

**TANZANIA HUMAN RESOURCE CAPACITY PROJECT**  
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**END OF PROJECT REPORT**

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## List of Acronyms

• APHFTA	-	Association of Private Health Facilities of Tanzania
• BAKWATA	-	National Muslim Council of Tanzania
• BMAF	-	Benjamin William Mkapa HIV/AIDS Foundation
• CCHP	-	Comprehensive Council Health Plan
• CHMTs	-	Council Health Management Teams
• CSSC	-	Christian Social Service Commission
• DC	-	District Council
• DHRO	-	District Human Resource Officer
• DMO	-	District Medical Officer
• FY	-	Financial Year
• GOT	-	Government of Tanzania
• HRH	-	Human Resource for Health
• HRIS	-	Human Resource Information System
• HRM	-	Human Resource Management
• HSSP III	-	Health Sector Strategic Plan III
• ICT	-	Information and Communication Technology
• ICTO	-	Information and Communication Technology Officer
• iHRIS	-	Open source HRIS software developed by IntraHealth
• IMA	-	IMA World Health
• LGA	-	Local Government Authority
• MOFEA	-	Ministry of Finance and Economic Affairs
• MoHSW	-	Ministry of Health and Social Welfare
• M&E	-	Monitoring and Evaluation
• OPRAS	-	Open Performance Review and Appraisal System
• POPSM	-	President's Office Public Service Management
• PMO-RALG	-	Prime Minister's Office Regional Administration and Local Government
• PMP	-	Performance Monitoring Plan
• RAS	-	Regional Administrative Secretary
• THRP	-	Tanzania Human Resources Project
• USAID	-	United States Agency for International Development
• UDSM	-	University of Dar es Salaam

## Background

The Tanzania Human Resources Project (THRP) was a four-year project funded by the U.S. Agency for International Development (USAID) and led by IntraHealth International. The Christian Social Services Commission (CSSC) led the HRIS implementation for faith-based and private sectors with technical assistance provided by IMA World Health (IMA). An overall goal of the THRP was to support government efforts to address challenges that Tanzania faces in developing an adequate health and social welfare workforce within a context that comprises a complex system of public and private professional and paraprofessional cadres and those in the non-formal sector.

### THRP Strategic Objectives

- To assist the MOHSW and PMORALG in the implementation of the human resource for health (HRH) strategy and the human resource components of the Health Sector Strategic Plan (HSSP) III, as requested by the MOHSW.
- To strengthen the capacity of the national and local government authorities to predict, plan for, and recruit the health and social welfare workforce.
- To improve the deployment, utilization, management, and retention of the health and social welfare workforce; and
- To increase the productivity of the health and social welfare workforce.

The project strategy focused on:

- 1) Supporting the MOHSW to implement the HRH strategic plan;
- 2) Development of a comprehensive HRH strengthening program that will provide district managers with the needed tools and competencies to identify and tackle their own HRH problems;
- 3) Establishing a comprehensive HRIS system to provide routine HR data on health workers for decision makers in the public and private sectors; and
- 4) Building capacity of the health and social welfare workforce to provide quality health care services to address the need of MVCs.

#### THRP implementing partners

- IntraHealth International (prime partner),
- Benjamin Mkapa AIDS Foundation (BMAF)
- Christian Social Services Commission (CSSC)
- University of Dar es Salaam (UDSM)
- Aghakan Foundation (AKF)
- Management Sciences for Health (MSH)
- Training Resources Group (TRG)
- IMA World Health (IMA)

## **CSSC THRP Team - Structure, Scope and Functions**

### Christian Social Services Commission (CSSC)

The CSSC health and education core business covers all of Tanzania through a zonal management structure. This structure consists of the following five zones:

- Lake Zone - Mara, Mwanza, Kagera , Shinyanga, Geita and Simiyu Regions
- Western Zone - Kigoma, Tabora and Singida Regions
- Eastern Zone - Dodoma, Morogoro, Coast, Dar es Salaam, Tanga Regions & Zanzibar
- Southern Zone - Rukwa, Mbeya, Ruvuma, Iringa, Mtwara, Katavi, Njombe and Lindi Regions
- Northern zone - Kilimanjaro, Arusha and Manyara Regions

In terms of CSSC health system support, each zone is led by a full-time Zonal Manager and supported by an IT Technician and Data Clerk. The ICT Unit at the CSSC-HQ Secretariat led and managed the overall FBO and Private sector implementation. This HQ office is led by a Coordinator with the support of other program staff, including the ICT Officer, Content Officer, System Administrator, Assistant Accountant, Office Management Secretary and Driver. The management role of CSSC on the THRP team was to coordinate zonal and selected Christian hospital implementations at all levels and to lead the consortium with APHFTA and BAKWATA overall.

### Association of Private Health Facilities of Tanzania (APHFTA)

The APHFTA health network is structured into six zones, with each zone supervised by a Liaison Zone Coordinator. The zones are named as follows:

- Mbeya – including Mbeya, Ruvuma, Rukwa and Iringa regions
- Moshi – including Tanga, Kilimanjaro, Manyara and Arusha regions
- Mwanza – including Shinyanga, Mwanza, Mara and Kagera regions
- Dar es Salaam – including Dar es Salaam, Morogoro and Pwani regions
- Dodoma – including Dodoma, Singida, Tabora and Kigoma regions
- Mtwara – including Mtwara and Lindi regions

The APHFTA THRP Team was led by IT Manager, supported by an IT Technician and a Data Clerk at the head office. At zonal levels, each office also supported THRP efforts by a Data Clerk who worked closely with the Liaison Zone Coordinator. APHFTA's primary THRP role was to coordinate HRIS deployment and implementation with and through their selected Private Health Facilities.

### National Muslim Council of Tanzania (BAKWATA)

The BAKWATA network is organized under a region and district administrative structure, with each member facility connected via individual (franchise) agreements. BAKWATA's THRP Team was led by a Programme Officer, with the support of Data Clerks at the head office, and their primary THRP role was to coordinate HRIS deployment and implementation with and through their selected Muslim Health Facilities.

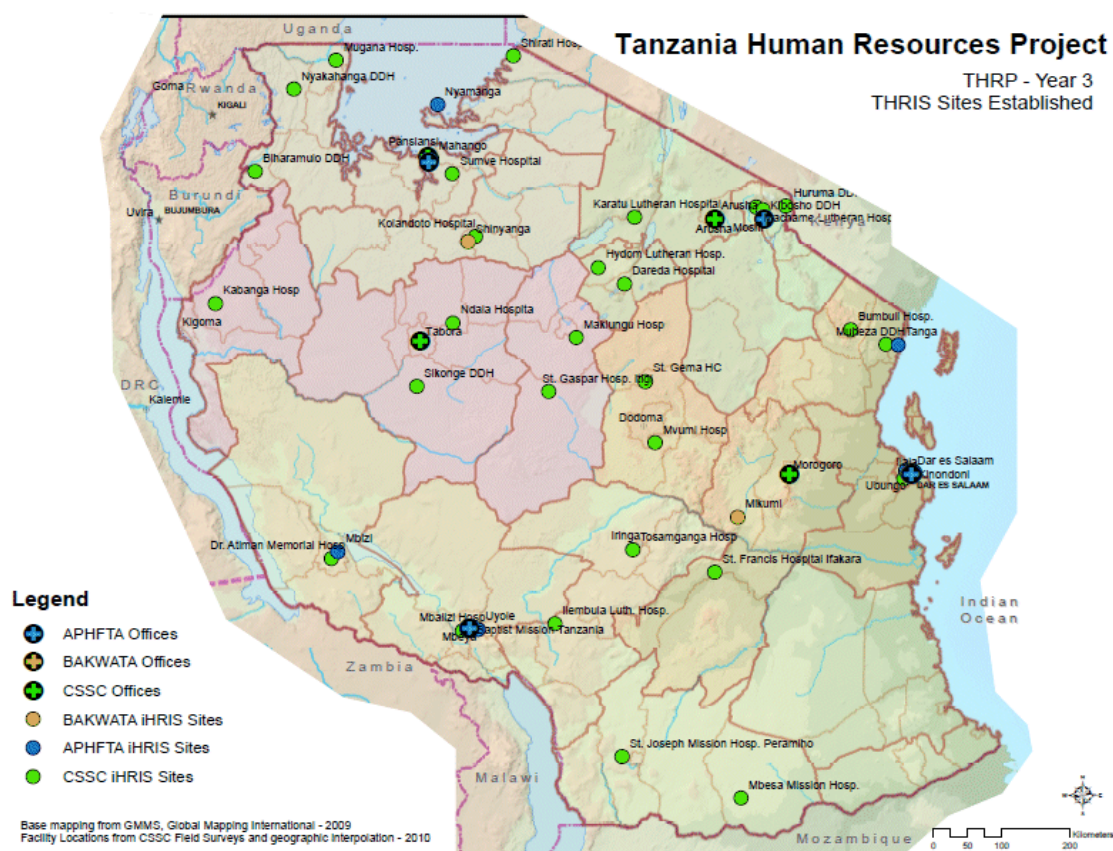
## CSSC Team - THRP Specific Objectives

During the four project years, CSSC was responsible for implementing three THRP Specific Objectives that applied a guiding structure across the annual workplans of APHFTA, BAKWATA, CSSC and IMA. These specific objectives guided the structure of planned project activities and regular reporting for the team as follows:

1. Specific Objective 1.0: To advocate using Human Resource for Health Data in Decision Making at all levels (Government and Private Sector) by April 2013.
2. Specific Objective 2.0: To improve Human Resource Management skills (retention and statistical analysis) at all levels (CSSC, BAKWATA and APHFTA) by April 2013.
3. Specific Objective 3.0: To improve data collection, entry, analysis, storage and utilization of HRH in the Human Resource Information System at all levels (National, zone and facility) and the Private Sector by April 2013.

Accordingly, this report is organized within each of the primary sections to present project results, lessons learned and the provisions for ongoing sustainability through essentially the same uniform headings that reflect the three specific objectives as Advocacy, Skills and Systems & Data.

The map below shows THRP Team coverage and deployment sites around Tanzania.



