needs. From the PMO-RALG perspective, the two existing systems did not meet broader multisectoral HR management needs at the district level. After considerable efforts to bring donors and line ministries together, USAID and IntraHealth took the decision to move forward with a new HRIS for PMO-RALG, and it became a significant component of the THRP.

For nearly two years before the start of THRP, iHRIS deployment was well underway on Zanzibar and with CSSC; IntraHealth discussions regarding District Health Information Software (DHIS) and iHRIS interoperability on Zanzibar have now become the model for HRIS/HMIS interoperability in several other countries. THRP absorbed previous Capacity Project commitments made to the MOH of Zanzibar and to CSSC to develop the system and expand their capabilities to address the problem of lack of quality data for making health workforce decisions.

LGHRIS in the Public Sector

The THRP baseline study (THRP 2011a) found that whereas LGAs maintained some hard-copy employee data, they only irregularly updated the information in the personnel files. The main source of staff data was a non-computerized seniority list (called the Tange list) that was prepared annually to meet PMO-RALG planning and budgeting requirements.

At the request of PMO-RALG, THRP adapted iHRIS to meet the specific information needs of LGAs. PMO-RALG coined the acronym LGHRIS (local government human resources information system) to denote the new system as part of its mandate. THRP designed LGHRIS to fulfill the overarching objectives of capturing worker-specific information and making it available in formats and places that would enable PMO-RALG, regional administrations, and LGAs to make better workforce projection, recruitment, and deployment decisions.

The LGHRIS makes data reliable and easily accessible, replacing the previous paper-based system that made information updates and retrieval difficult. The system has fully computerized the data that were available in the Tange list and also includes additional fields of information requested by district HR officers. Because of the flexible properties of the open source iHRIS software from which LGHRIS was adapted, LGHRIS is versatile and can address specific information gaps at the LGA level as well as at higher levels.

LGHRIS needed to operate within the national context and work within expectations of the existing systems embedded in other ministries, also at different stages of development. THRP forged strategic partnerships between the UDSM Department of Computer Science (UDSM-DCS), PMO-RALG, CSSC, the National Muslim Council of Tanzania (BAKWATA), and the Association of Private Health Facilities of Tanzania (APHFTA) to develop a broader interoperability strategy. These partnerships made it possible for a wide variety of organizations to agree on a standard dataset and approaches for the collection, management, and reporting of HRH data.

THRP's primary mandate was an HRIS that captured local and regional health worker data. However, PMO-RALG subsequently requested that the system be expanded to include data for all civil service staff across all sectors working in local government. THRP was able to accommodate this expanded scope, improving LGAs' efficiency and ability to support all local civil service employees rather than requiring separate systems for non-health staff.

A parallel process of HRIS implementation took place with the MOH in Zanzibar. On the semi-autonomous region of Zanzibar, the HRIS captures information on approximately 3,500 health workers through a central server based at the ministry which connects with 12 districts via Virtual Private Network (VPN). See the Zanzibar success story below.

HRIS Revolutionizes Management of the Health Workforce in Zanzibar

Overview

Prior to THRP, the Zanzibar MOH reached out to the USAID global Capacity Project as a result of dissemination efforts from the East, Central and Southern African Health Community (ECSA-HC), which shared iHRIS successes from Uganda, Rwanda, and Kenya. As a result, THRP subsequently supported the rollout of iHRIS on the island of Zanzibar, which became the first region of Tanzania to implement iHRIS. THRP worked with the Zanzibar MOH to develop a robust information system that would improve on previous approaches (i.e., manually recording information in personnel files; using MS-DOS dBASE IV software) that achieved limited data accuracy and versatility.

The Zanzibar HRIS originates staff information such as name, date of birth, cadre, facility, and district. Through quarterly workshops of district health management teams, daily updates, and data audits, the information is up to 95% up-to-date. The HRIS can provide Zanzibar decision-makers with accurate reports on specific topics, including aging of the workforce, staff available by cadre, age by cadre, and retirement projections. By mapping the health staff available by cadre with GIS, it is also possible to present visually compelling evidence about staff vacancies and skewed deployment.

Data use and successes

Zanzibar uses HRIS data in a variety of ways, including for strategic and annual HR planning, development of training plans, deployment decisions, and to justify new staff. Three committees in the MOH HR Department (the training, deployment, and HR planning committees) make use of the data. In addition, the MOH publishes updated HR data annually in an HRIS reference bulletin.

Using information from the system, the HR planning unit established the number of staff available and the number of staff required for different cadres. Using that information and data about workforce age, the HR planning unit successfully built a case for asking for a larger number of employment permits from the Department of Civil Servants from 2011 to 2013. Moreover, by analyzing HRIS data in conjunction with data produced by WISN (Workload Indicators of Staffing Needs), a tool created by the WHO, MOH officials saw that the population's need for health workers was much greater than its current workforce. Rather than the 30 new personnel the ministry was adding annually, in fact it needed to add closer to 300 new workers every year. Thanks to these clear, data-based justifications for additional staff, the MOH was able to secure funds for an additional 315 employees of different cadres in 2011, 239 in 2012, and another 174 in 2013. The government is now recruiting an additional 169 health workers.

The reliability of HRIS data also shaped the MOH decision to reinstitute risk and responsibility allowances. Reliable, updated information facilitates paying allowances only to those employees who deserve the extra payment. Additionally, HRIS information has enabled the HR unit to respond to ad hoc requests for statistics from different international and local organizations.

Public Sector Results

LGHRIS deployment in LGAs

By the end of the project, LGHRIS had matured into a robust system recording data for more than 323,000 civil servants countrywide, deployed and installed in 154 LGAs and 21 Regional Administrative Secretaries' (RAS) offices (excluding the newly created LGA and RAS offices of Geita, Katavi, Simiyu, and Njombe that have yet to have permanent office structures). The system's rapid deployment reflected the strong PMO-RALG leadership and investment in the LGHRIS as well as close THRP partnership with the Division of Information, Communication and Technology (DICT) in planning and managing the rollout at every stage.

By mid-project, the LGHRIS was installed in 29 LGAs and RAS offices. Installation included training PMO-RALG teams of local information technology (IT) personnel and human resources officers on how to manage the system and enter staff data accurately. Upon successful completion of this phase, PMO-RALG wanted to quickly go nationwide. It developed a cost-sharing arrangement with IntraHealth to extend deployment to the remaining LGAs and RAS offices in Tanzania. The initial approach was to establish individual servers to share data between local, regional, and PMO-RALG central offices via the Internet. However, high equipment costs and poor Internet connectivity proved challenging, especially in remote locations. Meanwhile, by 2012 PMO-RALG had created its own VPN, effectively networking all LGAs and RAS to PMO-RALG's central server, vastly improving the efficiency and security of sharing data. As a central ministry, PMO-RALG is now able to aggregate all LGA data, quickly producing the Tange retirement list and other management information as needed. The chart in Appendix 5 summarizes the extensive activities that took place from 2009–2013 to deploy a national system.

PUBLIC SECTOR HRIS RESULTS AT A GLANCE

- ❖ **The LGHRIS records and aggregates data for civil servants countrywide.**
- ❖ **Interoperability with other HR systems is an achievable goal.**
- ❖ **National capacity for LGHRIS management and use is growing.**
- ❖ **Help desks are in place to assist users with troubleshooting.**
- ❖ **Collaboration is increasing between decision-makers and HR officers.**
- ❖ **Tanzania leads the iHRIS community in the region with the local capacity within UDSM.**

Interoperability with existing HR systems

THRP and its partners designed the LGHRIS to interoperate with other existing HR systems. Ultimately, interoperability will integrate the HCMIS and HRHIS with LGHRIS; currently, all three systems are able to upload and extract data from Excel files. LGHRIS has the potential to incorporate data from Zanzibar as well as the FBO and private sectors. The national eHealth strategy calls for this interoperability to be achieved through the establishment of a national provider registry. All of the component systems have contributed a minimum dataset into this registry, creating a master list of all health providers across Tanzania. This level of interoperability will ease the data management burden that

currently falls to HR officers and district-level health secretaries and will create opportunities for sharing resources, including data and computing infrastructure. This in turn will reduce the cost of supporting the systems, enhancing sustainability and LGA ownership.

Extensive interoperability testing between the different systems has proven the technical approach to be workable. Testing focused on key areas of interoperability, including report generation; data migration; geographical security (enabling districts to access their own data and records but not the data and records of other districts); and staff transfers. For the existing systems to be truly interoperable, however, senior-level engagement from POPSM, PMO-RALG, and the MOHSW will be needed to negotiate data flow and system management and clarify roles and responsibilities for those who manage the system, enter data, and analyze the information. Initial discussions started at the end of 2012 and surfaced again during a technical session on data use during the national HRH conference in September 2013. A major HRH conference recommendation was for POPSM to provide a concrete vision on utilizing an HRIS to enhance effective data use in making HR decisions. POPSM is to lead and facilitate the necessary interministerial discussions that will result in alignment of the multiple HRIS.

National capacity for LGHRIS management and use

THRP capacity-building activities focused on building the skills and capacity of LGHRIS implementers, supervisors, and system users, including the District Executive Director, district HR officers, members of CHMTs, and heads of departments. Point-of-use training for the LGHRIS involved 1600 HR officers and other LGA and RAS staff, while 60 information and communications technology (ICT) officers participated in intensive technical training on LGHRIS maintenance and support.

In addition to training LGHRIS local government users, THRP through its UDSM partner initiated a program to train third-year computer science students at UDSM. The initial idea, later known as the iHRIS Academy, brought together 28 iHRIS developers and implementers from seven African countries to share their experiences using open source software and develop solutions to common challenges. The curriculum for the Academy was based on IntraHealth's HRH Global Resource Center's free eLearning program, which had by October 2013 enrolled 699 people from over 90 countries.

PMO-RALG employee records

PMO-RALG aimed to have all individual employee records entered into the system, meaning approximately 400,000 staff across all the health and non-health sectors employed under PMO-RALG. The initial level of effort required data entry from the physical personnel files, followed by regular updates uploaded electronically. By August 2013, data from 323,663 (>81%) LGA staff across all sectors had been entered into the LGHRIS. From this information, users will now be able to generate a variety of reports to assist with workforce planning, hiring, and retention.

Troubleshooting and sustainability

Having successfully installed a functional LGHRIS, sustainability of the system was a crucial consideration and an important project goal for THRP. THRP introduced an internship program

for PMO-RALG ICT staff. Over the project period, THRP selected ICT officers from the local, regional, and central (PMO-RALG) levels who received advanced skills training in LGHRIS troubleshooting. Common user problems that ICT officers may be called upon to correct are system failures, database server crashes, and server malfunctioning. All 25 regions established help desks staffed by PMO-RALG ICT staff in a number of districts, and help desk staff responded to incidents reported by fellow LGHRIS users in nearby districts. This arrangement took advantage of PMO-RALG connection to LGA servers through VPN, allowing help desk staff to communicate with users and solve issues online. ICT officers can log the successfully attended cases for future reference and refer difficult cases to UDSM programmers. Once issues have been resolved, the solutions are made available to all troubleshooters for reference.

Data use

Having learned the importance of data in HR planning and decision-making, LGA decision-makers have gradually adopted the practice of consulting with their HR officers on personnel data before making staffing decisions. HR officers are increasingly engaged in the CCHP annual planning cycle. Improved collaboration between HR officers and health leaders has the potential to improve the quality of data in both the LGHRIS and HRHIS. Similarly, LGAs now can track retirements in their workforce and plan replacements accordingly. Data from the LGHRIS and HCMIS also support decisions about promotions, retention, and benefits.

Summary

Table 5 summarizes key achievements resulting from THRP’s public-sector LGHRIS activities.