**Figure 1:** THRP HRIS Deployment Site Locations

## **Results**

### **Advocacy**

One of CSSC's first priorities in the project was to establish the THRP Coordinating Committee. This committee consisted of nine senior staff members, with three from each organization, and a chairperson who rotated annually between APHFTA, BAKWATA and CSSC. The high level representation by these senior staff members contributed strongly to advocacy efforts. Regular quarterly meetings also enabled the coordinating committee to work together closely throughout project implementation to coordinate, perform and follow up on shared activities. The shared productive interaction of this committee was a key factor in achieving the intended results described in this report.

During the first two years, CSSC pursued advocacy efforts through 10 sensitization workshops and 5 dissemination workshops that successfully introduced THRP project objectives to 665 participants from CSSC, BAKWATA and APHFTA. As part of these efforts CSSC also collaborated with MoHSW Department of Policy and Planning staff to distribute 262 HRH Strategic Plan documents, 200 HSSP III documents, 2000 MAMM and 1000 National Health Policy documents. Disseminations were successfully led by a custodian from the MoHSW who provided the above policy documents to hospital managers throughout the five CSSC zones. Sensitization meetings empowered hospital managers to use the policy and guidelines for dialogue and planning at district levels.

Additional advocacy efforts continued in the third year and the impact was seen through higher demand for meaningful HR data at all MoHSW, Hospital, Diocese, BAKWATA and APHFTA levels. Third year advocacy also included HRIS orientation and training events. Throughout THRP duration, CSSC has also featured updates and stories on the HRIS implementation status in their newsletter, which has also promoted advocacy efforts.

In the final year demand is still increasing from hospitals who want HRIS capabilities in order to improve access to their own data. Some intend to connect through the zonal servers and others plan to dedicate their own computers for local installation. This increased demand for both system deployment and HR data is clear evidence of THRP success in advocacy. Another final year advocacy activity yielding good results was the production of a video documentary on how the HRIS data is being used in the CSSC Western Zone. The video has been released and 200 DVD copies are being distributed in order to further advocate for sharing and exchange of experiences and best practices in HR data utilization among the various health stakeholders in Tanzania.

## Skills

In addition to sensitization and dissemination activities, CSSC also performed several iHRIS Manage orientation and implementation trainings targeted at zonal, health facility and HRM levels. While all trainings served an advocacy function, their primary objective was to provide new HRIS knowledge and strengthen IT skills at CSSC zonal and hospital levels during the first three years. While other skill-building tools and techniques were also transferred during the project, these training events served to establish a distributed base of new HRIS users and trainers who have continued to further expand HRIS adoption to additional health facilities throughout the FBO and Private sectors.

### Zonal Level Skills

As part of initial iHRIS Manage deployments to zonal levels, the CSSC ICT Unit trained 5 data clerks at CSSC zonal offices, 4 data clerks at APHFTA zonal offices and 2 data clerks at the BAKWATA head office. These new data managers were trained on using HRIS, coordinating data collection, and performing data entry, update and utilization. At this time the customized system started being called the HRIS.



Zonal level stakeholder trainings



Zonal office training for THRP HRIS staff

Later in the first year, CSSC organized and performed 2 integrated HRIS TOT training workshops in collaboration with IMA World Health.



New HRIS user TOT at UDSM – April 2010

While the workshop at UDSM focused on HRIS use in a classroom context, the one at the CSSC Eastern Zone office in Morogoro focused on HR assessment, systems installation and HRH data development in a field context. Participants attended from all 3 THRP partners, UDSM and public sector, and most attended both workshops. In total, 31 participants attended the TOT workshop at UDSM and 34 attended the TOT workshop in Morogoro.



In addition to broad representation of new users trained on HRIS data update and management, report export and data utilization, 5 CSSC Zonal Data Clerks, 5 Zonal Secretaries and 4 other CSSC THRP team members were equipped with the training skills, presentation materials and resources to replicate workshop content to support further deployments at their own zonal levels. After organizing and performing all of the workshops, CSSC noted great improvements in HR data entry, quality, and report generation capabilities, as well as an increase in interest from higher levels in using HR data for planning and forecasting.



Hands-on THRS TOT - EZ Office, April 2010



iHRIS Appliance demo - EZ Office, April 2010

In the second year the CSSC ICT Unit trained 5 new IT Technicians at CSSC zonal offices and 1 new IT Technician at the APHFTA HQ office. In addition to training on using HRIS system in data collection, update and data utilization, IT Technicians were also trained to perform various system troubleshooting and data backup procedures to support HRIS adopting health facilities in their zones.

At the same time, 5 CSSC Zonal Secretaries, 5 APHFTA Zonal Coordinators and 1 BAKWATA Program Officer were trained on THRS operations and HR data utilization, including hands-on practice using the reporting functions available from the system. All trainings were organized by CSSC, and tremendous changes were noted in each of the zonal systems data entry quantity, quality and verification performance. In addition, follow-up visits to all zonal offices and health facilities were performed each year to further improve skills in HRIS practice, performance and data quality as well as to empower new focal persons at facility levels.

In the third year, higher level system training was performed to strengthen follow-up capabilities for each of the 5 CSSC IT Technicians on Linux administration to support their ongoing interest to improve HRIS troubleshooting, data aggregation and backup practice and procedures. Since those follow-up trainings both data quality and quantity

have improved, and all CSSC IT Technicians have now implemented functional systems and schedules for data backup from all sites, up through the zones to the national level.

### Health Facility Level Skills



Health facility level iHRIS Manage deployment training and coordination activities

Over the course of the 3-1/2 year THRP, many new users at selected hospitals and health facilities were trained as HR Focal Persons. Total people trained in this capacity at facility levels for HR data entry, management and utilization included 92 from CSSC, 44 from APHFTA and 6 from BAKWATA. These trainings enabled the new data entry focal personnel to update, expand and verify their health facility HR data by using each of the employee's personnel information. HR Focal Person skills were also developed to report and export data for higher level utilization, and which also led to further improvements in data quality.

### HR Manager Level Skills

In addition to HRIS training focused on data entry and management skills, CSSC also realized that health facility HR managers and administrators needed training to improve their understanding of general HR management practice in order to take advantage of HRIS capabilities. In the third year, 36 HR managers and administrators from CSSC, APHFTA and BAKWATA health facilities were trained on Human Resource Management practices that would enhance their ability to use the HRIS data in HRM decision making. The outcome of this HRM Training workshop was that many participants returned to their health facilities and put the plans, people and practices in place to ensure reliable data from the system and to make use of the HRIS reporting capabilities to use in decision making.



HR Managers Training - EZ Office, April 2012

CSSC discovered several examples of the positive impact resulting from the HRM skills and knowledge transferred in the workshops. One example was at Bumbuli Hospital, where they had customized and used HRIS reports to provide lists of filled position for management meetings. In Lushoto District, the hospital adapted procedures using a HRIS customized version of the traditional Tange Report for submissions to the DMO.

### **CSSC Secretariat - National Level Skills**

Another target of HR skill strengthening was the CSSC HQ Secretariat in Dar es Salaam. At CSSC-HQ, 25 senior personnel were trained in leadership and management skills to achieve results and value. After the training, CSSC senior staff managed to review their strategic plan. In another training 7 THRP CSSC staff were trained on monitoring and evaluation skills to better track project results. The CSSC THRP team then designed different tools to monitor HRIS follow-up with the support of IntraHealth International M&E expert. In a third training 4 CSSC staff members were trained on financial regulations, which improved CSSC staff capabilities for tracking expenditures and executing timely retirement of funds. Gender ethics training for 2 other staff members also led to system customization to improve gender aggregate reporting.

### **Systems & Data**

Implementing a national scale information system for the faith-based and private sectors in Tanzania was very challenging for many reasons. When the project began, most hospitals and health facilities lacked trained ICT personnel; years of top-down national HR policy and practice have been historically inconsistent relative to HR standards and organizational structures; and the same basic limits driving the HRH crisis apply to information systems development – lack of human, financial, organizational, equipment and dependable infrastructure resources. Despite these challenges and limitations, CSSC led the team of three implementing partners to accomplish substantial results in systems deployment, customization and data development.

#### **System Customization**

##### Needs, Deployment & Training

Even before the start of the project CSSC was aware of the ICT status and HR needs at many hospitals and health facilities through the coordination efforts of their zonal offices. However, the team also gained pertinent knowledge by conducting HRIS facility needs assessments, using the HRIS Strengthening Implementation Toolkit provided by IntraHealth. CSSC adapted the guidance and process from these tools to perform HRIS assessments prior to HRIS deployment and trainings at 15 CSSC hospitals, along with server installations at the 5 zonal offices during the first year. CSSC also performed needs assessments and assisted deployment of HRIS at the APHFTA and BAKWATA head offices in the first year.

In addition to assessment and procurement coordination to establishing these field site deployments, CSSC also established the domain and set up the HQ server with systems for all iHRIS appliances to share updated data and system upgrades during the first year. Despite ongoing power and Internet outages, CSSC maintained systems effectively during the next two years, enabling the THRP team to complete further assessments, deployments and trainings at 31 more CSSC hospitals, 22 APHFTA health facilities and 3 BAKWATA health facilities for a total of 76 HRIS deployments to date. A table listing the facility name, affiliation, location and HRIS status is provided as reference in Annex A.

### Customization

System customization required collection of extensive information on HR organizational structures, along with documentation and specification to set up the HRIS configuration. This information is contained on lists managed through database administration within the HRIS. The image at right shows the current structure of lists in the HRIS. The lists categorize HR information according to the way health facilities administer HR operations in the CSSC system relative to jobs, positions, and organizations, as well as employee, geographic and training information.

In addition, CSSC realized the information on many of these lists should match government standards in order to allow for potential integration of HR data in the future. While some of the standards for positions and salary scales were available through PMORALG, some other information on standard Cadres and Job Designations was more difficult to acquire due to MoHSW pending release of revised standards during the first 2 years, followed by a default back to the 2009 standards in the third year. These procedural barriers limited CSSC's ability to control data entry within standard Cadre and Job Designation values throughout the project, and the lack of confirmed standard values for these key factors also created confusion for data entry personnel at zonal, hospital and health facility levels.

Additional customization was performed to set up the reporting functions, and several existing system modules were modified to match system configuration with CSSC HR structures, including the leave module, promotion module,

## **Administer Positions**

### **Create Job Structure**

- [Cadres](#)
- [Job Classifications](#)
- [Salary Scale](#)
- [Jobs](#)

### **Manage Positions**

- [Salary Sources](#)
- [Terms of Employment](#)
- [Positions \(by Facility\)](#)
- [Positions \(by Status\)](#)

## **Administer Other Lists**

### **Organization Lists**

- [Facility Type](#)
- [Office/Facility](#)
- [Department](#)
- [Registration Councils/Board](#)

### **Employee Lists**

- [Education Level](#)
- [Qualification](#)
- [Language](#)
- [Leave Type](#)
- [Competency Type](#)
- [Competency](#)
- [Competency Evaluation](#)
- [Identification Type](#)
- [Pension Scheme](#)
- [Marital Status](#)
- [Reasons for Departure](#)
- [Workplace Accident Type](#)
- [Disciplinary Action Type](#)

### **Geographic Information**

- [Country](#)
- [Zone](#)
- [Region](#)
- [District](#)
- [Division](#)
- [Ward](#)
- [Village](#)
- [Currency](#)

### **Training Course Informati**

scanned document storage and retrieval, charting functions to support reporting analysis. Other customization has included development of an IKAMA module, which will be able to calculate the Standard Establishment (indicating compliment of basic staff cadres for setting approved bed capacity for each facility), which will also become possible when those standards are released by the MoHSW.

#### Collaboration

Throughout the THRP, joint collaboration between partners enabled customization and data development procedures for the HRIS to meet requirements of CSSC, APHFTA and BAKWATA health facilities. In addition to developer support from Capacity Plus and technical assistance from IMA World Health, the involvement of UDSM became a helpful resource. As part of their involvement with a parallel iHRIS Manage implementation for PMO-RALG, UDSM strengthened their focus and capabilities for HRIS customization through the THRP. A resulting benefit was that, as the number of FBO and Private sector HRIS deployments expanded, faculty and student participation was helpful in assisting customization needs.

There have been many challenges with system customization but overall, collaboration between all partners during the course of the THRP has clearly resulted in improved data development, data quality and enhanced data use at zonal, district and facility levels for HR planning, reporting, budgeting and recruitment; and has also increased demand for ICT use at all levels, especially at hospitals and health facilities.

#### **Data Development**

##### Data Standards

Years of top-down national HR policy and practice have been historically inconsistent in terms of HR standards and organizational structures in Tanzania. Decentralization is a strong force pushing more unified standards and structures, but much still needs to be worked out through local and regional levels. Therefore, getting all deploying health facilities to modify current practice to adhere to standards for HRIS without official dissemination from the MoHSW created an ongoing challenge for data development.

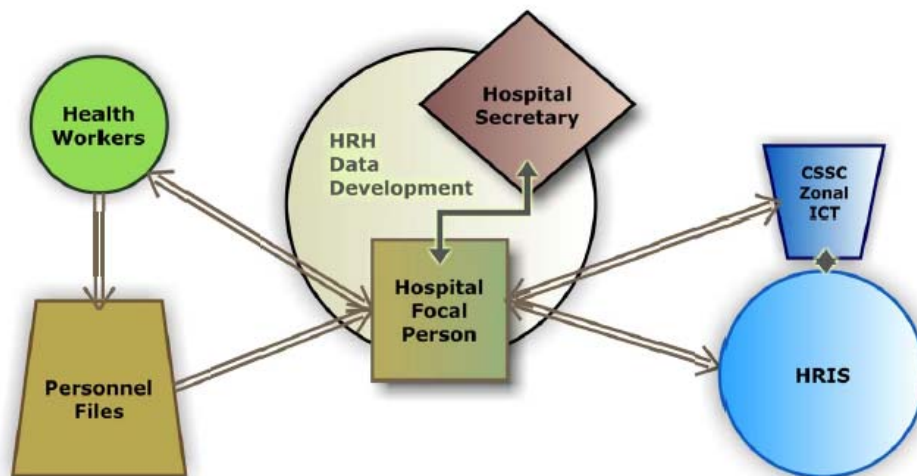
##### Source Documents

Hard copy HR records have been carried by faith-based and private health systems in Tanzania for several decades. The document that carries information on each worker is commonly called a personal particular form. Again, national level standards for format and content of these forms has been inconsistent over the years, and varies widely between different regions and health facility types, with many also having incomplete personal particular forms. In most health facilities, data recorders also have many other duties, and are already overloaded. Frequently, HR data recording has been a small part of these health worker's jobs and they may not even be trained to complete the forms.

Early in data development CSSC identified the full list of information to be carried in the HRIS on each health worker. A compiled list of this employee information is provided as Annex B. As part of data development procedures at each HRIS deployment, health worker information was collected using newly updated FBO and/or private standard personal particular forms. After being cooperatively updated by & with each employee, these new forms were further cross-checked with source records on file and verified by the HR Manager or hospital administrator prior to HRIS data entry. While this was a challenging process, and some gaps still remain, it has begun to establish more functional standard HR data collection and management practice that will remain in place going forward.

HR Data Knowledge and Practice

CSSC realized that a key to effective data development and to support reporting and data utilization would be to recommend establishing a designated HR focal person at each hospital deployment. This person was generally selected by the Hospital Secretary, and was designated with responsibility for HR data entry and management, to function as an HR information liaison between employee records, the Hospital Secretary and HRIS data input, maintenance and management. The diagram below shows how CSSC guided hospital administrators to designate an HR Focal person under their supervision to help guide HR data collection and HRIS data development.



**Figure 2:** HRH Data Development Functional Diagram

During the second and third project years CSSC also performed follow-up visits to all deploying hospitals in order to cross-check, confirm and validate HR data entry practice and procedures. Specific tools and approaches were initially used to perform these M&E exercises, and data quality improved as a result. In the third year the CSSC THRP

team, in collaboration with an IntraHealth International M&E expert, designed a more complete set of unified HRIS checklist tools to assist end users in confirming their status on system functionality, equipment, data collection, data verification, data validation and its use. Annex C provides the CSSC adapted M&E tools resulting from these efforts. After the comprehensive design of this HRIS M&E toolset, the CSSC secretariat, APHFTA and BAKWATA team, in collaboration with zonal staff, managed to coach and mentor hospital managers and focal persons to achieve more data quality improvement. These efforts paid off in the final year, when the CSSC THRP team began to witness first-hand, the applied data use that was now occurring at hospitals and health facilities as a result of more dependable data quality being available for decision making.

### **Data Utilization**

There is a strong connection between how well an organization's information systems are customized to match their HR operations and how well that organization is able to utilize their HR data. While there were many challenges with HRIS customization for the THRP team, the result was that after data was entered and validated, hospitals were able to more effectively begin using the data to generate internal and external reports. In the third year, as a result of collaborative training for HR Managers and IT Technicians, stronger linkage between these two groups enabled more effective data utilization to be put into practice at hospital, district and zonal levels. This was most evident in the final year, with 6 different hospitals officially reported examples of data utilization according to HRIS use log information provided in CSSC second quarter reporting. In addition to the documented examples, many other examples of creative data use were described by participants at HRIS user forum meetings that CSSC conducted in all five zones during the final year.

### Reporting

The most basic use of HR data comes through reporting. CSSC efforts to establish reporting capabilities spanned across both system customization and data development. System customization was needed for reports to provide useful data, in ingmeent existing reporting content needs at all levels. At the same time, data quality and standards were needed for reporting to function effectively in meeting at hospital level for decision making needs, and to permit aggregation of HR data at district and regional levels. In order to provide an easily customized template for various reporting needs, CSSC developed a standard "Tange Report" to contain current detailed information for 20 key HR data elements on every health worker in the system. Several variants of the Tange report were developed to provide a structure for reporting on job function, education, hiring, retirement and other factors. The figure below shows the report screen for a modified version of the Tange Report, which provides employee contact information that can be useful for many HR management functions, including as a staff directory.

## Staff Directory ( RIPOTI YA TANGE KWA WATUMISHI)

A list of all current staff with work contact information.

Results limited by: Facility: Bumbuli

Results found : 103

#	Cadre	Designation Title	Date of First Appointment	Sex	Date of Confirmation	Facility	Department	Facility Type	Terms of Employment	Check Num
1	Assistant Medical Officer	Assistant Medical Officer	1 January 1991	Male		Bumbuli	Medical	Hospital	Permanent	
2	Medical Doctor	Medical Doctor I	2 December 2009	Male		Bumbuli	Paediatric Ward	Hospital	Contract	
3	Assistant Medical Officer	Assistant Medical Officer	2 July 1999	Male		Bumbuli	Surgical Ward	Hospital	Permanent	
4	Clinical Officer	Senior Clinical Officer	8 March 2004	Male	4 September 2004	Bumbuli	Administration	Hospital	Permanent	110676
5	Assistant Lab Technologist	Assistant Lab Technologist	2 April 2004	Male	30 September 2004	Bumbuli	Laboratory	Hospital	Permanent	110680
6	Radiography Technologist	Senior Radiography Technologist	1 March 2002	Male	31 December 2002	Bumbuli	X-Ray	Hospital	Contract	110681
7	Medical Attendant	Medical Attendant	1 January 1991	Male	1 January 1991	Bumbuli	Pharmacy	Hospital	Permanent	
8	Assistant Nursing Officer	Senior Assistant Nursing Officer	10 March 2008	Female		Bumbuli	Male Ward	Hospital	Contract	116722
9	Medical Recorder	Medical	11 July 2005	Male	1 October	Bumbuli		Hospital	Permanent	110681

Figure 3: Tange Staff Directory report from the HRIS

A list of all the reports that were customized and/or developed for the HRIS is provided in Annex D. While some of these reports are modified versions of the standard iHRIS Manage report templates, several other reports were newly developed for specific purposes, like the Tange Report, which became a new template for various HR reporting needs. In addition, several other reports also required customization and standardized data, especially those related to employer designation, salaries and positions.

### Data Use at Hospital Levels

Another positive result of the THRP is that overall understanding of data utilization, especially at hospital and health facility levels, has moved far beyond basic reporting. Previously, with much of the health system structured from the top-down, data was something generated locally, but only used by higher-level decision-makers. While many in the Tanzania health system have been filling out data records and completing reports for many years, there was a prevalent view that HR reports were primarily a formality needed by supervisors for documenting progress and performance. However, as part of expanded HRIS implementation, and especially HRM training in year three, much broader understanding about the purpose of reports and data has been changing from formality to active engagement with HR information to make use of its potential for improving operations and access to resources.