Table 5: Key Achievements in Public Sector Information Systems, by Type of Intervention, 2009–2013

Intervention Focus	Key Achievements
LGHRIS deployment	- LGHRIS deployed and in use in 154 LGAs and 21 RAS offices
Interoperability	- Successful technical tests on data sharing between LGHRIS/HRHIS/HCMIS performed; discussions across three ministries initiated though decision awaits on how to operationalize the data sharing process
National capacity	- Over 1600 HR officers, health secretaries, and ICT officers from PMO-RALG trained on LGHRIS administration, use, management, and support
PMO-RALG records	- Over 81% of all PMO-RALG staff tracked on LGHRIS
Troubleshooting	- LGHRIS help desks (staffed by trained ICT officers) in place in 25 regions; TZHRIS google group a source of knowledge sharing
Data use	- Electronic Tange, Ikama and other HR decision-making reports now available on LGHRIS

Lessons Learned: Data for Decision-making in the Public Sector

1. It is important to foster district HR officers’ involvement with the information system.

We observed that HR officers frequently do not understand the benefits of LGHRIS for their day-to-day work. Orientation of all new HR officers and strengthening HR officer job descriptions to include responsibilities for updating and producing regular reports will encourage HR officer engagement with system management. During national LGHRIS

rollout, one success was to engage district HR officers and ICT officers who had mastered the system with LGHRIS deployment in nearby districts.

2. IT support is critical for achieving sustainable system use.

IT support is essential but can present a formidable challenge. At the district level, available support was minimal owing to the low number of IT specialists, conflicting priorities (such as support of other systems), and geographical barriers. PMO-RALG, with THRP support, addressed these barriers by setting up help desks to respond to issues raised by system users in neighboring districts. However, sustainable efficiency of help desk arrangements relies on availability of a central technical point that can play a referral role and regularly refresh the technical capacity of far-flung help desk staff. UDSM programmers currently fulfill this role. A central server at PMO-RALG headquarters in Dodoma has eased many of the technical issues considerably.

3. Interoperability is a cornerstone of sustainability and applicability.

Systems interoperability and data sharing among all government HR systems would go a long way toward increasing HR officers' interest in adopting computer-based information platforms. Interoperability would also increase HR officers' ownership and support to the extent that it results in increased budgeting to support the system, greater local capacity to manage it, and growing use of system data. Ultimately, however, demand for data to guide decision-making at all levels is the true potential driver for HRIS sustainability. The growing demand for data can be witnessed in places such as Njombe and Kilolo districts and Iringa town, where district and town councils have awarded internships to university students to enter data in the system.

HRIS in the Private Sector

The LGHRIS faced a similar limitation to the HCMIS and HRHIS in that it covered only the public sector. However, faith-based health facilities provide more than 40% of health services in Tanzania, particularly in rural areas. To supplement the three public systems (i.e., HCMIS, HRHIS, LGHRIS) with data from FBOs and other elements of the private sector, THRP facilitated the creation and management of a more comprehensive system through a partnership between CSSC, IMA World Health, BAKWATA, and APHFTA. By extending the benefits of HRIS to privately managed health facilities and FBOs, the broader system has the potential to fill a large gap in available health workforce information.

THRP deployed a comprehensive iHRIS through a collaborative effort engaging IntraHealth and UDSM technical assistance and four key partners:

- CSSC was responsible for leading HRIS implementation in the faith-based and private sectors. It deployed HRIS in 47 out of 101 hospitals across its five zones of operation, which cover the whole of Tanzania mainland.
- IMA World Health provided technical assistance, along with the UDSM-DSC, orienting new users on HRIS tools and strengthening the application of HRIS and other tools at FBO and private sector networks (IMA World Health 2013).

- APHFTA coordinated HRIS deployment and implementation in 22 private health facilities in its six zones of operation.
- The BAKWATA network is organized under regional and district administrative structures, with each member facility connected via individual (franchise) agreements. BAKWATA coordinated HRIS deployment and implementation in three Muslim health facilities.

Working through CSSC, THRP eventually linked data from CSSC, APHFTA, and BAKWATA facilities to the public sector in selected districts. This opened a new chapter in public-private partnerships, enabling local decision-makers to track the mobility of the health workforce as well as guiding policy decisions on prediction, recruitment, and deployment of health workers.

Private Sector Results

HRIS profile and demand

In the private sector, CSSC built demand for HRIS through its FBO constituency and affiliated health facilities. CSSC-sponsored workshops, dissemination meetings, and high-level meetings with senior leadership helped to raise the HRIS profile and increase demand among departments of health with the CSSC, APHFTA, and BAKWATA networks. THRP supported set-up and networking of servers at six CSSC offices, five APHFTA offices, and one BAKWATA office. The iHRIS web-based software was successfully deployed in 47 CSSC hospitals, 16 APHFTA health facilities, and 3 BAKWATA health facilities, where health facility staff were trained to collect and enter HR information on their personnel. In addition to the data entered by trained health facility staff, zonal and headquarters personnel from CSSC, APHFTA, and BAKWATA entered HR data on personnel from many smaller facilities.

PRIVATE SECTOR HRIS RESULTS AT A GLANCE

- ❖ **There is an increased profile and demand for HRIS in private health facilities.**
- ❖ **Skilled HRIS users can sustain and expand deployment.**
- ❖ **CSSC, APHFTA, and BAKWATA data have been linked with public sector data, providing national HRH workforce data coverage.**
- ❖ **Data are being used in HRM decision-making.**

The HR data collected from CSSC health facilities alone comprise almost 17,000 health worker personnel records. The project exceeded planned implementation milestones for site assessment, Internet and hardware provision, software installation, customization, and new user training. By the final project year, 66 FBO hospitals had HRIS capabilities to improve management of their own data. With THRP support, the facilities have staff who are trained to use and update system data and troubleshoot. The system currently carries HR data from all 66 hospitals and almost 300 health centers and dispensaries.

Skilled HRIS users

To foster HRIS ownership and continuity, THRP trained staff from CSSC, BAKWATA, and APHFTA headquarters to use and maintain the system. At health facilities where HRIS was installed,

designated data entry staff members received training to update, expand, and verify HR data. An HRIS focal person was trained to coordinate reporting and exporting of data for higher-level utilization, a step that also improved data quality.

IMA World Health coordinated a highly interactive workshop for 38 HR managers and administrators from CSSC, APHFTA, and BAKWATA health facilities in the Morogoro region on human resources management practices intended to maximize their ability to use HRIS data for HRM decision-making. Participants showed substantial improvements in their understanding of HRM topics. As a further outcome of the workshop, many participants put plans and practices in place at their health facilities to ensure that the information system would provide reliable data and to make use of HRIS reporting capabilities in decision-making. Training at this level created interest in development of a performance management system to be applied by the three organizations (IMA World Health 2012).

Linking public and private systems

Meeting data requirements and customizing HRIS for the FBO and private sectors involved tackling issues such as inconsistent HR policies and lack of the IT competencies needed to address the inconsistencies. For instance, the HRIS open data structure allowed facility-level HRIS users to enter inconsistent local-level data, which then need to be managed and cleaned at the zonal and/or central levels to support aggregation at the district, regional, and national levels. Although some data cleaning can and should be done record-by-record at the local level where the data are first entered, nationwide implementation also requires central system capabilities to clean up the database en masse.

With assistance from IntraHealth informatics staff, the three THRP private sector partners (i.e., CSSC, BAKWATA, and APHFTA) managed to develop consistent protocols for data generation and system standardization across the private-sector HRIS and public-sector HRIS.

"Whereas during the first and second years of deployment THRP bought hardware for installation, by the third and fourth year[s] of the project, health facilities budgeted to purchase their equipment and asked only for technical assistance to set up the system."

– Petro Pamba, THRP coordinator, CSSC, 2012

Data for HRM decision-making

Availability of HR data has revolutionized how health facilities make HRM decisions. Current data from HRIS can be translated into detailed, timely, and accurate reports from facilities. The CSSC is using HRIS to track employees seconded by MOHSW to faith-based facilities designated to provide district services where public-sector facilities do not exist. After extracting basic employer information from the HRIS, CSSC has used the information to advocate for support at higher levels. By the end of the project, 46 out of 47 CSSC facilities where HRIS had been installed were using the data for decision-making (THRP 2013b). As one example, Figure 3 shows retirement projections at Cardinal Rugambwa Hospital from 2015 to 2020.

Figure 3: Retirement Projections at Cardinal Rugambwa Hospital, 2015–2020

Retirement Planning (RIPOTI YA MPANGO WA WATUMISHI KUSTAAFU)

Staff totals by retirement year.

Results limited by: Retirement Year: 2015, 2016, 2017, 2018, 2019, 2020, Birth Date After: Greater than or equal to 1 January 1940, Birth Date Before: Less than or equal to 1 January 1975, Facility: Cardinal Rugambwa



Summary

Table 6 summarizes key achievements resulting from THRP’s private-sector HRIS activities.

Table 6: Key Achievements in Private Sector Information Systems, by Type of Intervention, 2009–2013

Intervention Focus	Key Achievements
HRIS deployment	- HRIS deployed and in use in 66 FBO hospitals (47 CSSC, 16 APHFTA, 3 BAKWATA)
HRIS capacity	- 38 HR managers and administrators from CSSC, APHFTA, and BAKWATA health facilities trained on HRIS data use for HRM decision-making
Public-private linkages	- Common core platform shared by HRIS and LGHRIS, allowing data to be easily aggregated and summed up to come up with a national HRH picture
Data for decision-making	- Hospital leadership increasingly using the data to negotiate for additional staff within diocese (“owners” of the facility) discussions

Sustainability

Demand for HRIS capabilities is growing within FBO hospitals and health facilities that want access to their own HR data. While increased demand for new deployments and HR data is clear evidence of success in advocacy, it is also a great indicator of success in terms of potential for sustainability. This demand shows that CSSC’s early advocacy efforts to introduce THRP objectives increased awareness among decision-makers, and also shows that these new users

shared evidence of their successful implementation efforts with other user constituencies at CSSC, BAKWATA, and APHFTA. The strengths and capabilities of the system have become well recognized.

In addition, the increasing demand for meaningful private-sector HR data from the MOHSW, leaders from various dioceses, and managers at BAKWATA and APHFTA is an indicator of raised awareness of HRIS capabilities. The higher-level demand for HRIS data will continue to reinforce sustainability. To be maintained, however, ongoing data quality improvements must continue to prove data reliability through their use in reporting.

Lessons Learned: Data for Decision-making in the Private Sector

1. iHRIS provides versatile functionality.

The web-based iHRIS open source software provides an excellent set of tools and level of functionality to support HRIS implementations, ranging from the context of an individual facility up to a national-level health system. The data model also incorporates many aspects of HR management and operation that enable users to develop and customize information to specifically meet the needs and structure of their facility and/or the overall system. This level of customization is required for developing data and implementing systems that fit with and build upon the existing health information strengths of user organizations.

2. Open customization at the local level can create barriers to full implementation at the national scale.

Fully implementing a national-scale system requires bringing health system levels together through reporting and aggregate analysis capabilities, from the individual health facility up to the national-level health system. A primary indicator of a successful system is operational data use at all levels to support decision-making at all levels. The Tanzania system was designed to allow adaptation to each organization's and facility's needs, but that same flexibility presents challenges when it comes time to aggregate the data. Approaches to more fully structure the data or to map the individual data and systems to a common shared minimum dataset and system (such as the provider registry referenced in Tanzania's national eHealth strategy) would address these challenges.

3. Skill development is vital at the beginning of technology-based interventions.

In the first project year, the office secretary and a data clerk were the only CSSC zonal staff members involved with THRP. In the second year, CSSC realized that higher-level IT capacity would be needed at zonal offices to support HRIS deployment at the hospital level. Had zonal IT technicians been added in year one, they would have been able to facilitate server set-up, strengthen customization, and inform their knowledge base for year two. Although the zonal IT technicians were still able to quickly improve HRIS performance, having skilled IT technicians in each field office where servers are being deployed should be planned from the start of a national information system project.

4. Efforts should be made early to develop data standards.

A wide variety of health worker information standards have been applied and modified at different levels and in different locations throughout the Tanzanian health system during the

past several decades. It is important to standardize domain values such as job function so that information such as “number of health workers performing the same job at different health facilities” can be aggregated and compared at higher levels (i.e., district, regional, national) beyond the local health facility.

There were misunderstandings between cadre and job standards defined in 2009 versus diverse older cadre standards at hospitals. These discrepancies added to delays in establishing report generation capabilities. The lesson learned was that in a national-level implementation, one should expect existing information standards to be diverse and should plan for a systematic assessment process to promote early reconciliation and standardization of key data items.

CHAPTER FOUR: INTRODUCING A VOLUNTEER CADRE OF PARA-SOCIAL WORKERS TO BRING SOCIAL WELFARE SERVICES CLOSER TO VULNERABLE CHILDREN

Background

As discussed in Chapter Two, the GOT implements a National Costed Plan of Action (NCPA) for MVC. The plan addresses the challenges of children who are under age 18 and falling under extreme conditions characterized by severe deprivation that endangers their health, well-being, and long-term development. Although poverty is the core of these issues, in Tanzania HIV and AIDS complicate the situation for children and their families. Services to MVC have been far from optimal because of insufficiently skilled human resources, lack of funding, and difficulties in conceptualizing social welfare issues at the district and village levels.

The Government's efforts to address the shortage of human resources in the social welfare sector include a strategic focus on volunteer para-social workers (PSWs) and PSW supervisors. PSWs and PSW supervisors are unpaid para-professional members of the social welfare workforce who provide valuable care and support to MVC at the village level, filling a gap in social services until the country can produce enough professional social welfare workers to meet community needs. PSWs and their supervisors live and work in the communities they serve and provide direct psychosocial support and referrals in the areas of health, education, livelihood, legal protection, housing, and nutrition. The US government (USG) supported initial curriculum development and testing through the Twinning Program between the Jane Addams College of Social Work (JACSW), the American International Health Alliance (AIHA), and the Institute of Social Work (ISW).

THRP's program of MVC-focused activities was born from these government efforts (THRP 2009) and an initial pilot in the field. The program focused on training and deploying PSWs and strengthening an interministerial approach to advocate for provision of psychosocial support to MVC at the district level. THRP's international partner in this area, TRG, provided critical technical and strategic assistance in moving this program from a pilot in six districts to a comprehensive program in 27 districts in four regions with critical monitoring and evaluation (M&E) and LGA advocacy components.

Program Approach

THRP's PSW program partnered with local institutions to build capacity, advocate with LGAs, and provide technical assistance to the DSW and PMO-RALG. THRP rolled out the program in partnership with GOT stakeholders (such as DSW, PMO-RALG, and the ISW) and with international groups including JACSW, AIHA, and FHI360. Together, THRP and partners worked to develop and mainstream the new cadre of PSWs into existing local government structures and to internally strengthen LGA systems to improve support for MVC. Through the PSW program, THRP supported implementation of the NCPA I (2007–2010) and contributed to Strategic Objective 10 of the HSSP III. SO 10 emphasizes, among other things, closing gaps in

the social welfare workforce, promoting a community-based approach to social protection, and addressing social welfare issues at both the grassroots and central levels through intersectoral collaborations (MOHSW 2008, pp. 44–45).

Through comprehensive training activities, TRHP worked to equip PSWs with foundational skills in social welfare. PSWs learned how to identify psychosocial needs in families and how to refer to community and governmental partners to address those needs. PSWs and supervisors also deepened their understanding of MVC issues. The ISW, with JACSW and AIHA technical assistance, continued to develop a core cadre of master trainers. A review of the curriculum in 2011 indicated the need for stronger HIV and AIDS content and to incorporate increased sensitivity on gender issues in providing services to MVC and in work relationships. Specific training topics and skills are summarized in Table 7.

Table 7: Overview of Training Topics for Para-social Workers

Sessions	Topics
Social work process	<ul style="list-style-type: none"> - How do we find MVC?
Developmental, legal, and ethical issues	<ul style="list-style-type: none"> - Human development - Legal and ethical issues - Crisis and trauma - Stigma and loss
MVC and their families	<ul style="list-style-type: none"> - Engaging clients - Communicating with and interviewing families - Communicating with children - Obtaining major information - Assessing the needs of the child and family
Plan of support and system rules for PSWs	<ul style="list-style-type: none"> - Developing a plan of support - Case management process - Models of implementing plans of support - Mapping community resources - Self-care and support to avoid burnout
HIV-affected children and orphans	<ul style="list-style-type: none"> - Overview of HIV/AIDS (infection control, risk reduction) - Prevention of mother-to-child transmission - Adherence to medication, including antiretroviral therapy - Case planning
Family support framework	<ul style="list-style-type: none"> - Parenting skills - Building the parenting relationship - Family transitions

Additionally, TRHP’s mandate was to go beyond training to strengthen essential systems support for the PSWs. TRHP worked with LGA leadership—specifically, the social welfare and community development officers—to establish district advocacy teams (DATs) in 27 project districts in Dodoma, Mwanza, Iringa, and Mtwara. Each DAT comprises officials from different sectors (including education, health, and social services) with responsibility for children’s welfare to bring the MVC agenda into district planning and district budgeting discussions.

Results

PSWs in the social welfare workforce

Over the four project years, 4,683 PSWs and 702 PSW supervisors participated in the foundational 9-day training from four regions (Dodoma, Mwanza, Iringa, and Mtwara) and three additional districts (Nzega, Bukoba Rural, and Musoma Rural) (Table 8). Of these participants, 2,474 PSWs and 517 supervisors received a 5-day refresher training following a six-month practicum.

Table 8: Number of PSWs Trained, by Region and by Sex, May 2009–June 2013

Region		Male	Female
Single districts	Tabora (Nzega District)	30	31
	Kagera (Bukoba Rural)	29	26
	Mara (Musoma Rural)	32	29
All Districts	Mtwara	584	338
	Iringa	623	503
	Mwanza	695	641
	Dodoma	667	455

Source: THRP 2013f. PSW program results. PowerPoint presentation. Dissemination meeting, July 31, 2013.

MVC PROGRAM RESULTS AT A GLANCE

- ❖ **Over 4,600 PSWs have been trained and deployed in the social welfare workforce.**
- ❖ **THRP facilitated a formal career path for PSWs, taking advantage of the new social welfare assistant cadre.**
- ❖ **PSWs have provided support and referrals to nearly 36,000 MVC.**
- ❖ **Districts have increased support of PSWs and MVC due to district-level advocacy.**
- ❖ **More social welfare officers have been deployed to LGAs (from 22 in 2009 to 52 in 2013).**
- ❖ **Some LGAs budgeted funds in support of MVC and PSWs.**
- ❖ **A formalized network of PSWs (PASONET) has been created.**
- ❖ **THRP guided development of a social welfare workforce strategy.**

PSWs assist to improve the relationship between the child and their family members or school. Being present in the community and acquainted with local dynamics, PSWs give practical assistance in assessing needs, helping families and children overcome obstacles to access available services, and linking MVC and their families to district social welfare officers.

Career path established

The idea of establishing a new government position for a professional social welfare assistant (SWA) had been under discussion for some time by the MOHSW. The PSW program helped make the new cadre a reality, also contributing to efforts to motivate the volunteer PSWs through the opportunity of a government career track to which they could advance. As a result of THRP advocacy, and with ISW assistance for curriculum and institutional development, the Kisangara Social Welfare Training

College launched a one-year social welfare certificate course in 2012. Graduates are eligible to apply for the new SWA positions in the civil service. PSWs (who previously met the minimum academic criteria of completing Form 4 of secondary school with passing grades) are uniquely positioned with their PSW training and experience to qualify for the formal certificate course. The inaugural certificate class registered 35 PSWs.

Linking most vulnerable children and essential services

One of the most important tasks that PSWs perform is to link MVC to services. From 2009 through early 2013, MVC received over 100,000 services after contact with PSWs (see Table 9), including psychosocial support, education, vocational training, food and nutrition, protection, shelter, and economic strengthening (THRP 2013f). The PSW role of linking needy children with service providers intertwines with psychosocial support services. By default, therefore, the most frequent service provided by PSWs was psychosocial support—35,948 MVC served (THRP 2012d). Nearly half the psychosocial support cases also received health support services.

Table 9: Cumulative Number of Services Accessed by MVC per Domain in Four Regions

Region	Direct service	Referrals						Total
	Psycho-social support	Health	Education/vocational training	Food & nutrition	Child protection	Shelter	Economic	
Dodoma	5,136	1,700	759	1,494	2,163	706	539	12,497
Iringa	32,581	18,355	18,589	22,520	13,570	10,075	5,760	121,450
Mwanza	15,000	1,943	4,139	1,749	1,164	760	3,549	28,304
Mtwara	254	2,592	2,039	1,615	1,577	1,814	3,272	13,163
Total	52,971	24,590	25,526	27,378	18,474	13,355	13,120	175,414

Source: THRP 2013f. PSW program results. PowerPoint presentation. Dissemination meeting, July 31, 2013.

Building capacity for local advocacy

Through involvement in the MVC program, LGAs have come to appreciate the human resources necessary to provide social welfare services. The realization was partly a result of the formation of the DATs, led most frequently by the district social welfare officer, whose role includes working with central government entities such as the DSW to advance issues related to MVC welfare. The advocacy teams were active in the 27 districts of Dodoma, Mwanza, Iringa, and Mtwara, bringing together staff from departments of community development and social welfare, education, HIV/AIDS coordination, health, and planning as well as a representative from the national network of PSWs (PASONET). The teams also conducted monitoring and supervised PSW activities. Eleven out of 22 district councils in Dodoma, Mwanza, and Iringa have budgeted for PSWs and MVC from their own sources of funds, as opposed to allocations from the MOHSW. When a district has no social welfare officer on staff, the advocacy team chairperson is the direct contact for PSWs at the LGA office.



District-level social worker staffing

As a result of THRP's central and district-level advocacy efforts, there has been a significant increase in hiring of social welfare officers in the district councils. The numbers particularly increased in districts where THRP's MVC program worked. There are now nine social welfare officers in Dodoma region (up from three in 2008), 28 in Mwanza region (versus 18 in 2008), and 20 in Iringa region (up from 13 in 2008) (THRP 2012d).

LGA budget commitments

Among other responsibilities, DATs represent MVC issues in district planning and budgeting meetings. A number of district councils have successfully incorporated MVC activities in their annual plans, and some even set a budget to implement the activities. By the end of THRP, 20 out of 27 MVC project districts had allocated funds to support PSWs and PSW supervisors (THRP 2013f). Additionally, village-level MVC committees (MVCCs) coordinated a considerable number of activities involving collection of resources for MVC. MVCCs facilitate community development and social welfare department affairs from a platform from which to advocate for MVC in their respective villages. They work with PSWs and community members to identify MVC and find locally appropriate ways to raise resources to meet their needs. For example, THRP documented MVC community funds established in 43 villages in Mwanza, 42 villages in Dodoma, and 31 villages in Iringa (THRP 2013f). Where MVCCs exist, there is anecdotal evidence of notably faster progress in identifying MVC and more effort to link them with local service providers such as churches, community-based organizations, and other nongovernmental organizations in communities.

PSW network (PASONET)

Working with particularly dedicated PSWs, THRP coordinated the formation and organizational development of a nationwide network of PSWs. The network, known as the PSW Network or PASONET, was established to represent PSW interests to LGAs and the Tanzania Association of Social Workers (TASWO). Formally registered as a nongovernmental organization in 2011, PASONET had established regional offices in Dodoma, Mwanza, and Iringa and 27 district offices by the end of THRP. Formal financial and operational procedures were put in place with the technical assistance of THRP.

PSW database

Building upon the success of the LGHRIS for public employees, the THRP developed a database repository of the names, personal details, and locations of PSWs by region and district. This work was done in collaboration with THRP partner, UDSM-DCS, which initially housed the database. The system is web-accessible, open source and based on open database connectivity architecture and is thus versatile for integration with other HR systems. The PSW database contains updated information accessible to district administrators through LGHRIS. It serves as a

useful reference for policy-makers and program implementers, allowing them to identify who is in their district, which areas are covered, and where additional services are needed. The database has also been transferred to the DSW within the MOHSW and PMO-RALG for their maintenance and use. Although ownership has transferred to the government, there is considerable need to strengthen capacity within the DSW to manage, support, and sustain the system with an emphasis on data quality, analysis, and use. The DSW needs to be able to scale up the system for use at the district and regional levels, quickly and easily generate reports for stakeholders for informed decisions, and dynamically link it with other HR systems.