Results of how THRP team efforts to promote data utilization have paid off in terms of expanding this broader understanding have been seen at many levels in the final year. In addition to examples of these results being noted in CSSC quarterly reports this year, several hospitals have been using data through HRIS reporting in both tabular and graphic formats to improve HR management, planning a decision-making on an ever-widening scope of issues. The figure below shows a chart on pending retirements that are on record to occur at Cardinal Rugambwa Hospital from 2015 to 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

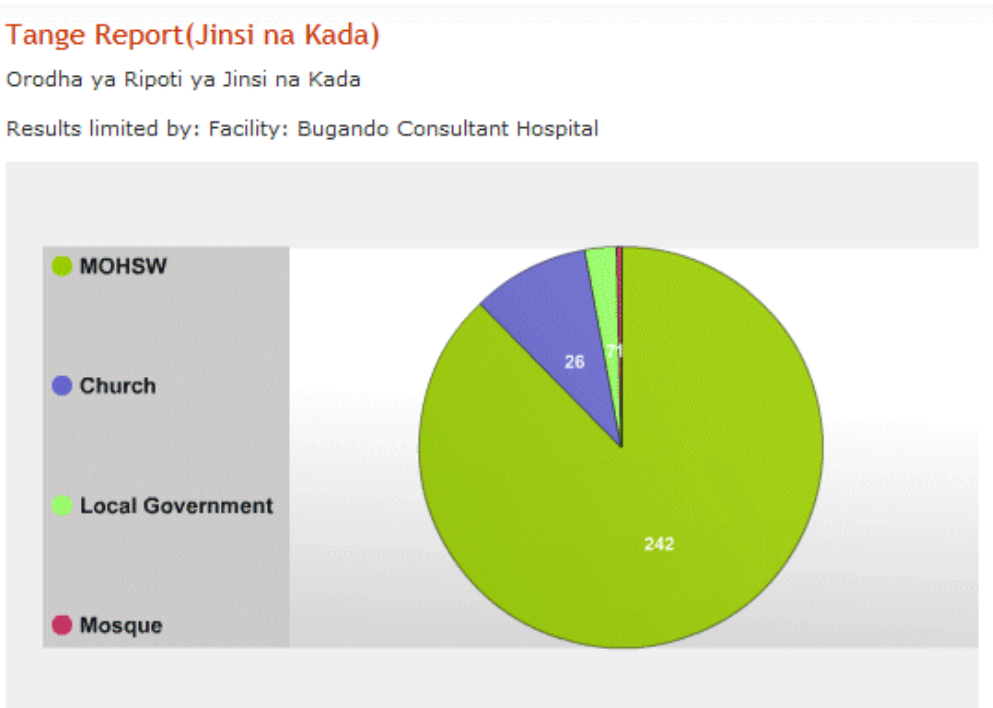


Figure 4: 2015-20 Retirement Projection for Cardinal Rugambwa Hospital

By having access to tools like this, along with valid data for query and analysis, many hospital administrators and HR managers are finding creative new ways to use their HR data to support better planning and decision-making.

Expanded data utilization has not only resulted at hospital levels. During the last year, as data quality has improved and allowed for larger scale aggregation, both CSSC and APHFTA have managed to use data in a variety of areas to improve decision making capacity and guide policy decisions. In one of these examples the CSSC head office generated reporting and statistics to help inform decision-making about the number of pharmacists available to hospitals as a part of projection during a recent pharmaceutical

development of a listing MoHSW seconded employees from all hospitals, along with check numbers, in order to verify their placement at faith-based CDH, DDH and Referral hospitals. Despite difficulties in collecting and confirming personal data from many of these MoHSW health workers seconded to faith-based facilities, CSSC was able to extract this basic employer information from the HRIS and used it to advocate for support at higher levels. An additional example to illustrate complexity and confusion associated with seconded staff is provided in the chart below which shows a comparison of health workers employed from various types of organizations at Bugando Consultant Hospital. This chart is very helpful for understanding the percentage of MoHSW health workers being paid at this hospital through the FBO health system.



**Figure 5:** Employers of Health Workers at Bugando Consultant Hospital

Another example of HRIS data use at higher levels was that of CSSC sharing the type and status of hospitals to their higher organs meeting. In this case HRIS data was used to verify number of staff in key standard establishment positions at various hospitals. It was later sent to the MoHSW, with a request to review official numbers of available beds and approved beds, a key determinant of hospital funding. CSSC also has data use logs on various requests for information received over the past two years. An example of a recorded log is provided in Annex E. Another good example of data utilization results by APHFTA was also provided in the last year. In this case, the APHFTA head office developed a listing of key information on health workers which the MHSW that was required to justify their inclusion for support in the Vodacom mobile network program that provided mobile phone vouchers to health workers.

## **Lessons Learnt**

### **Advocacy**

The entire THRP team learned much from monthly meetings between CSSC, PMO-RALG, UDSM and IntraHealth. The meetings were a joint collaboration between FBO, Private and Local Government implementers, initiated and led by IntraHealth International and rotated between partner offices. They showed partners how good collaboration can strengthen project implementation and advocacy efforts. The sharing and exchange of experience during these meetings also contributed knowledge among partners about overall project activities, which greatly assisted advocacy at all levels and helped to coordinate project implementation. This also enhanced good performance of system deployments, customizations and facilitated local government training led by UDSM.

Another lesson learned relative to advocacy efforts between team partners was to promote advance communication to establish shared expectations. One example of this was that shared understanding of partner responsibilities earlier in the project could have helped avoid delays with initial partner agreements and MOU's. Another lesson learned was to insist on advance partner communication with stakeholders in order to improve full participation in joint needs assessments and dissemination workshops.

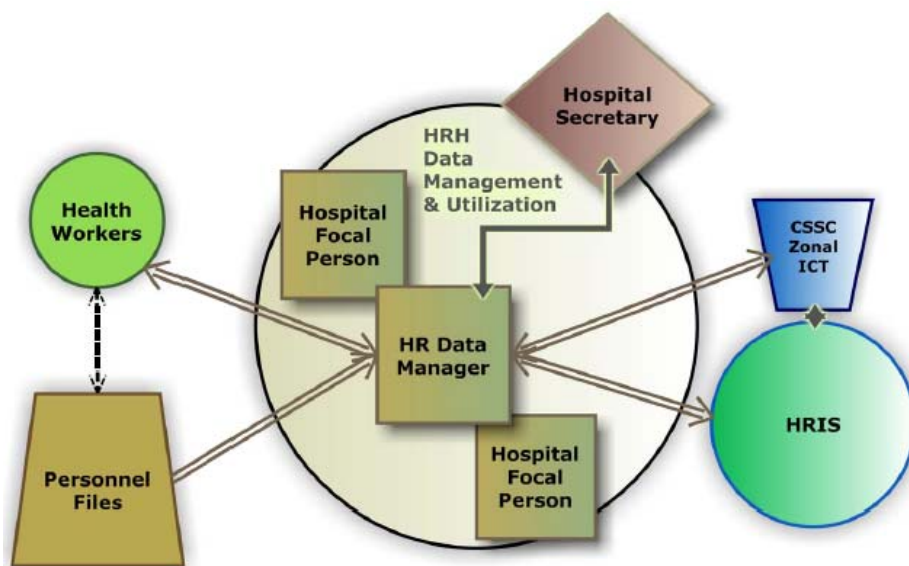
On another side of learning about advocacy, the team has realized a lesson about planning ahead for successful advocacy. Many of the non-implementing hospitals and health facilities that were sensitized early on about the HRIS have also now seen the benefit of its use at the health facilities where deployment occurred. This has created high demand for access to the THRS, especially from hospitals and health facilities that have their own equipment. This increased demand is welcomed, but it also creates expanded needs for technical support and training from zonal levels, and required additional planning to sustain HRIS deployment expansion after project support ends.

### **Skills**

Many lessons were learned at all levels through activities aimed at building skills. In the first year of the project, CSSC zonal staff on the THRP included only the Secretary and a Data Clerk. CSSC realized that higher level IT capacity would be needed at zonal offices in the second year to support deployment of the HRIS to hospital levels. Therefore the addition of zonal IT Technicians had been planned for year two from the beginning but, if they had been added in year one, they would have been able to facilitate zonal server set-up, strengthen customization and informed their knowledge for year two. While the IT Technicians greatly improved HRIS performance quickly, the lesson was clear that 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.

A similar lesson was learned in the third year from HRM and TOT workshops that were performed at zonal levels. In these workshops, zonal Data Clerks and IT Technicians were learning together with hospital HR Managers and Focal Persons. This greatly strengthened links between these groups and empowered both to make tremendous improvements to project performance and data utilization in the fourth year. While HRM training was offered through the THRP in the second year, those trainings were in large group settings that did not allow for applied learning with the HRIS. If hospital HR Managers and Focal Persons had been trained on HR practice that was oriented to the HRIS, along with access to IT Technicians in the second year, performance, data quality and utilization would have improved sooner.

Other skill building lessons were learned at hospital and health facility levels related to data quality and utilization. In the early stages, many deployments had some difficulty with data quality due to incomplete personal particular forms. While there was a strong focus on getting these source documents updated by all employees, there was still some incomplete information. Often the hospital staff assigned to data entry were also overloaded with other activities and initially this limited their ability to follow up on gaps in HR data. While CSSC had suggested earlier, during follow-up visits, that hospitals should dedicate a focal person to manage HRIS activities, not many learned this lesson and understood the necessity of having full time HR Focal person until after the HRM training. However now that this lesson is understood, more hospitals are also following CSSC advice to get more HRIS users trained in order to further improve HR data quality and to better use the HR data. The diagram below illustrates how expanding the number of HRIS users can enable better HR data management, improve data use and require less direct supervision by hospital administrators.



**Figure 6:** HRH Data Management & Utilization Functional Diagram

Another lesson learned by HR Managers was that more time was required to perform data collection, validation and update than they expected. This learning also resulted from the HRM training that was performed in the third year, which had great results in terms of improving data utilization by hospital level decision makers. In addition, other skills were also strengthened through coordinated THRP supervision at different levels.