Social welfare workforce strategy

THRP collaborated with the DSW and FHI360 to undertake the first assessment of the social welfare workforce, guiding the local consultant team that conducted the assessment. Assessment findings indicated that LGAs are an emerging and important employer of social welfare workers in the public sector and that there is a need to integrate and harmonize the roles and functions of social welfare workers and community development workers (who are not trained in social work), particularly at local level. Findings also showed a general shortage of staff for the tasks expected of social workers both in LGAs and in regional social welfare offices. Consequently, there is need for continuing education to enhance the technical capacity of existing staff, clarify performance expectations through revised job descriptions, and delineate a professional development path for social welfare officers. The assessment provided a guide for development of a draft national social welfare workforce strategy that focuses on three key areas: workforce planning; training and development; and workforce management. THRP facilitated the consultative process that produced the draft strategy, which is now in the MOHSW awaiting final approval.

Summary

Table 10 summarizes key achievements resulting from THRP’s activities in support of the social welfare workforce.

Table 10: Key Achievements in Social Welfare, by Type of Intervention, 2009–2013

Intervention Focus	Key Achievements
PSW deployment	- Trained and deployed over 4,600 para-social workers
PSW career path	- Advocated for creation of social worker assistant position as career path for PSWs
PSW referrals to services	- 175,414 referrals to services made
District-level advocacy	- Formed and trained 27 district advocacy teams
District-level staffing	- Influenced increased hiring of social welfare officers by LGAs (from 22 social welfare officers in 2009 to 52 in 2013 in the regions of Dodoma, Mwanza, and Iringa)
LGA budgeting	- Budgeting for PSW/MVC support in many LGAs - 11 of 22 districts dedicated their own resources for PSW and MVC support (as opposed to central allocations from MOHSW) - 20 of 27 project districts allocated funds to support PSWs
PASONET	- Helped create PASONET and established 27 district offices
PSW database	- Created PSW database and turned management over to the DSW
Social welfare workforce strategy	- Facilitated development of the national social welfare workforce strategy

Sustainability

The MVC program benefited from the overarching systems-strengthening approach of THRP. The MVC program grew from a pilot program focused on training a new cadre of village-level workers to advocacy for the HR system inputs essential for the new cadre to be successful. Advocacy by the DATs and THRP staff reports indicate that inputs of improved supervision, incentives for retention, appropriate remuneration, and adequate staffing with professional social workers are needed at the LGA level to support village-level PSWs. Engaging with relevant government systems such as PMO-RALG and established nongovernmental actors, the MVC program carried out interventions within the context of particular LGAs. The various partners took part in the design, implementation, and evaluation of MVC-related efforts through an inclusive approach that cultivated a sense of ownership.

Some of the results of the intervention have been institutionalized. For example, the admission of PSWs to the inaugural social work assistant course at Kisangara Social Training College offers



a career path for volunteer PSWs to become government SWAs. Moreover, formalization of the PASONET nationwide network of PSWs has made the volunteers members of a national organization advocating for their interests.

Throughout program implementation, we have documented the techniques, skills, and knowledge in various formats. These include a program review with practical information about what worked and what did not work (THRP 2011c), and a program implementation guide that gives step-by-step guidance on how to implement a similar program. It is encouraging to note that other organizations have replicated the PSW program model as a training resource for their MVC service delivery programs, including World Education in Karatu District. In addition, Pact and Africare have engaged PSWs trained through THRP to extend social welfare services in their programs. The integration of the THRP-initiated PSW database at DSW and PMO-RALG has made it easier for other organizations to access and engage PSWs in relevant activities. Simply by calling up the list of PSWs in a particular area, the DSW can see who is a PSW and their location and thus can seek them out to assist the organization's efforts.

Lessons Learned: Para-social Workers and MVC

1. Promoting the importance of social welfare issues among decision-makers is crucial.

The MVC welfare program with trained village PSWs and supervisors in place was more successful at generating community ownership and concern for MVC at the village level than at the district level. THRP noticed that constant advocacy was vitally important to changing the mindset of decision-makers and development planners so that they accord due priority

to social welfare issues. THRP worked with the district advocacy teams to influence district planners to more seriously consider social welfare issues.

Partnership with LGA leadership in all elements of community welfare programs (including sensitization, planning, training, follow-up, and monitoring and evaluation) proved instrumental for continuation and support to PSW activities at the village level. In general, district welfare departments and LGA leadership need stronger technical capacity to assess and analyze the welfare needs in their communities. That capacity should be coupled with the ability to inform decision-makers and devise a way to tap into available resources, or align available efforts to respond to emerging social welfare needs.

When working with government partners at all levels (national, regional, district, and community levels), message consistency is paramount for program success. District councils are willing to support PSWs, especially in co-funding arrangements when planning coincides with the LGA budget cycle. District social welfare units do not have enough funds in their budgets and resources to perform the entire range of social work functions, but when councils were sensitized, they were usually willing to budget for MVC by supporting PSWs.

2. PSW selection needs criteria review and adjustment.

The eligibility criteria used to select PSWs—a minimum of Form Four education (the first four years of secondary school)—produced lessons and created challenges. The Form Four standard for participation as a PSW excludes potential volunteers who lack academic qualifications but may have valuable work experience with children or volunteer skill-building. Lowering the educational standard criterion might also increase the number of female PSWs, given that more males than females meet the education criterion. However, reducing the academic requirements below secondary education would limit the potential for PSWs to pursue a career path and job opportunities as a SWA in the civil service, which requires reaching at least the level of Form Four. It is possible that additional criteria (such as experience volunteering in the community, interest in volunteer social services, or recognition as leader) could be added to the application process to help identify older, established community residents who are Form Four leavers. This would increase the number of female PSWs already recognized in the community and might also reduce PSW dropout due to financial remuneration through job possibilities elsewhere.

3. Partnerships are essential to establish and sustain PSWs.

Partnering with professional social work organizations, local nongovernmental organizations, and USAID-funded implementing partners at all levels is important for establishing PSWs within existing systems of community services and exposing them to potential organizational resources. USAID-funded MVC service delivery implementing partners have recognized the important role of PSWs in supporting MVC and are recruiting PSWs to work in their programs where feasible; however, these groups do not have the budget to continue the PSW program to the program standard of having one PSW based in every village.

4. PSWs need opportunities for advancement from volunteer to paid positions.

The SWA cadre is endangered if LGAs do not budget for these civil service positions and hire staff accordingly. Few SWA positions have been created thus far, and the number of PSWs

trained as SWAs greatly outnumbers the positions available for them. Continued advocacy involving the MOHSW and PMO-RALG is necessary.

Para-social Worker Organizes Community to Take Care of the Most Vulnerable Children

Due to the high prevalence of HIV, there are a staggering number of most vulnerable children (MVC) in Idunda, a village community on a hilly terrain east of Njombe town, headquarters of Tanzania's newest Njombe region. Disintegrating traditional social networks have weakened parental support and diminished the availability of school fees, food, and shelter for children.

Eloy Kihindo, a caring ex-village executive, was emotionally affected by the poverty-fueled vulnerability of children in the village. Armed with mere enthusiasm, he struggled to find resources to meet the children's acute needs. When the USAID-funded Tanzania Human Resource Capacity Project (THRP) organized a training for volunteer para-social workers (PSWs) in Njombe, nearby Idunda village sent Kihindo to the training. There, he received skills to identify vulnerable children, provide critical counseling, and organize locally available resources. Assisted by the village government, he enlightened villagers about the problems of children who lack parental care, and as a result, the village formed a committee that coordinates community efforts to care for MVC.

"Many people in Idunda now feel obliged to take care of MVC," says Kihindo, who has identified 50 MVC in the village out of a total of 200 children.

In 2011, each of the six subvillages of Idunda grew an acre of sorghum to raise funds for MVC care. Through May 2012 the project had cashed in TZS 400,000 (USD \$258) in sorghum to provide school fees and purchase learning materials for MVC in public primary and secondary schools. With fewer worries over resources, Kihindo believes the problem of MVC in his village is now manageable. "We have identified all of the MVC, and we have encouraged their clan members to take them in; and the village will complement their efforts."

PSWs trained through the THRP coordinate similar efforts in 21 districts across Tanzania, filling a gap in village-level social welfare services. As of July 2013, almost 4,700 PSWs had been trained and deployed.

CHAPTER FIVE: BUILDING THE CAPACITY OF LOCAL ORGANIZATIONS TO LEAD

Background

In the spirit of USAID Forward and PEPFAR II, the THRP coalition was designed with the intent for the prime partner, IntraHealth International, to “lead from the sidelines.” IntraHealth and BMAF co-led the project, with additional direct implementation by a coalition of local partners, namely the CSSC, AKF, and the Department of Computer Sciences at the UDSM.

Though not a direct project objective or stated intermediate result, THRP was committed to building the institutional capacity of BMAF and CSSC. Both experienced tremendous organizational growth during the project period. The focus was not only on strengthening the organizational potential of BMAF and CSSC to receive direct funding from the USG but also to prepare the organizations to be HRH champions in Tanzania. This involved establishing systems and equipping staff at all levels with the essential leadership and management skills to assess risks and realities, manage people for optimal performance, and achieve results. With the focus on building overall institutional capacity, THRP facilitated technical assistance through MSH’s network of local experts to strengthen financial management, procurement, and performance management systems at BMAF and CSSC. MSH initiated the process in the first year with participatory self-assessments, using the Management and Organizational Sustainability Tool (MOST) (MSH 2010), which identified priority actions for particular attention. Beyond focused attention on individual operational systems, THRP facilitated work with BMAF and international management consultants and local HR experts to focus on overall organizational leadership, structure, and systems.

IntraHealth provided orientation on gender and HRH issues to 16 THRP partner organizations (including BMAF, CSSC, AKF, and ISW), strengthening participant knowledge about gender; gender equality in the workforce; forms of gender discrimination and workplace violence; and the protections provided in international and Tanzanian labor standards against gender discrimination. Representatives from the Ministry of Gender and Community Development presented the Tanzania Employment and Labor Relations Act (ELRA) and the development of Tanzania’s gender policy. The project also worked closely with all four local organizations to strengthen their ability to manage USG funds through training on USAID rules and regulations; workshops on effective program management with a focus on results and how to plan for and monitor them; annual management reviews; and monthly financial and compliance monitoring. Efforts to strengthen organizational capacity in monitoring and evaluation are discussed below.

Results

BMAF

BMAF is a strong organization that is consistently solicits feedback looking to improve. In 2010, in anticipation of a large amount of Global Fund funding and vast program activities to be implemented, BMAF leadership and key development partners were anxious to see the organization scale up to meet implementation requirements and donor expectations. THRP

supported two strategic management consultancies to assist BMAF in the process of planning and managing tremendous organizational growth. A comprehensive organizational review identified priority actions required for scaling up. One result was the preparation of an organizational plan of priority actions for 2011, the implementation of which required an enhanced staff complement and skill mix. In conjunction with the organizational review, THRP supported a review of the organization’s staffing structure, resulting in an expanded staff structure, new positions, and some redeployment.

Through the course of program implementation, IntraHealth worked closely with BMAF to raise standards for reporting, consultant management, evidence-based project documentation, and quality of project communications. BMAF’s skilled leaders across programs accepted feedback incorporating different management processes to manage IntraHealth and USAID expectations.

By the third year of the project, BMAF had grown, and efforts to establish numerous operational systems had paid off. Financial management, HR, and IT systems, among others, were in place, although they are not yet all functioning at full capacity. The organization now develops an annual operational plan using an electronic dashboard to provide regular progress on organizational performance. BMAF adopted a new organizational structure leading to an increase in staffing and opened three field offices in Mtwara, Iringa, and Mwanza to effectively manage the expanding scope of work. BMAF is also focusing on building a sustainable business model; it established a resource mobilization unit, is strengthening staff skills, and is targeting Tanzania’s private sector as one strategy for the Foundation’s sustainability. In anticipation of developing its latest strategic plan (2013–2018), BMAF identified its current strengths and weaknesses, as shown in Table 11.

Table 11: BMAF Identification of Organizational Strengths and Weaknesses

Internal Strengths	Internal Weaknesses
Strong and competent leadership to steer the attainment of BMAF vision and mission	Fully dependent on donor funding
Effective operational policies, structures, and systems	Lacking an integrated and electronic financial, human resources, and payroll system
Headquarters office and three regional offices in place with effective management and coordination of program activities	Inadequate internal and external communications, resulting in weak linkages and coordination
Competent and adaptive staff members deployed in all positions; providing quality technical and advisory services to implementers	Monitoring and evaluation system not automated or comprehensive; concentrates on outputs and less on outcomes of BMAF interventions, affecting effective coordination of multiple projects
Strong and trusted partner of the Government of Tanzania	BMAF systems and staff overstretched by development partners’ different policies on program design, planning, and implementation
Credibility enhanced by positive feedback from external audits and evaluation by different institutions	
A niche in human resources for health and a good reputation nationally and internationally	

Source: BMAF 2013. Strategic plan 2013–2018.

CSSC

Since 2009, CSSC has undergone a change in leadership and a period of significant programmatic and financial growth which, while desirable, placed strain on key operational systems that were initially designed and functioning under different conditions. Throughout the project, CSSC worked with MSH technical experts to build its institutional capacity on several priority systems challenges, including strengthening procedures and accountability between CSSC’s central and zonal offices; strengthening the implementation of established procurement procedures and policies; and establishing an executive dashboard to streamline information for key decisions.

Summary

As lead local coalition partner, BMAF was the public face of THRP at the national and district levels, providing critical support for THRP outcomes. BMAF has an important political and contextual understanding that informed program design and facilitated convening of key stakeholders. BMAF’s relationships at the national level supported legitimacy in its work with local government authorities; at the same time, the increased exposure and understanding of local government challenges added to the organization’s legitimacy at the national level. BMAF’s growing reputation as an HRH leader will strengthen the organization’s future efforts as a key HRH development partner.

Table 12 summarizes key achievements resulting from THRP’s leadership-building activities with BMAF and CSSC.

Table 12: Key Achievements in Building Leadership Capacity, by Type of Intervention, 2009–2013

Intervention Focus	Key Achievements
Organizational development: BMAF	<ul style="list-style-type: none"> - Supported comprehensive organizational restructuring and strengthening of operational systems - Supported staff rationalization and performance management - Implemented operational plan of action for programmatic and support services - Reviewed and updated organizational strategic plan (2008–2013) - Facilitated use of accounting program - Developed ICT policies and guidelines - Developed operational plan of action
Organizational development: CSSC	<ul style="list-style-type: none"> - Strengthened institutional capacity through stronger operational systems - Streamlined finance and accounting manual - Developed operations manual for zonal offices - Established procurement policies and guidelines - Improved filing system - Revised ICT policy and strategy - Implemented executive dashboard - Strengthened performance appraisal process - Developed gender policy
USG funds management	<ul style="list-style-type: none"> - Ensured that BMAF, CSSC, and UDSM staff are well acquainted with USAID rules and regulations for financial management and compliance

Sustainability

BMAF is poised for organizational success, contributing to Tanzania's response to HIV/AIDS and maternal and reproductive health challenges while providing leadership in the national HRH agenda. In its second strategic plan (2013–2018), BMAF is building on the experiences and lessons learned from the implementation of multiple programs since its inception. It has set the stage for identifying evidence-based solutions for HRH, improving related program efforts, and managing complementary information, education, and communication efforts. BMAF continues to build a sustainable business model for itself, strengthening the effectiveness of its operational systems and structure and the technical leadership of its team.

CHAPTER SIX: MONITORING, EVALUATION, AND KNOWLEDGE MANAGEMENT

Background

During project start-up, the M&E staff developed a performance management plan (PMP) to guide the monitoring of program results and activities on an ongoing basis and to ensure a shared understanding among staff across all local organizations of how to define, calculate, and report project indicators. The PMP consisted of 15 key indicators and 34 subindicators comprising PEPFAR (President’s Emergency Plan for AIDS Relief) and USAID-recommended and country-specific custom indicators designed to measure the immediate and intermediate effects of project activities. Each local organization developed a PMP to reflect its subproject expectations. PMP indicators focused on the project’s primary technical areas:

- HRH strategy, system implementation, and planning
- Workforce recruitment, management, and retention
- Productivity
- Knowledge management (cross-cutting)
- Gender (cross-cutting).

At a broader level, the core indicators assessed changes at the national or subnational levels to measure the existence or strength of systems related to HRH and human capacity development (HCD) (immediate outcomes) as well as program-level output and outcome measurements. The project’s M&E plan included a results framework (Appendix 6) and PMP and performance indicator reference sheets with detailed definitions for all core and subindicators to ensure reliable measurement. The primary THRP M&E activities included the following:

1. Conduct baseline assessments, studies on select HRH themes, and CCHP analyses
2. Monitor changes in core performance indicators to assess the effects of the project’s work on national and subnational-level HRH systems and assess program-level effects
3. Provide M&E technical assistance to field-supported programs, local partners, and to the Government
 - a. Coordinate data collection activities to inform program strategy; for example, by strengthening the process of data collection by PSWs documenting their support for MVC and reporting from village to ward and on up the district
 - b. Ensure adequate documentation of project contributions to USAID and PEPFAR objectives.

Program Monitoring Activities

In addition to the activities already described, THRP used the following standard data collection and reporting tools to collect data on indicators in the PMP:

- **Training, workshop, and meeting reports**
THRP reviewed all partners' training and workshop reports for information on the number and sex of participants in all training programs and workshops.
- **Quarterly progress reports and partner meetings**
THRP reviewed partners' quarterly progress reports to obtain data to measure progress implementing activities related to district HRH strengthening, HRIS development and support, and the para-social worker program. THRP collected additional qualitative information during quarterly THRP progress and planning meetings.
- **Coaching and mentoring reports**
Coaching visits to THRP districts were a regular program activity. The coaching teams reviewed each district's CCHP to obtain data on HRH activities designated within each district's budget. They also discussed progress of the activity plans developed during initial HRM training.
- **District health worker reports**
The districts provided data on district staffing levels such as staffing requirements by cadre, retained staff, and vacant positions by cadre.
- **PSW database**
The PSW database provided data for measuring several indicators tracking PSWs and PSW supervisors. The database also provided PSW and supervisor personnel information such as name, sex, age, location, contacts, current economic activities, and average income per month.
- **Human resources information system (HRIS)**
In collaboration with PMO-RALG, the MOH Zanzibar, and CSSC, IntraHealth installed HRIS to provide routine HR data for health workers in public and private health facilities, respectively. The HRIS provided data on several indicators on health workforce planning and management at the district level, on Zanzibar, and in CSSC zones.
- **HRIS assessments**
THRP M&E staff (in collaboration with PMO-RALG, UDSM, and CSSC) collected data at the sites where HRIS was installed to measure indicators in the PMP measuring function as well as use of HRIS for decision-making in districts and CSSC zones.
- **PSW program assessments**
The M&E unit also collaborated with PSW program staff to conduct an assessment in Iringa region to obtain data on indicators to measure the capacity of PSWs to deliver quality services to MVC.

Data Quality

THRP conducted a series of data quality assessments (DQAs) over the course of the project, the purpose being to determine the validity, reliability, timeliness, precision, and integrity of results produced by key project indicators. THRP employed a standard IntraHealth DQA tool to assess data and used the findings to pinpoint and address weaknesses in the reporting system. Routine DQA activities included:

1. **Quarterly partner reports:** These were physically verified by counterchecking electronic reports against available hard copies.
2. **Regional systems follow-up and mini-DQAs:** IntraHealth carried out mini-DQAs of the LGHRIS in December 2012 and May 2013 in Iringa region. Verifications were done by comparing data in the HRIS database against data in physical files. THRP also randomly selected a predetermined number of physical files and compared their contents with those in the database.
3. **Capacity building:** Following a jointly-conducted DQA of FBO hospitals in CSSC's northern zone in 2010, CSSC continued to conduct mini-DQAs as part of supportive supervision visits to its other zonal offices.

In addition to routine assessments, the project M&E staff carried out a number of more extensive DQA activities. In 2009, the project carried out a DQA in Dodoma to assess the PSW program data reporting system and progress in program implementation in three districts. Through consultations, document reviews, and interviews, the DQA found inconsistencies between site and headquarters data; possible overreporting of the number of MVC served; and poor and incomplete report submissions. Once these problems were identified, THRP took actions to improve the analysis and reporting of program results. Similar DQAs were conducted in Iringa and Mwanza, resulting in development of strategic plans for program implementation.

THRP strengthened CSSC internal capacity to conduct DQA on HRIS data, for example, entered into systems established in faith-based facilities. During one field support effort, CSSC staff visited 13 sample sites (five CSSC hospitals, five CSSC zonal offices, and three APHFTA zonal offices) to assess the completeness and utilization of generated data. The percentage of complete data ranged from 63.5%–90% (see Table 13). CSSC sites performed better than APHFTA sites at the time.

Table 13: Data Quality Assessment (DQA) for Select Private-Sector Health Facilities, August 2012

Hospital/Office		% completed (quality)	% incomplete data	% wrongly filled	Data utilization	Type of data utilized
CSSC facilities	Sumve District Designated Hospital	90	9.1	7.4	Retirement report	Retirement and list of available cadres for planning
	Mbalizi Council Designated Hospital	83.7	16	17	In process	
	Dareda Council Designated Hospital	90	14	9.1	List of medical officers	
	St. Gaspar	89.4	19.5	10.6	None	
	Mvumi District Designated Hospital	68	27	8.9	Preparation of Tange list	List of designation titles
APHFTA zonal offices	Lake Zone	89	11	10	List of facilities for credit funding	List of all Lake Zone facilities for planning in providing credit to private facilities
	Southern Highland Zone	63.5	34	75	None	

Source: CSSC, THRP Quarterly Report July-September 2012.

CSSC continued to raise awareness and make use of available data for managerial purposes. CSSC is emphasizing the utilization of data for decision-making and will continue to provide assistance to BAKWATA, APHFTA, and APHFTA's zonal offices.

Program Assessment and Studies

Prior to and during program implementation, THRP carried out several program assessments. In April–May 2010, IntraHealth collaborated with the MOHSW on a baseline assessment examining current HRM systems and practices. The purpose was to develop a benchmark system consisting of a set of process indicators that would be used to measure progress toward achieving program outcomes. The baseline assessment was conducted in 13 districts of Mtwara, Lindi, and Iringa regions. The baseline data covered the indicators outlined in Table 14.

Table 14: Key Indicators from Baseline Assessment

Domain	Indicators
Vacancy	<ul style="list-style-type: none"> - Number of staff required - Number of staff available (by cadre and FY)
Retention	<ul style="list-style-type: none"> - Number of positions approved - Number of positions posted - Number of new health workers reported - Number of new health workers available (disaggregated by cadre and FY)
Supportive supervision	<ul style="list-style-type: none"> - Number of visits conducted per FY - Number of HR components supported during visits - Existing process of using the findings for HRM strengthening - Existence of training on supportive supervision, HR, and management skills - Challenges district faces and support needed
OPRAS	<ul style="list-style-type: none"> - Total number of staff - Number of staff with performance agreement - Completed OPRAS form at mid-year - Number of staff appraised at the end of the year
HRM financing	<ul style="list-style-type: none"> - Budget allocated for HRM activities - Percent of HRM activities (excluding program evaluation) making up total budget - List of HRM activities budgeted for - Percent of activities implemented

THRP used the baseline assessment findings to guide selection of the interventions that would best improve staff retention, productivity, work climate, and human resources management information systems in project districts. THRP put forward recommendations to the MOHSW and used the information to develop the approach described in Chapter Two to strengthen district HR management practices.