Enhanced learning also came for the THRP team by applying new skills as part of overall implementation activities. Many skills were built in terms of leadership and project management, financial regulations, procurement and technology implementation, open source software systems customization and development. In addition, the CSSC head office team also learned lessons by applying new skills in monitoring and evaluation. Both IntraHealth International and IMA World Health were helpful with this, because early in the project, the initial targets and indicator measures were not closely related to deployment and sensitization efforts that were the focus of activity. Lessons learned came in terms of identifying more specific measures that would support documenting progress and performance until the implementation progressed to a point where overall indicator targets for data utilization were starting to be realized. Annex F provides the documentation for each quarter of all years related to activity based M&E targets for progress and performance during the project. Annex G provides the final M&E PMP sheet that was initially developed and used to address specified THRP PMP indicators.

## **Systems & Data**

### **System Customization**

One of the first lessons learned was in HRIS needs assessments, and was related to identifying customization requirements. These issues arose out of differences in how Christian, Muslim and Private health facility systems have evolved. All three operating structures differ somewhat in terms of ownership, funding, reporting, HR and other factors. This meant that the HRIS needs assessments on facilities in each sector had to be approached differently within their own context, and the results of assessments had to reflect different priorities according to each sector's reporting channels, resource allocation, information security and other factors. In addition, HRIS needs assessments for training institutions also differed from health facility operations at faith-based and private sector facilities, and this also provided new learning. Different operating practice and policies between sectors also impacted efforts later on when UDSM developers assisted customization, which required CSSC to sort and prioritize a wide variety of requests in coordinating these efforts.

In addition to the needs for more diverse customization increasing with expanded deployments, there was also increased demand for customization as users became more

knowledgeable about system capabilities and wanted to be able to do more with HRIS data utilization. This was especially true with the leave module, promotion module, scanned document functions, reporting formats and graphical report analysis. This was another example of the lesson that, as implementations expand, there is also a need to expand trained IT staff to be able to assist with ever-growing needs. Fortunately, when some of the more complicated IT issues arose, technical support from iHRIS developers at IntraHealth and data developers at IMA was also available, which helped clarify and resolve various issues and errors. An example of this assistance was related to improved HR information security. As more hospital users became familiar with HRIS utilization, concerns arose in regard to visibility of HR records to other hospitals. In response to this concern, IntraHealth developers created another module to help restrict viewing capabilities within HR management limited to their own hospitals and health facilities.

In addition, all partners and zonal offices learned about the benefits of using the iHRIS Launch Pad for updates, upgrade and other technical support required for resolving many of the errors, which helped to ensure that the system stayed up and running. While this functionality for data and upgrade exchange was very beneficial, CSSC also learned from users that frequent system upgrades sometimes confused and frustrated new users in adjusting to changes. Again, since many of those changes needed support at zonal levels in the early part of the project, the previous lesson learned about adding IT Technicians at zonal level earlier in the project also applied to this situation.

One of the largest difficulties for all partners at all deployments was that of unreliable electricity. This not only made it difficult to keep systems running, but it also increased difficulty with expanding data input and improving quality. Issues with Internet access also varied widely depending on location due to the limited broadband service in some regions. One of the lessons learned in this regard would be to set up more installations on local computers to allow off-line capabilities. Another would be to expand power back-up beyond UPS, at server locations, with battery bank solutions and/or solar back-up generators to sustain power for full-time access. To accommodate Internet, another lesson learned was for zonal offices to facilitate mobile network connectivity at some of the less connected zonal office and hospital facilities via a USB modem. Additional efforts to broker cooperative agreements with service providers would also assist to maintain “always on” operation.

### **Data Development**

Many lessons were also learned in data development. CSSC remained committed in adhering to MoHSW guidance and directives on collecting documents, information and waiting for data standards they sought to comply with. The issue described earlier with delay of updated Scheme of Service standards also precluded reconciling the existing

cadre and job designation at hospital levels until the decision was made in year three to replace 2002 Scheme of Service job data standards with 2009 instead of waiting further. The lesson learned was that this decision should have been implemented sooner. This also created issues with data entry staff mismatching 2009 standardized cadres against the older cadre and job designation values that had been in practice. In guiding adoption of the 2009 standards, CSSC also learned that the older standards in practice differed relative to region/district and at various facility levels. The misunderstanding of 2009 cadre and job standards against the diverse older cadre standards at hospital levels also added to delays in establishing report generation capabilities. The lesson learned was that, in a national level implementation, diversity of existing information standards should be expected and planned for as part of system assessment to promote early reconciliation and standardization of key data items.

There were also lessons learned specifically related to data entry from hospital source HR records. During early follow-up visits for data verification CSSC found that some of the information needed was missing from the hard-copy personal files. Having health workers update their own information on the new personal particular forms assisted with this, but there were still various levels of missing or erroneous data collected, which then required additional follow-up efforts in verification. Hospital and zonal recognition that these follow-up visits would occur also assisted greatly in improving consistency, completion and understanding. The guidance and tools described earlier (Annex C) from IntraHealth advisors, and the data reconciliation and standardization tools from IMA World Health that were used in these follow-up visits further assisted.

### **Data Utilization**

Addressing data quality issues was also connected with guidance in how to effectively utilize HR data. Learning to emphasize this connection also helped CSSC show the importance of utilization through their supervision efforts. This was especially helpful where data verification was most needed to cross check data quality because improved ability to utilize data could be seen as a direct result of the data quality improvements. Recognizing where these issues had to be addressed every time also guided priorities for follow up, coaching and mentoring at CSSC hospitals, APHFTA health facilities and BAKWATA HQ deployment accessing the HRIS. This learning also contributed to targeting CSSC advice in promoting addition of HR Focal Persons with a proper role in data collection and verification procedures where needed.

The THRP team also learned the valuable lesson that an iHRIS Manage implementation which prioritizes customization of this open system is more able to achieve positive results with data utilization. This became clearer as hospitals with quality data became more engaged with utilizing it by customizing HRIS reporting parameters to meet their

specific internal and external needs for HR data in planning and decision making. This lesson was also highlighted by the misunderstanding of 2009 cadre and job standards against the old information at hospital level since data consistency was needed in order to effectively aggregate and compare HR capacity across departments. Many of these issues came to the surface at the sites visited where they needed staff category fields to link with information like check number, confirmation date, birth date and promotion date. These utilization difficulties at facility levels also helped HR Managers and Health Secretaries better understand the importance of adopting 2009 Scheme of Service standards that had been missing in order to allow comparison between various other factors that relied on Cadre and Job Designation. This also further increased efforts on system update to replace 2002 Scheme of Service and other erroneous standards that existed in various locations.

Through many of these efforts to utilize data more effectively, HR Managers and Focal Persons also learned how to analyze data within the systems in order to identify most critical areas for quality improvement. Figure 7 below provides a good example of how this sometimes occurred through further modifications to the customized Tange Report. The pie chart below shows the distribution of staff at Ilembula hospital by Job Designation Title. While Ilembula has achieved good results in improving data quality, further analysis through data utilization highlighted the fact that many non-standard "other" classifications may require further investigation and data quality verification.

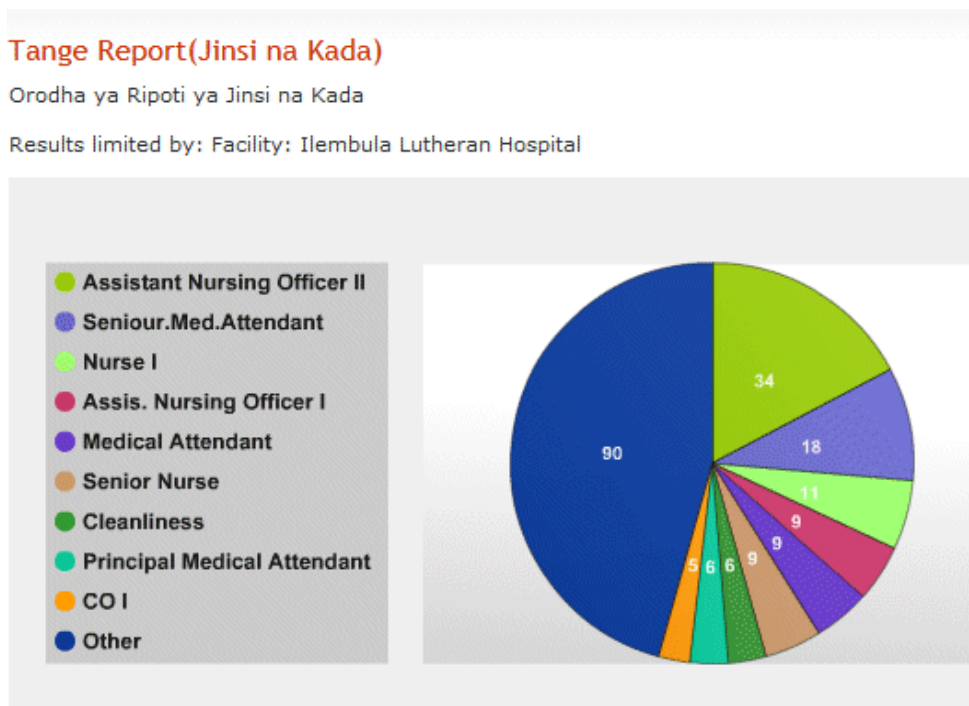


Figure 7: Pie Chart of Job Distribution at Ilembula Hospital



## Sustainability

### Advocacy

At the end of the THRP final year, demand for HRIS capabilities is still growing from hospitals and health facilities who want access to their own HR data through the system. 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 not only increased awareness among decision makers, but also that these new users shared evidence of their successful implementation efforts with other user constituencies at CSSC, BAKWATA and APHFTA and the strengths and capabilities of the system have become well recognized.

In addition, the increasing demand for meaningful HR data from the MoHSW, various diocese, and upper levels at BAKWATA and APHFTA also indicates raised awareness of HRIS capabilities at some of the highest decision making levels. This higher level demand to utilize HRIS data will continue to reinforce sustainability, but in order to be maintained, ongoing data quality improvements must continue to prove data reliability through its use in reporting. At many deployments, technical support to maintain systems and HRIS access at hospitals must come from zonal offices or local IT personnel at larger hospitals, where available. While some hospitals have also identified HR Focal Persons to maintain and improve systems and data, further expanding the number of trained users beyond this, as shown in Figure## below, will also increase sustainability through internal advocacy, more skilled users and stronger HRIS reporting capacity.