As discussed in Chapter Three, THRP conducted a number of select analyses to augment existing knowledge on HRH issues and challenges. These studies varied in their rigor and formal assessment processes, and several were never finalized due to lack of evidence or citations to back up general statements. The focus was to use the findings to inform and/or improve various program interventions in the areas of human resources management, recruitment and retention, and social welfare, as shown:

- **Human resources management**
 - Council Comprehensive Health Plan (CCHP) analyses (2)
 - Tracking study of posted health workers
 - Makete baseline assessment of HRIS
- **Recruitment and retention**
 - Recruitment bottlenecks study
 - Survey of orientation processes and practices
 - Work climate initiatives assessment
 - Multisectoral criteria study
- **Social welfare**
 - Social welfare workforce assessment
 - MVC program baseline studies (Mwanza and Iringa)
 - MVC program assessment (Iringa)

Lessons learned from these studies informed decision-making on the content of interventions. For instance, findings from two studies (multisectoral criteria for defining underserved areas, baseline study) provided empirical evidence about the potency of formalized orientation and guided development of an orientation package for health workers that the MOHSW endorsed for use not only in THRP project districts but countrywide through the Global Fund health system strengthening program. The THRP social welfare workforce assessment gave rise to Tanzania's first national social welfare workforce strategy.

To better understand the true story behind staff vacancies and retention, BMAF conducted lengthy analyses of the 2009/10–2012/13 CCHPs for the 54 THRP districts to determine the contribution of the THRP district strengthening component to reducing human resources shortages in the selected districts. Vacancy rates for CHMT members and other district-level health workers were the unit of analysis. Despite problematic data quality in the early 2009/10 and 2010/11 CCHPs, analysis of the CCHP data helped to establish trends over the years. The information also assisted in identifying priority areas for intervention during project implementation. The data were collected through desk reviews of CCHPs submitted by 54 districts to the MOHSW with follow-up by BMAF staff to confirm much of the information in the 2009/2010 plans.

Knowledge Management

Over the course of implementation, the project generated a great deal of useful information on effective ways to execute successful HRH programs and identify root causes of HRH challenges. THRP disseminated this knowledge through a variety of venues, including printed articles and reports, dissemination meetings, and conferences, described in greater detail below.

Technical documents

Key THRP studies investigated underlying reasons for ineffective recruitment, lack of local incentives, slow adoption of OPRAS, and criteria for defining underserved areas. These

investigations and assessments, including the 2009 Dodoma DQA, generated the eight technical publications listed in Table 15.

Table 15: Key THRP Technical Publications, by Year

Title	Year	Available from
OPRAS study: A critical analysis of studies done on OPRAS, its governing policies, systems, guidelines, and processes as applied in the Tanzanian health sector under local government authorities (published report)	2010	BMAF and IntraHealth
Recruitment bottlenecks study: Review of recruitment challenges of health workers in Tanzania and ways of closing the gaps (final report)	2010	IMAF, IntraHealth and MOHSW
HRH tracking analysis for posted health workers in financial year 2007/2008–2009/2010 (published report)	2011	BMAF, IntraHealth and MOHSW
Baseline study: Human resource management systems at the district level (final report)	2011	BMAF and IntraHealth
Multisectoral criteria for defining underserved areas: A basis for developing an incentive package (published report)	2012	BMAF and IntraHealth
Monitoring and evaluation report: Continuing education program Iringa (final report)	2013	AKF and IntraHealth
HRM district strengthening training: Facilitator’s guide (published guide)	2013	BMAF, IntraHealth and MOHSW
Social welfare workforce strategy	2013	IntraHealth and MOHSW

Dissemination meetings

THRP organized two dissemination meetings in 2013 as part of the project exit strategy. THRP convened members of CHMTs and central government officials from the MOHSW in May to engage in the district health strengthening component. The purpose of the meeting was for LGAs to give feedback about how well the current HRM system was functioning and review LGA effectiveness in applying the HRM practices included in the district strengthening component. The meeting was designed to expose THRP best practices to stakeholders. THRP recognized two districts, Ukerewe and Makete, which had demonstrated notable improvements in HRM processes. The event was also an opportunity to launch four important guidelines that the project has contributed toward HRM improvement in the health sector, especially at LGA level. On behalf of the Principal Secretary, the MOHSW representative declared the ministry’s commitment to scaling up the best practices across the country and sustaining project results.

IntraHealth conducted its final PSW program dissemination meeting at the end of July 2013. Participants included public-sector stakeholders (MOHSW and PMO-RALG) and stakeholders from ISW, PASONET, nongovernmental organizations, and the donor community. The overall purpose of the meeting was to disseminate a vast range of project information (progress and accomplishments, lessons learned, and challenges for the future) and generate ideas and buy-in for future program sustainability. The meeting’s focus was on systems strengthening,

partnerships, and linkages for success. A lively exchange followed the presentations, raising serious issues sparked by the program for broader discussion. These included:

- How to scale up the program and continue support for the current regions following the end of THRP
- How best to use trained PSWs at the local level, given confusion over the functions of the social welfare officers
- How to clarify and strengthen the role of social welfare officers within districts
- Advocacy for the social welfare assistant cadre
- How to motivate PSWs
- More emphasis on preventing MVC in the first place.

National HRH conference

Tanzania's first national HRH conference, held in September 2013 and jointly organized by THRP and the MOHSW, represented a national platform for the project to communicate critical information about program successes and lessons to policy-makers and national leaders. The conference provided an opportunity to disseminate lessons learned, best practices, and THRP implementation methods. The conference also provided a forum for presenters from districts well outside Dar es Salaam to share their experiences—a voice that is often neglected in national gatherings.

Application of Project Methodologies and Information

Over the course of the project, four THRP-developed guidelines and models were adopted and integrated into the national HRH system:

1. **District strengthening:** The THRP HRM district strengthening model is currently being rolled out nationwide by the MOHSW and BMAF under Global Fund Round 9. The rollout includes scaling up the orientation package, introducing supportive supervision for HRH, active coaching and mentoring, and facilitating job fairs in addition to HRM training (as discussed in Chapter One).
2. **District advocacy:** The district advocacy team model in support of the PSW and MVC program introduced under THRP has been replicated in northern Tanzania by World Education Inc. (WEI), a USAID-funded Pamoja Tuwalee partner (World Education 2013).
3. **PSWs:** The DSW has adopted the THRP para-social worker program guide as a reference for implementing similar programs in the future.
4. **Social welfare workforce:** The social welfare workforce strategy, developed with technical support from THRP, has been finalized and will be used to guide management and utilization of the social welfare workforce. The concepts are also to be included in the next HRH strategic plan (2014—2018) currently in development.

Data Use

The MOH in Zanzibar used the HRIS to justify increasing its health workforce by 27% between 2011 and 2013. This represents one of the best THRP-related examples of using data to make concrete changes. The HRIS tool provided the sound data that the MOH required to substantiate the need for more clinic staff.

On the Tanzanian mainland, the LGHRIS has successfully recorded data for 81% of LGA staff, a substantial improvement over the prior Excel-based system, which lacked a comprehensive format and could not effectively integrate with the national HRIS designed for payroll purposes. Moreover, the new LGHRIS links data from both the public and private sectors and also will be able to draw on personnel information for all public-sector employees, not just those in the health sector. These comprehensive features will save costs in data collection and storage.

CONCLUSION

The timing for renewing the visibility and energy around Tanzania's HRH agenda could not be better. Tanzania is in the process of developing its next five-year national HRH strategic plan and is already conceptualizing its Health Sector Strategic Plan IV. In addition, development of a national health care financing strategy is well underway, a pay-for-performance pilot program is being redesigned for national scale-up, and the health sector is a strong candidate for inclusion in Tanzania's next Big Results Now round. All these initiatives, most outside the health sector, necessitate a dialogue for integrating HRH.

Ultimately, the national movement to increase the reach of health services needs to embrace cross-sectoral HRH initiatives and sustain HRH achievements to ensure that a skilled health and social welfare workforce is available to community members across Tanzania. While tremendous HRH progress has been achieved under THRP, it is increasingly clear that more work is needed to address HRH priorities in the context of overarching health-systems-strengthening priorities so as to improve the overall health care system in Tanzania and sustain current initiatives once donor support ends.

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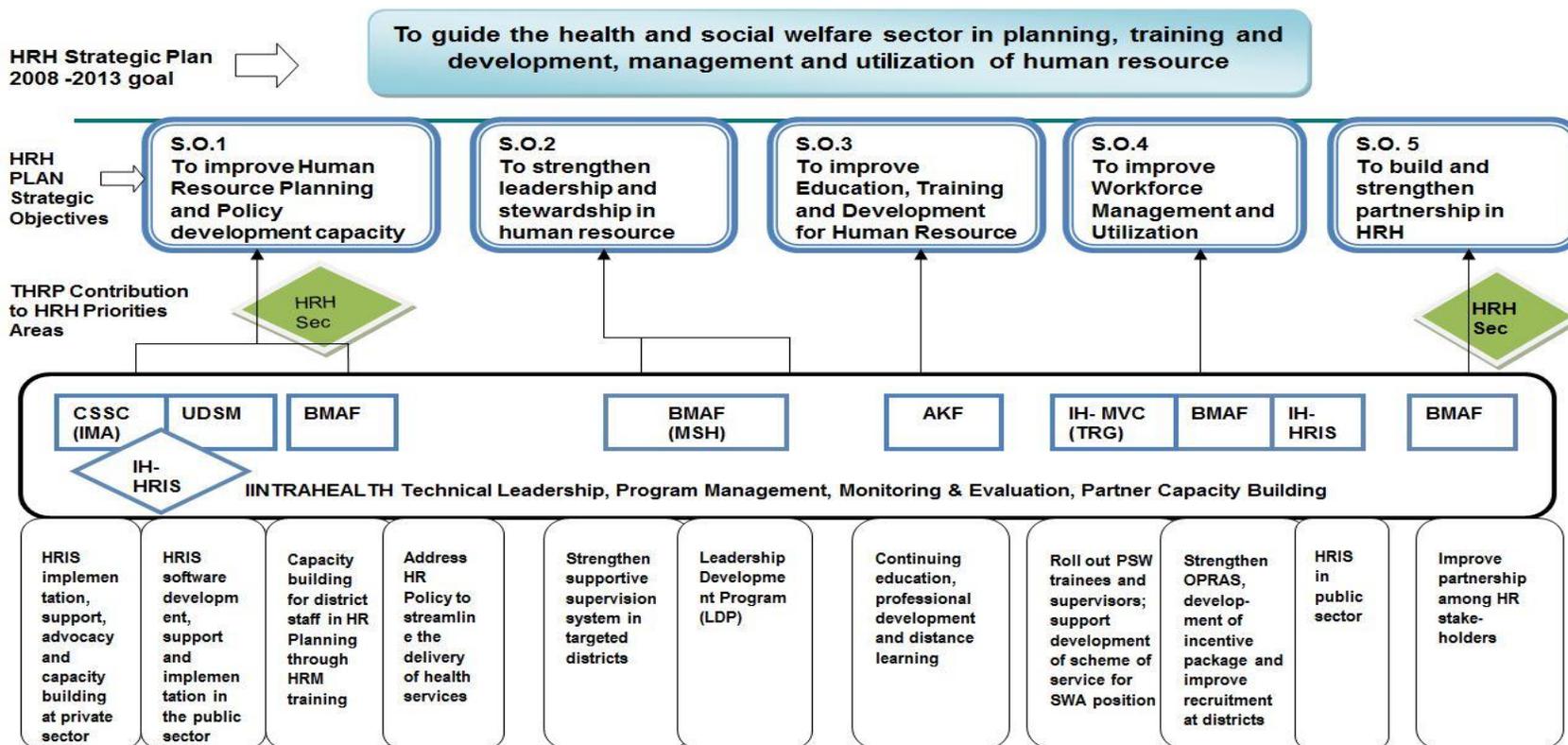
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APPENDIX 1: THRP CONTRIBUTIONS TO NATIONAL HRH STRATEGIC PLAN 2008–2013