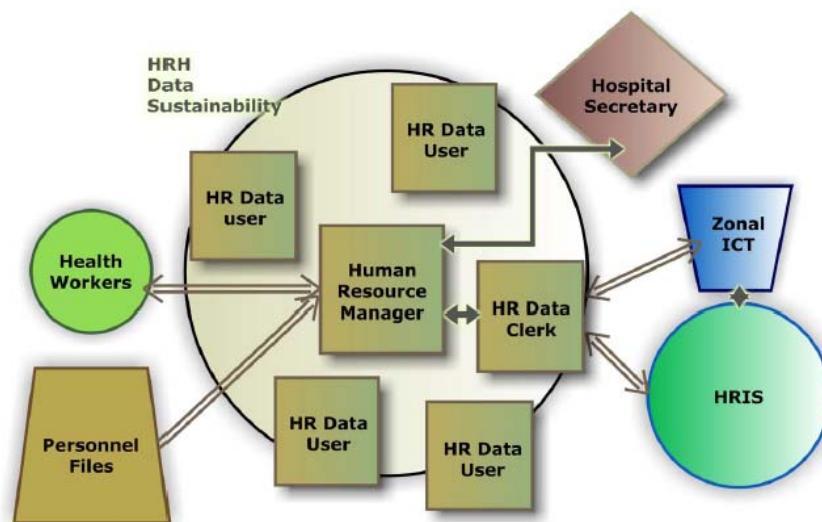


Figure 8: HRH Data Sustainability Functional Diagram

Identifying HR Focal Persons among the hospital staffs to maintain systems and improve data has already proven to greatly improve data use, but in order for HR data use to expand further as shown in this model, buy-in from health facility owners and high level administrators is required. This will also require incorporating HRIS maintenance into their budgets. Most of the hospitals that designated an HR Focal Person for data entry early on in system deployment have realized the benefits that justify this approach, both in terms of increased data utilization and by less direct supervision being required from Hospital Secretaries. Therefore, they are now in a good position to further encourage long-term sustainability by committing to expand the number of HR data users through internal training and upgrade of HR Focal Persons to become Data Managers.

### **Skills**

The increased skills developed at all levels will greatly strengthen potential for ongoing sustainability of the HRIS. At zonal levels the skills acquired through the TOT training and HRM workshops that established strong connections between HR Managers and IT Technicians across district levels will be a key to support ongoing sustainability. These strengthened relationships have continued to show how increased collaboration has expanded data utilization and increased demand. The increased data utilization and the positive demand-driven effects realized are also clearly shown in several success stories highlighted at CSSC HQ and CSSC zonal and hospital levels in the next section.

At hospital and health facility levels the data entry, verification and utilization skills that HR Focal Persons have gained is allowing for improved data quality, expanded data use and the ability to promote training of more than two focal persons at each hospital. The skills established for HR Managers and Health Secretaries has also allowed for them to recognize that designating a data manager to check data quality and supervise will not only improve data quality and use, but it will also allow higher level administrators to spend less of their own time supervising HR data efforts and more time gaining the benefits of good data with skilled users to provide effective information for HR planning and decision making.

### **Systems & Data**

Sustainability for systems is greatly enhanced by the availability of CSSC IT Technicians and Data Clerks at each zonal office. The direct connections that have been established with hospitals and health facilities in each zone indicate a level of dialog that will only continue to grow along with increased utilization that is currently being driven by data demand from all levels. In addition, one of the biggest limiting factors throughout HRIS implementation has been the lack of consistent electricity and Internet. To fully establish sustainable full-time system operations and expansion, given the unstable electricity, Internet and climate factors at zonal and hospital levels, the recurring impacts

related to power and connectivity must be eliminated. To address these systems sustainability requirements CSSC and IMA have continued to recommend provision of power back-up alternatives, either in the form of solar back-up generators and/or expanded battery bank power backup. An additional benefit to system sustainability in terms of cost was recently realized with CSSC consolidating all HRIS URLs into single domain, which will reduce ongoing service and maintenance costs. Finally, discussions that have been ongoing between PMO-RALG, UDSM, CSSC and IntraHealth have continued to facilitate a way forward to may enable ongoing customization support from developers and programmers to be available for potentially addressing future customization and support needs, which could be of great value to sustainability.

Indications are also very good that future data development efforts will be much more sustainable now that the quality and consistency of current HRIS data is becoming greatly improved. Recent efforts to fully standardize staff category data values have been implemented and these are being followed by stronger system controls being established to maintain future data integrity. As new hospitals and health facilities gain deployment access these new cadre and job designation controls within the system will only allow for selection of standard values for these variables system-wide. These controls will enforce the kind of data integrity that will not only avoid future needs for mass cleaning of data values, but they will also allow new users to begin working with data for utilization that will be clean and consistent, and thereby produce more effective results for reporting and analysis. In addition, new THRIS upgrades to v 4.1.6 that were posted at end of this project will greatly simplify database cleaning and update where it may become needed in the future. These crucial tools will also greatly benefit the early stages of data development in future HRIS implementations through improved capabilities for cleaning and configuring data, and the combination of quality data that can be more readily utilized will further benefit new user entry and hence sustainability.

As increased knowledge and use of the HRIS is being established at current levels, a new recognition of the need for consistency in reporting is becoming more apparent. While the hospitals with HRIS are submitting higher quality system generated reports to the MoHSW and other levels, other facilities without HRIS are still submitting reports using prior formats and content. In recent zonal meetings of HRIS users a growing desire became evident to have all hospitals and health facilities utilizing the HRIS to provide uniform reporting to the MoHSW, DMOs and local HMTs. While this desire was reflected in tension about the need for consistency of reporting across all CSSC facilities, the recognition of this need for consistency is a very positive indicator that system adoption has taken hold to a level where internal pressures will continue to reinforce the need to establish universal coverage of the HRIS, and this will ultimately be a strong driver of sustainability.

## Human Interest Success Stories

### Success Story 1 - HRIS Use in the CSSC Southern Zone

Deployment of the Human Resource Information System (iHRIS) to faith based organization (FBO) health facilities in the CSSC Southern zone has created high demand for the system and increased the awareness of needing an HRIS at more CSSC facilities. The HRIS connected facilities now have improved data storage and analysis, and are using quality data for planning and budgeting. Hospital's administrators are also now able to access easier information on their staff and to prepare reports with correct data.

The CSSC Southern zone deployment included 9 hospitals. They were – Dr. Atiman, Ilula, Mbalizi, Mbesa, Ilembula, Ndanda, Nyangao, Peramiho and Tosamaganga hospitals. Mbalizi is the district designed hospital for the Mbeya Rural district in the Mbeya region of Tanzania. As part of the iHRIS installation



**Front photo of Mbalizi District Designated Hospital (Mbalizi DDH)**

at Mbalizi hospital, CSSC organized training for 3 staff members, including 2 data clerks and the hospital administrator who were all trained to use it. The implementation of the system at Mbalizi hospital has helped its management to know exactly the status of their human resources based on professional cadres. Mr. Goodluck Hezlon, the hospital administrator, says that "before HRIS it was difficult to get data on staff and usually took 30 to 40 minutes searching in the paper-based manual system for information – and sometimes the available information was not even correct. Therefore the electronic system (iHRIS) has both improved the speed of access and quality of HR information."

In addition, Mr. Goodluck indicated that previously they did not check paper HR forms for errors, but now that data has been entered into the system by data clerks, he can use it to see if there are errors in the HR information. If so, he can correct any minor errors, thus improving the quality of their HR data. He also says the system is very user friendly and can easily generate reports, which was much more difficult before, using paper forms.



**CSSC team conducting M&E at Mbalizi Hospital - Southern Zone - Mbeya**

Mr. Goodluck stressed that, *"before awareness and demonstration of the system, I knew nothing about HRIS. Then, even after being sensitized, I still doubted that we could manage. But now, after being fully trained, I understand much better - it is a very simple system"*.

The use of the system at these hospitals has also influenced other facilities in the zone to request access to the system as well. Mr. Petro Pamba, THRP Coordinator at CSSC, confirms that Ndanda hospital is one of these hospitals. In fact, since they already had their own computer equipment, they only needed deployment support from the THRP team in order to train their personnel to use it.

## Success Story 2 - HRIS Users Trained on Human Resource Management

The Christian Social Services Commission (CSSC) was the lead agency for FBO and private actors undertaking the THRP. Their primary objectives in this role included advocacy, skill building and HRIS deployment activities to improve capacity for health service provision in Tanzania. In line with advocating and promoting the HRIS, CSSC realized that additional skills in basic human resource management (HRM) were needed at health facilities in order to take advantage of the capabilities in the HRIS. Therefore, in collaboration with the IMA World Health and Capacity Plus, CSSC organized a four day training workshop on HRM for decision makers and THRP ICT Technicians.



***HRM training participants using the system for knowledge sharing***

This training was designed to equip human resource managers and leaders with the necessary skills needed to apply HRIS in HRM and decision making. It was conducted in Morogoro near the CSSC Eastern Zone office, which is centrally located to HRIS deployments at 11 FBO and Private sector health facilities, including St. Francis Referral Hospital in Ifakara and Al-Jamiah Health Centre in Mikumi. Many different issues were shared and discussed during the training. Among the topics presented were HRM systems in the context of the HRM action frame work, workforce planning, recruiting and deployment, health worker retention, career development, performance management, gender and leadership in HRM. Participants were also taken through the functionalities of the human resource information system to help them understand its application to their HRM responsibilities.

At the end of the training 36 trainees were awarded certificate for participation. Speaking after the completion of the training, some of the participants appreciated the organizers for the useful training which added to their skills in HR management issues. Sr. Dr. Leonila Ifunya, a doctor from Cardinal Rugambwa hospital, mentioned human resource management as a key component of retaining staff within a facility.

She also noted that -



**Participants receiving their Certificate of Completion after the HRM workshop**

*"In fact, by attending this training I have learnt something [more], I expected to learn how to motivate staff. Before I thought that motivation is only salary increment but that is wrong perception, you can motivate staff through a letter of recognition for the nice job that he/she is doing."*

Another participant, Dr. Faustine Memu from Al-Jumaa Health Centre, said that he had hoped to learn more about how to mobilise staff to collect quality data and to properly fill in the staff file, and therefore his ambitions were very well-covered by the HRM training.

### **Success Story 3 - CSSC Produced HRIS Film Documentary**

As part of THRP advocacy and promotional efforts, the Christian Social Services Commission (CSSC) produced a film documentary to show how the Human Resource Information System (HRIS) is being used at selected health facilities in the CSSC Western Zone, and to show how it has benefitted those facilities by strengthening data quality for their utilization. The CSSC Western zone is covered by the three 3 regions of Tabora, Kigoma and Singida. Out of the 12 CSSC hospitals in this zone, 6 are now using HRIS. These are St. Gaspar, Baptist hospital, Kabanga, Sikonge, Makiungu and Ndala hospital. The use of HRIS at these facilities has helped them improve the human resource information by getting data corrected so that it can now be used for HR management and planning.



***Film documentary exercise on progress at Baptist Hospital in Kigoma***

CSSC decided to undertake this video documentary in order to enhance sharing and exchange of experiences and best practices in HR data utilization among the various health stakeholders in Tanzania. The documentary focused on three FBOs hospitals that were selected as good examples of those in the CSSC western zone that have been using the HRIS. They were Sikonge, Baptist and Kabanga. These hospitals were selected because the data entered in their systems is of good quality and matches well with source documents. Now that the systems are established there has also been good utilization of data captured in the system.

People who were interviewed included a Doctor In-charge, various HR managers, and hospital administrators. Data clerks were also interviewed, along with an IT Technician, a Zonal Secretary and other health staff. The documentary primarily focused on areas of data utilization, achievements, challenges and alternative solutions adapted to improve data quality. Hospital administrators also shared how support from CSSC zonal staff improved their policy and technical knowledge, along with their positive expectations for system sustainability.



***Taking clips of video in the field***



Several examples of how health facilities have been using the HR data are presented in the video. One of these is Sikonge hospital, where they described using HR data to plan for staff leave requests. Another was Kigoma Baptist hospital, where they described using HR data for salary scale planning and a third example presented was at Kabanga hospital, where they described using the system for recruitment of new staff. To date the facilities highlighted in the video documentary have continued to achieve good results in terms of the quality of data in matching paper records on their staff and they are now realizing further benefits through easier identification of staff needs according to their current allocation across various cadres.

## Success Story 4 - CSSC to Deploy HRIS to more Health Facilities in Northern Zone

***“We have got requests from Marangu, St. Elizabeth, Kilema, Ngoyoni, Wasso and Enduleni (6) hospitals, but our plan for the period of March to April was (only) to install system and train staff at Marangu, Ngoyoni and St. Elizabeth (3) hospitals”.***

*Mr. Ireneus Lyimo – CSSC Northern Zone Secretary*

Successful THRP advocacy, skill building and system deployment efforts have increased demand for the Human Resource Information System (iHRIS) beyond expectations. The Christian Social Services Commission (CSSC) is now working to further expand their northern zone iHRIS deployments by adding 3 more FBO health facilities to the 10 originally planned, bringing the total number of CSSC northern zone hospitals to 13.

Speaking at a meeting to share experience among decision makers and managers of health facilities rolling out HRIS in the CSSC Northern Zone, CSSC Zonal Manager, Mr. Ireneus Lyimo, made the above statement about future demand for the system that will drive its sustainability. He also explained that the CSSC Northern Zone ICT staff have managed to deploy the HRIS at 7 hospitals so far (Dareda, Kibosho, Arusha Lutheran Medical Centre (ALMC), Karatu, Haydom, Huruma and KCMC) and trained 18 staff at these hospitals on data entry, verification and generating reports.



***Mr. Ireneus Lyimo, CSSC Northern Zone Secretary***

Mrs. Janeth Itemba is the Human Resource Officer at ALMC, and also one of the health facility managers who was presenting at the meeting. She described their use of the system and reported that the ALMC has found the HRIS to allow generating staff reports (Tange) easily. In addition, some of the data they have retrieved through system includes number of staff assigned to various jobs and their employment status. Mrs. Itemba also mentioned that, they have used the leave reports extracted from the system to set up a clear roster of staff that will be going for leave. The hospital also has future plans to use the Tange reports in the system to set a plan for coordinating their staff members to take different training courses for their professions.



***Mrs. Janeth Itemba, ALMC HR Officer***

## Success Story 5 - HRIS Users Satisfied with System Function

Most of the hospitals using the Human Resource Information System (iHRIS) testify to the usefulness of the system as a tool that is strengthening hospital manager's ability to deliver staff reports timely. Many also point to the system's efficiency in organizing and storing human resource data and to the easy access it provides to such data. At a recent meeting of HRIS users in the CSSC Northern Zone, Arusha Lutheran Medical Centre (ALMC), Kibosho, Dareda and Hydom hospital HR managers all agreed that the iHRIS is a unique tool that has greatly facilitated their ability to generate accurate reports that are currently being used in budgeting and planning.

During this meeting the Chief Finance Officer of ALMC, Mr. Amini Mungure, reported that the HRIS was very useful this year during their budgeting sessions. As part of that effort, they used the HRIS several times to plan staff salaries by comparing salary scales.

Mr. Mungure explained further that -

*"when we need information, we just tell the data clerk that we need someone's information on salary scale or information about date of recruitment. We then take those data, we compare them to make sure that they are accurate, and then we start using them in the budgeting session".*



**Mr. Amini Mungure, CFO of ALMC, sharing iHRIS success at the meeting**

Because of its value in this effort, he now understands why all data getting entered into the HRIS must be well verified and he insists that every employee's data entered must be compared to their personal physical file, which each employee fills out upon recruitment.

In regard to ongoing system sustainability, almost all of the users indicated that they are currently working to allocate additional budget to be used for sustaining systems through preventive maintenance and other technical services. Most also reported that they are still planning to conduct more training to additional staff on using the system.

The CSSC-THRP Coordinator, Mr. Petro Pamba, affirmed this positive acceptance of the HRIS as clear success, indicating that throughout the project, CSSC has encouraged the hospitals to take ownership and responsibility of their systems by budgeting for ongoing maintenance of the equipment. This same sense of system ownership was further realized during follow-up visits conducted at other facilities in the CSSC network where most of the hospitals visited have also established preventive maintenance plans to sustain the HRIS after THRP support ends.

The THRP Specific Objectives that CSSC has been responsible for implementing are:

- 1) To **ADVOCATE** using Human Resource for Health Data in Decision Making at all levels (Government and Private Sector) by April 2013.
- 2) To improve Human Resource Management **SKILLS** (linking to HRIS use) at all levels (CSSC, BAKWATA and APHFTA) by April 2013.
- 3) To improve **DATA** collection, entry, analysis, storage and utilization of HRH in the Human Resource Information **SYSTEM** at all levels (National, zone and facility) on the Private Sector by April 2013.

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**Annexes:**

- Annex A – HRIS Installation & Training Status – April 2013
  - Annex B – Data Collection Tools
  - Annex C – HRIS Data Quality & Use Supervision Tools
  - Annex D – HRIS Customized Reports
  - Annex E – HRIS Data Utilization Log – Request Form
  - Annex F – CSSC THRP Performance Management Plan – Activity Record
  - Annex G – Performance Monitoring Plan Indicator Results Table
-