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



CSSC: Christian Social Services Commission

UDAM: University of Dar es Salaam

BMAF: Benjamin Mkapa AIDS Foundation

AKF: Aga Khan Foundation

MSH: Management Sciences for Health

IMA: Inter-church Medical Association

TRG: Training Resources Group

APPENDIX 2: LOCALIZED INCENTIVES AND RETENTION STRATEGIES FROM 16 LGAs

District	Financial Incentives	Work Environment Incentives
Makete DC-Iringa	NA	<ul style="list-style-type: none"> Provides tea for staff on night duty Supplies charcoal for night-duty staff
Iringa DC-Iringa	<ul style="list-style-type: none"> With funding from CUAAM (local NGO), implements pay for performance strategy for best performing health facilities Pays salary advance to staff whose salaries are delayed for more than a month 	<ul style="list-style-type: none"> Prioritizes difficult-to-reach areas when distributing bicycles, motorbikes Provides transport to new work stations Pays a week of full-board lodging for freshly reporting staff
Ludewa DC-Iringa	<ul style="list-style-type: none"> Pays nutrition allowance to health workers who are living with HIV 	<ul style="list-style-type: none"> Stations new staff at district hospital for six months before posting to lower-level facilities Provides temporary accommodation for newly recruited staff
Ruangwa DC-Lindi	<ul style="list-style-type: none"> Pays Tsh 50,000/- nutrition allowance to health staff living with HIV 	NA
Nachingwea DC-Lindi	<ul style="list-style-type: none"> Provides Tsh 300,000/- for each new staff, in addition to subsistence allowance Provides salary advances to newly recruited staff before names appear in standard payroll system 	<ul style="list-style-type: none"> Pays for accommodation for new employees up to one month Provides mattresses for newly employed staff
Liwale DC-Lindi	<ul style="list-style-type: none"> Provides salary advances to newly recruited staff before names appear in standard payroll system 	<ul style="list-style-type: none"> Allocated two houses as “rest houses” to accommodate new staff for six months
Kilwa DC-Lindi	<ul style="list-style-type: none"> Provides salary advances to newly recruited staff before names appear in standard payroll system 	<ul style="list-style-type: none"> Provides temporary accommodation to new staff for the first two months
Bukoba DC-Kagera	<ul style="list-style-type: none"> Provides salary advances to newly recruited staff before names appear in standard payroll system 	
Bukoba MC-Kagera	NA	<ul style="list-style-type: none"> Pays for hotel accommodation for new staff for seven days
Chato DC-Kagera	NA	<ul style="list-style-type: none"> Provides bed and mattress for new staff
Kishapu DC-Shinyanga	<ul style="list-style-type: none"> Provides allowance for paying house rent for newly employed staff 	
Newala DC-Mtwara	<ul style="list-style-type: none"> Provides salary advances to newly recruited staff before names appear in standard payroll system 	<ul style="list-style-type: none"> Provides tea for staff on night duty
Nanyumbu DC-Mtwara	NA	<ul style="list-style-type: none"> Provides tea for staff on night duty Provides work station transport for new staff Provides two weeks’ free housing for new employees
Tunduru DC-Ruvuma	NA	<ul style="list-style-type: none"> Provision of mattresses to newly employed health workers
Songea MC-Ruvuma	NA	<ul style="list-style-type: none"> Provision of tea to all staff
Mbinga DC-Ruvuma	<ul style="list-style-type: none"> Rewards a bonus to health workers who performed well, based on OPRAS 	<ul style="list-style-type: none"> 50% subsidy to buy motorcycle for health workers and other district staff Placed water tanks in 20 health facilities for staff to get water in their houses Provides airtime subject to position, amount in LGA incentive policy, and fund availability Provides accommodation to all newly employed health workers

APPENDIX 3: NATIONAL HRH CONFERENCE RECOMMENDATIONS

Cross-Cutting Priorities

1. Coordinate and align HRH priorities across four key ministries: MOHSW, PMO-RALG, POPSM, and MOF
 - Continue quarterly interministerial meetings, include senior MOF participation
 - Identify an entity or individual who is accountable to follow up decisions from interministerial discussions and agreed-upon next steps
 - Develop communications mechanism to advise and provide feedback to established technical working groups: HRH TWG, National CHW task force, HRH Task Sharing task force, national pay for performance task force, etc.
2. Coordinate and align HRH priorities with LGA needs
 - Ensure LGAs have sufficient planning tools and specific information (national priorities, financial status, production trend and ceilings from POPSM, and relevant policy direct for that year) to guide their annual staff planning
 - Strengthen HRH coordination across districts within each region. Consider the existing Regional Secretariat role in overseeing HR in LGAs; build technical capacity for HRM (in much more detail) for RHMT
3. Coordinate and rationalize public sector and private sector priorities for HRH
4. Promote use of data to inform decisions, national plans and priorities
 - Use data from existing research; continue to support research for HRH; action agenda should continue to inform research topics
 - Increase emphasis on client perspective and experiences. What is the quality of services? How do health workers behave to patients? Studies suggest women are less inclined to deliver at HF if they perceive poor attitude of HWs. Use findings to address the problem.
 - Strengthen feedback mechanisms for sharing information; strengthen the coordination of information-sharing among various HRH stakeholders

Planning and Recruitment

5. Increase the annual recruitment of mid-level cadres and specialized professions with staffing requirements as generated from the LGAs
 - For example: nutritionists, social welfare officers, bioengineers, data clerks. Need to align LGA request vis-à-vis recruitment permit
6. Align production plan with staffing norms and projections of need by cadre
 - Conduct a labor market survey (including the private sector, government, non-health sector, unemployed or self-employed) to understand the current unabsorbed workforce and determine the reasons (pull versus push factors) of non-absorbed HW

- by cadre to inform priorities in employment production and incentives and retention strategies
7. Align existing multiple HRIS, provide concrete vision and clear milestones on the system utilization at all levels to enhance effective utilization of data in HR decisions
 - POPSM to take the lead to facilitate interministerial discussion
 8. Define underserved/hard-to-reach areas
 - POPSM to move forward with finalizing this definition in collaboration with partners and stakeholders and using the definition to prioritize areas during annual staff allocation
 9. Advocate for increase of HRH budget to MOF using hard data to show importance of health workers (and related costs) to health outcomes
 - Need to document relationship between productivity of health workers and health outcomes. Conduct comparison study on productivity of facilities that are staffed and have favorable working conditions and those which are not staffed with limitation of working conditions
 10. Prioritize HRH activities in the other charges (OC) budget at all levels
 - Leverage the OC budget to ensure that workers receive the benefits and other financial and material incentives due to them with the intention to encourage them to stay in their postings
 - Conduct analysis of OC for HRH budget to identify the priorities for the OCs for the LGAS and how to prioritize HW retention, particularly for the low-level facilities
 - LGAs to prioritize issues related to staff retention while prioritizing activities to be incorporated into the CCHP based on the provided ceilings
 11. Finalize the costing exercise for the HRH strategic plan, production plan, and HSS strategic plan and incorporate it into the health financing strategy (operational)
 12. Increase deployment in public service of health workers over 45 years; implement current policy
 13. Review the process and bottlenecks to increase recruitment of health workers over 45 years of age
 - Give preferential treatment (for specialists and/or those with 10 years of training) for increasing the retirement for HWs, focusing on investment and accumulated experience

Retention

14. Finalize development of operational guide for public service pay and incentive policy

- Based on final list of underserved areas, POPS M to collaborate with MOFEA to prioritize allocation of resources necessary for retention in these areas
 - Disseminate survey (fact-finding from 29 districts) and finalize operational guide
15. Scale up LGA best practices related to staff distribution and retention in dispensaries and health centers
- PMO-RALG and POPS M to support scale-up of best practices on retention from LGAs and partners to other geographical areas
 - Utilize formalized system such as annual regional/district forum to promote sharing of best practices
 - Promote operational research to establish what works in what context and impacts on health outcomes
16. Establish an accurate retention rate
- By cadre, by level of care, and geographical distribution to include all sectors (public and private) and to identify pull and push factors to inform retention strategies
 - Establish cause and effect analysis of retention versus productivity
 - Assess the reporting rate versus retention—Is retention more challenging or reporting rate? Important to inform key priorities (related to staff allocation priorities for example) and thus to design appropriate strategies
17. Strengthen partner coordination at local and regional levels on HRH with focus on underserved areas
- MOHSW regionalization of partners to enhance effective utilization of resources, coordination of support, and duplication of efforts
18. POPS M and PMO-RALG to support LGAs to have enabling environment (policies, guidelines, etc.) to increase their opportunity and flexibility to develop and institutionalize local retention schemes
- Provide support (capacity building, guidance, and more flexibility in use of available resources) to LGAs to increase the potential for self-sustaining their innovations; increase investment in improving management and leadership capacity of LGAs, including resource mobilization and financial sustainability
19. Engage private-sector efforts to strengthen infrastructure for health services
- Government and partners to advocate for private-sector support through social corporate responsibility to complement government efforts in improving working conditions and infrastructure development in underserved areas, for example, building staff houses and schools, improving other social services, infrastructure development, including telecommunications, water, and solar power
20. Scale up efforts to recognize and formalize task shifting in Tanzania

- Develop an operational guide of service delivery based on WHO guidelines, including operational guidance, quality assurance issues, and skills development plan (e.g., on-the-job training guidance) and other compliance issues
- Expand the existing task sharing task force (a component of the HRH TWG) to implement a system-wide approach (i.e., QUAD approach) that includes representation from other departments across different health cadres, including regulatory bodies, training institutions, licensing bodies, and policy-makers to decide on common areas for task sharing across health care cadres
- Develop a task sharing policy that addresses issues from designing a production system to enhancing effective and sustainable task shifting practices

21. Review career path for medical attendant cadre

- To allow lower-level staff to progress through a defined and approved carrier progression ladder

Performance Management and Productivity

22. Expand stakeholder engagement in P4P analysis

- Structure to support P4P should be redesigned, streamlined; implementation goals and financial sustainability need to be addressed
- Need to align P4P with government's OPRAS and public service pay and incentive policy, otherwise P4P will remain a "project"
- Need to consolidate various evaluations on P4P and the lessons learned from pilot regions to inform the scale-up of P4P with clear timeline
- Link HMIS (DHMTs) with P4P to align with health outcomes, which implies improving data management and utilization

23. Improve accountability for performance management

- Strengthen so that merit, salary increments, career progression planning are aligned with performance assessments
- Implement OPRAS true to its design and structure beyond filling out the forms

Production

24. Strengthen existing oversight and regulatory bodies to fulfill their roles, including continuing professional development

- Adopt continuing professional development practices that strengthen professional growth and skill gain; performance monitoring should be basis

25. Review and strengthen financial allocation support to HTIs

- Strengthen potential for self-sustaining; government needs to strengthen an environment to meet this potential

26. Develop scheme of service for health tutors with career progression plans

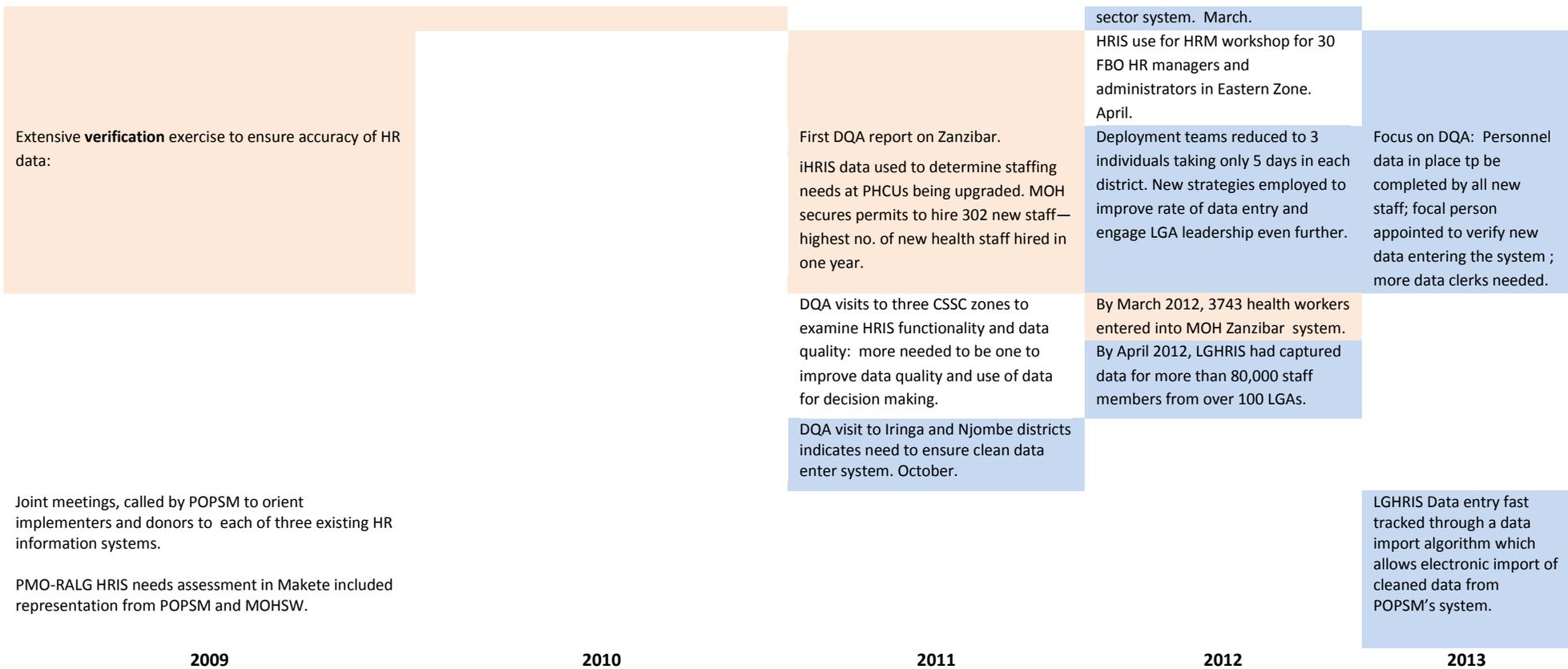
- Remuneration associated in recognition of teaching skills, supervision, and clinical practice
 - Recognition of skills (training methodology, master of education) and professional growth
27. Expand discussion of a possible cadre of community health workers
- Convene a key stakeholder summit to discuss community health workers: policies, guidelines, recommendations, and strategies for training, assessment, and regulation
28. Ensure production plan takes into consideration the following:
- That a mismatch exists between staff produced and those deployed, reporting and entering public service despite increased production
 - That production is strategically focused on highly-required cadres to fill the gap and have the correct skill mix needed; for example, continue to invest in nurses since they are the backbone of the service delivery system
 - Cost: need to know the unit cost to train a health worker to assist production projections; if this information is not available from existing studies, recommend commitment to conducting such a study
29. Address barriers to private health sector access to affordable financing to expand for-profit investment in health worker production
30. Promote the use of technology for distance medicine
- Expand consultation at a distance when additional expertise is needed in remote places
 - Assess possibilities for distance learning
31. Scale up piloted medical entrepreneurship initiative (currently limited to Muhimbili University of Health and Allied Sciences) to prepare graduates for private practice and hence expand private practice and employment opportunities in the private sector

APPENDIX 4: COMMITMENTS TO GHWA FROM THIRD GLOBAL FORUM ON HUMAN RESOURCES FOR HEALTH: TANZANIA NATIONAL HRH COMMITMENTS

1. Increase the availability of skilled health workers at all levels of health service delivery from 46% to 64% by 2017 based on staffing levels of 2013.
 - a. The government of Tanzania commits to increase the density of health worker to population ratio of the districts with below national average of 1.47 health workers per 1,000 populations in 5 regions (Kigoma, Tabora, Rukwa, Shinyanga and Singida) from 0.73 health worker per 1,000 population to the national average.
 - b. The government of Tanzania commits to continue increasing production of skilled health and social workers from 4,364 in 2012 to 9,000 by 2017.
 - c. The government of Tanzania commits to rationalize employment permits for health and social workers based on production and needs in all areas of technical profession.
2. Increase financial base (Other Charges and private sector investment) to operationalize the pay and incentive policy by 2017 in order to promote retention, productivity and quality of health services.
3. Develop and implement a task sharing policy on HRH by 2017.
 - a. Tanzania Ministry of Health and Social Welfare commits to develop an operational guideline based on consolidated 2013 WHO guidelines on task sharing to enhance existing production and quality assurance systems by 2015.
 - b. The government of Tanzania commits to implement a system-wide approach that includes representation from other departments across different health cadres, including professional associations, regulatory bodies, training institutions, accreditation bodies, and policy-makers to decide on common areas for task sharing across health care cadres by 2017.

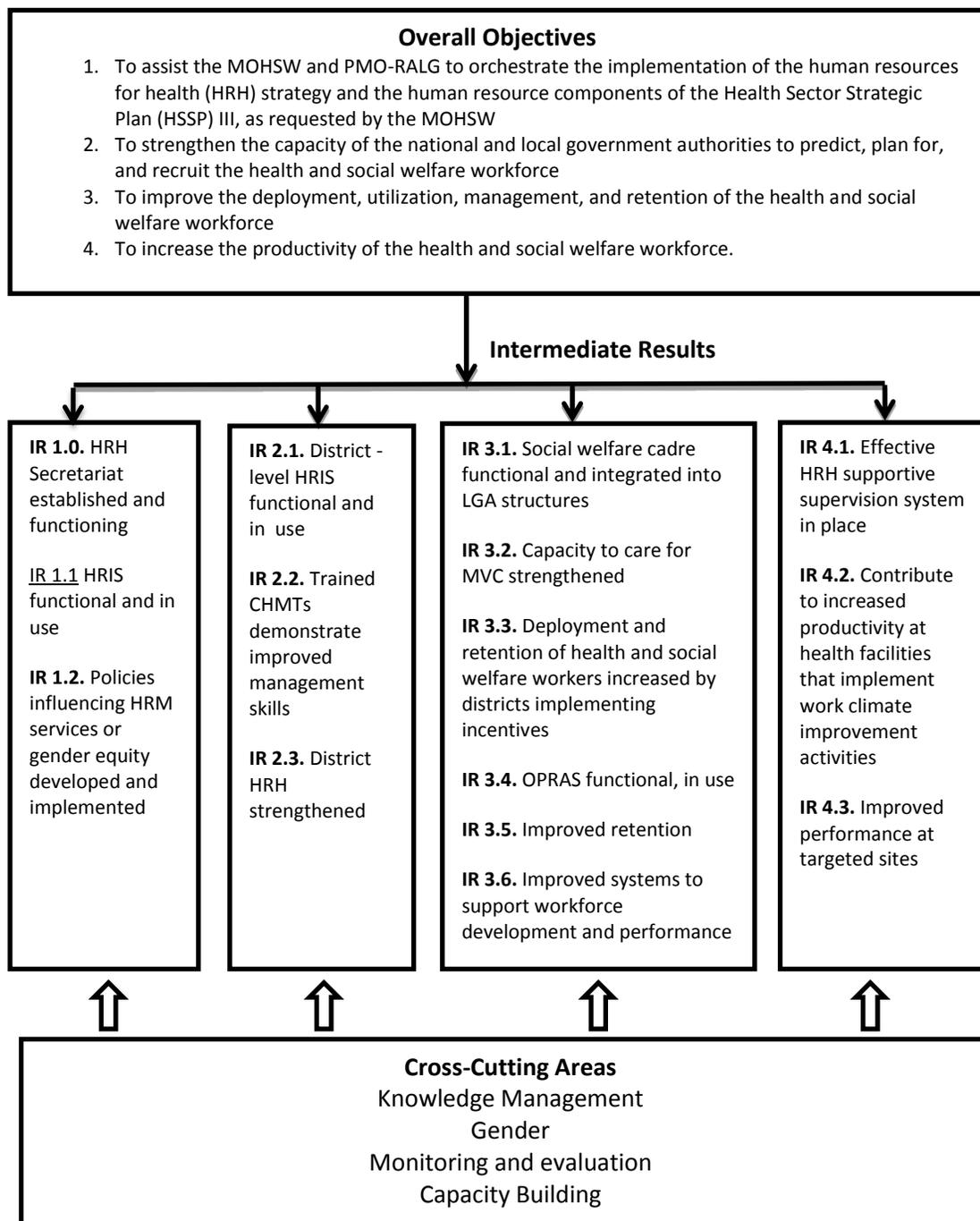
APPENDIX 5: MILESTONES ACHIEVED: HRIS IMPLEMENTATION, 2009–2013

	Introduction, System Assessment Needs, Customization	Testing, Customization	National Rollout Data Use	National Roll out
Customization	<p>Project introduction and awareness to stakeholders (PMO-RALG, MOHSW Mainland & Zanzibar, PO-PSM, Private FBOs, NGOs etc)</p> <p>UDSM customized iHRIS Manage 4.0 to meet PMO-RALG requirements</p> <p>Review and documentation of HRIS specific systems in Tanzania and system requirements for a comprehensive and inclusive public and private sector HRIS;</p> <p>Needs assessment in Makete District, November.</p>	<p>HRIS pilot in Kondo District, project sensitization and deployment; followup assessment in March 2010</p> <p>Secondary HRIS customization and testing in 4 districts: Makete, Njombe, Ludewa and Iringa which led to expansion of data elements and design of additional key reports.</p> <p>Needed to find solutions to work with insufficient computing infrastructure and few staff available to enter HR data. Biggest challenge was incomplete HR data and need for increased DED support.</p>	<p>FBO iHRIS expanded to include APHTA's for zonal offices and BAKWATA</p>	
System Installation	<p>iHRIS installed with MOH Zanzibar</p>	<p>Seconded HRIS Advisor to PMO-RALG</p> <p>PMO-RALG's LGHRIS user acceptance test and signing of the MOU—LGHRIS branded to include Tanzanian flag, map and official government logo</p> <p>The newest version of iHRIS installed at central CSSC office and five Zonal Offices</p> <p>HRIS deployment with Zanzibar MOH completed. HRIS accessible from in the MOH LAN and via zanhealthlink</p>	<p>Second Phase: Deployment expanded to rest of Iringa region, Lindi and Mtwara; Pwani and Dar es Salaam. June-August 2011.</p> <p>Teams of four or five individuals took 7 days in each district: hardware training, software installation, connectivity and data entry work</p>	<p>Third phase LGHRIS deployment covering 43 LGAs in 4 Lake Zone regions: Mwanza, Mara, Kagera and Shinyanga. January.</p> <p>Fourth phase LGHRIS deployment covering 33 LGAs in 4 Northern Zone regions, Arusha, Kilimanjaro, Manyara & Tanga. March-April.</p> <p>Deployment teams reduced to 3 individuals taking only 5 days in each district. New strategies employed to improve rate of data entry and engage LGA leadership even further.</p> <p>Fifth phase LGHRIS deployment covering 53 LGAs in 8 regions: Dodoma, Morogoro, Kigoma, Tabora, Rukwa, Singida, Mbeya and Ruvuma.</p>
Capacity Building	<p>ICT Officer training focused support for open source technology. November.</p> <p>30 district personnel trained in system installation, data entry and report generation.</p>	<p>ICT officer and PMO-RALG project team training focused on LGHRIS administration empowering them to use, manage and support system. April.</p> <p>60 MOH officers trained on the system use, data accuracy importance and use</p>	<p>ICT Officer training focused on programming, iHRIS management and troubleshooting. January.</p> <p>Extensive training of data clerks for FBO sites</p>	<p>Focus on on-site training; over 1000 LGA and RAS staff trained</p> <p>Inter-ministerial study visit to Namibia to study successful public</p>



Source: THRP. 2012e. Human Resource Information System. Subproject Progress Report, 2009-2012.

APPENDIX 6: THRP STRATEGIC RESULTS FRAMEWORK



Source: Tanzania Human Resource Capacity Project Performance Monitoring Plan, 2009-2013. Final. July 2013.