## **Annex A**

### **HRIS Installation & Training Status April 2013**

Count	Organization	Facility Name	Zone	Location	Facility Type	THRIS Status	Install/Training Date	Staff Trained	HR Data Status
<b>CSSC ZONAL OFFICE HRIS TRAINING STATUS</b>									
1	CSSC	HQ Office	HQ	Dar es Salaam	Office	Operational	Yr-1: Qtr-1	4	HRH Compile & E
1	CSSC	EZ Office	East	Morogoro	Office	Operational	Yr-1: Qtr-3	2	HRH Update & E
1	CSSC	LZ Office	Lake	Mwanza	Office	Operational	Yr-1: Qtr-3	2	HRH Update & E
1	CSSC	NZ Office	North	Arusha	Office	Operational	Yr-1: Qtr-3	2	HRH Update & E
1	CSSC	SZ Office	South	Mbeya	Office	Operational	Yr-1: Qtr-4	2	HRH Update & E
1	CSSC	WZ Office	West	Tabora	Office	Operational	Yr-1: Qtr-4	2	HRH Update & E
6								14	
<b>EASTERN ZONE HRIS TRAINING STATUS</b>									
1	CSSC	St. Francis Ifakara - Referral	East	Ifakara-Kilombero	Hospital	Trained	Yr-2:Qtr-4	2	HRH Update & E
1	CSSC	Mvumi - DDH	East	Mvumi-Chamwino	Hospital	Trained	Yr-2: Qtr-4	2	HRH Update & E
1	CSSC	Bumbuli - VAH	East	Bumbuli-Lushoto	Hospital	Trained	Yr-2: Qtr-4	2	HRH Update & E
1	CSSC	St Gema - VAH	East	Dodoma Town	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Teule Muheza - CDH	East	Muheza	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Cardinal Rugambwa - VAH	East	Ilala	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	St Francis Kwamkono - VAH	East	Handeni	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	Berega - VAH	East	Kilosa	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	Turiani - CDH	East	Mvomero	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
9								18	
<b>LAKE ZONE HRIS TRAINING STATUS</b>									
1	CSSC	Nyakahanga - DDH	Lake	Nyakahanga-Karagwe	Hospital	Trained	Yr-2:Qtr-4	2	HRH Update & E
1	CSSC	Sumve - DDH	Lake	Sumve-Kwimba	Hospital	Trained	Yr-2:Qtr-4	3	HRH Update & E
1	CSSC	Biharamulo - DDH	Lake	Biharamulo	Hospital	Trained	Yr-2:Qtr-4	2	HRH Update & E
1	CSSC	Kolandoto - CDH	Lake	Shinyanga	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Shirati - CDH	Lake	Shirati - Mara	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Mugana - DDH	Lake	Bukoba	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Murugwanza - DDH	Lake	Ngara	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	Ndolage - VAH	Lake	Muleba	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	Bunda - DDH	Lake	Bunda	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
9								19	
<b>NORTHERN ZONE HRIS TRAINING STATUS</b>									
1	CSSC	Kibosho - CDH	North	Kibosho-moshi	Hospital	Trained	Yr-2:Qtr-4	2	HRH Update & E
1	CSSC	ALMC - Referral	North	Arusha town	Hospital	Trained	Yr-2:Qtr-4	3	HRH Update & E
1	CSSC	Dareda - CDH	North	Dareda - Manyara	Hospital	Trained	Yr-2:Qtr-4	2	HRH Update & E
1	CSSC	Huruma - CDH	North	Rombo	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Karatu CDH	North	Karatu - Arusha	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Hydom Referral	North	Mbulu - Arusha	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Marangu VAH	North	Moshi R	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	Ngoyoni VAH	North	Rombo	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	St Elizabeth CDH	North	Arusha U	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	KCMC referral	North	Moshi U	Hospital	Trained	Yr-4:Qtr-1	4	HRH Update & E
10								23	
<b>SOUTHERN ZONE HRIS TRAINING STATUS</b>									
1	CSSC	Mbalizi - CDH	South	Mbalizi	Hospital	Trained	Yr-3:Qtr-1	2	HRH Update & E
1	CSSC	Ilembula - Referral	South	Ilembula	Hospital	Trained	Yr-3:Qtr-1	2	HRH Update & E
1	CSSC	Tosamaganga CDH	South	Tosamaganga	Hospital	Trained	Yr-3:Qtr-1	2	HRH Update & E
1	CSSC	Peramiho Referral	South	Songea	Hospital	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	CSSC	Mbesa VAH	South	Tunduru	Hospital	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	CSSC	Dr Atman CDH	South	Sumbawanga	Hospital	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	CSSC	Nyangao Referral	South	Lindi R	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	Ilula CDH	South	Kilolo	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	Ndanda Referral	South	Masasi	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
9								18	
<b>WESTERN ZONE HRIS TRAINING STATUS</b>									
1	CSSC	Kabanga Referral	West	Kabanga	Hospital	Trained	Yr-2:Qtr-4	2	HRH Update & E
1	CSSC	Sikonge CDH	West	Sikonge	Hospital	Trained	Yr-2:qtr-4	3	HRH Update & E
1	CSSC	St. Gaspar Referral	West	Itigi - Singida	Hospital	Trained	Yr-3:Qtr-1	2	HRH Update & E
1	CSSC	Ndala VAH	West	Nzega	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Baptist CDH	West	Kigoma	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Makiungu CDH	West	Singida	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	CSSC	Kilimatinde VAH	West	Manyoni	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	CSSC	Nkinga Referral	West	Igunga	Hospital	Trained	Yr-4:Qtr-2	2	HRH Update & E
8								17	
<b>51 CSSC (6 Offices &amp; 45 Hospitals)</b>								<b>109</b>	<b>New CSSC Users</b>
<b>APHFTA HRIS TRAINING STATUS</b>									
1	APHFTA	HQ Office	HQ	Dar es Salaam	Office	Operational	Yr-2:Qtr-3	2	HRH Compile & E
1	APHFTA	LZ Office	Lake	Mwanza	Office	Operational	Yr-2:Qtr-4	2	HRH Update & E
1	APHFTA	NZ Office	North	Moshi	Office	Operational	Yr-2:Qtr-4	2	HRH Update & E
1	APHFTA	SZ Office	S. Highland	Mbeya	Office	Operational	Yr-2:Qtr-4	2	HRH Update & E
1	APHFTA	Cst-Z Office	Coast	Dar	Office	Operational	Yr-2:Qtr-4	1	HRH Update & E
1	APHFTA	Muzdalifah Disp	Coast	Dar	Dispensary	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	APHFTA	Bochi HC	Coast	Dar	HC	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	APHFTA	Tanzania Charitable	Coast	Dar	HC	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	APHFTA	Massana hospital	Coast	Dar	Hospital	Trained	Yr-3:Qtr-3	2	HRH Update & E
1	APHFTA	Safi medical hospital	North	Tanga	Hospital	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	APHFTA	Arusha H/C for Women	North	Arusha	HC	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	APHFTA	Uyole Hospital	South	Mbeya	Hospital	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	APHFTA	Sifika Health Centre	South	Mbozi	HC	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	APHFTA	Mwananchi hospital	Lake	Mwanza	Hospital	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	APHFTA	Rao hospital	Lake	Shirati-Mara	Hospital	Trained	Yr-3:Qtr-4	2	HRH Update & E
1	APHFTA	Mbagala Mission HC	Coast	Temeke	HC	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	APHFTA	Arfa Upendo	Coast	Temeke	HC	Trained	Yr-4:Qtr-2	2	HRH Update & E
1	APHFTA	Kamumed HC	North	Arusha U	HC	Planned	Yr-4:Qtr-2	0	planned
1	APHFTA	Arusha Old HC	North	Arusha U	HC	Planned	Yr-4:Qtr-2	0	planned
1	APHFTA	Arusha HC for women	North	Arusha U	HC	Planned	Yr-4:Qtr-2	0	planned
1	APHFTA	SIMA HC	North	Moshi	HC	Planned	Yr-4:Qtr-2	0	planned
<b>21 APHFTA (5 Offices &amp; 16 Health Facilities)</b>								<b>33</b>	<b>New APHFTA Us</b>
<b>BAKWATA HRIS TRAINING STATUS</b>									
1	BAKWATA	HQ Office	HQ	Dar es Salaam	Office	Operational	Yr-2:Qtr-4	2	HRH Update, Coi
1	BAKWATA	Al jamiah HC	Mikumi	Morogoro	HC	Operational	Yr-3:Qtr-4	2	HRH Update & E
1	BAKWATA	Aljumaa HC	Mwanza	Mwanza City	HC	Operational	Yr-3:Qtr-4	2	HRH Update & E
1	BAKWATA	Majengo Dispensary	Shinyanga	Shinyanga City	Dispensary	Operational	Yr-3:Qtr-4	2	HRH Update & E
<b>4 BAKWATA (1 Office &amp; 3 Health Facilities)</b>								<b>8</b>	<b>New BAKWATA</b>

## **Annex B**

### **Data Collection Tools**

Compiled list of standard HR Information collected on CSSC Health Workers using Tools developed for the THRP

**Personal Data (Taarifa Binafsi)**

English	Kiswahili	
No	Namba	_____
First Name	Jina la Kwanza	_____
Middle Name	Jina la Kati	_____
Surname	Jina la Ukoo	_____
Date of Birth	Tarehe ya Kuzaliwa	_____
Sex	Jinsi	_____
Marital Status	Hali ya Ndoa	_____
Number of Children	Idadi ya Watoto	_____
Nationality	Uraia	_____
Religion	Dini	_____
Place of Domicile	Makazi ya Kudumu baada ya kustaafu	_____
Check No	Cheki Namba	_____
File No	Namba ya Jalada	_____
E-mail	Barua Pepe	_____
Mobile No	Simu ya Mkononi	_____
Next of Kin	Mrithi	_____
Relationship to next of kin	Uhusiano na mrithi	_____
Registered disability	Ulemavu uliohibitishwa	_____

**Employment(Ajira)**

Cadre	Kada	_____
Present Designation	Cheo	_____
Position Title	Wadhifa	_____
Department	Idara	_____
Job Classification	Mchanganuo wa kazi	_____
Starting Designation	Cheo cha Kuanzia	_____
Date of First Appointment	Tarehe ya Kuanza Kazi	_____
Date of Confirmation	Tarehe ya Kuthibitishwa Kazini	_____
Date of Last Promotion	Tarehe ya Mwisho ya Kupandishwa Cheo	_____
Terms of Employment	Masharti ya Ajira	_____
Employment Status	Hali ya Utumishi	_____
Salary Source	Chanzo cha Mshahara	_____
Basic Monthly Salary	Kiwango cha Mshahara kwa Mwezi	_____
Pension Scheme	Mfuko wa Mafao	_____
Employer	Mwajiri	_____

**Education(Elimu)**

Education Level	Kiwango cha Elimu	_____
Qualification	Sifa / Ujuzi	_____
Institution Name	Jina la Chuo alichosoma	_____
Institution Location	Mahali Chuo Kilipo	_____
Course(s) of Study	Kozi Aliyosoma	_____

**Professional Registration(Usajili wa taaluma)**

Registration No	Namba ya Usajili	_____
Registration Councils / Authority	Mamlaka ya Usajili	_____

**In Service Training(Mafunzo kazini)**

Date of last training	Tarehe ya mafunzo ya mwisho	_____
Type of training	Aina ya mafunzo	_____



## **Annex C**

### **HRIS Data Quality & Use Supervision Tools**

**TOOL 1: Assessing Human Resource Information System Functionality**

For each component of HRIS system, choose the category that best describe the status of HRIS system (working properly, need repair and not working)

Item	YES	Somehow	No	Remarks/comment
	2	1	0	
<b>Human Resource Information System Infrastructure</b>				
The computer with HRIS are functioning well				
The LAN accessible and functions well				
There is internet access via computers with HRIS				
There is IT staff who is qualified to keep the computers functioning well, and is routinely available				
iHRIS appliances are functioning well				
<b>Human Resource Information System Software</b>				
HRIS application is functioning well				
There is a technical support for the HRIS application				
There is a system or process for sending comments for improving this HRIS application				

## HRIS Follow up visit Action Plan

<b>Organization name:</b>			
<b>Date of follow up visit:</b>			
<b>Date of Proposed Follow-up visit</b>			
<b>Description of Action Point</b>	<b>Person Responsible</b>	<b>Time Line</b>	<b>Follow-up date and comments</b>

### TOOL 3: DATA USE FOR HR DECISION MAKING

#### TOOL 3.A: Data Demand and Production

##### About this interview

The ultimate purpose of developing a Human Resource Information System is to collecting and analyzing HR data is to improve to improve HRM systems by enabling more informed decisions based on facts. However, information is always used to make decisions. This tool should be completed by HRIS administrator to enable the program to determine successes and challenges in data demand, analysis and utilization at district level.

Date:	
Interviewer Name:	
Title of Respondent:	
Specialization:	
Responsibilities:	

Data Demand and Production	
1	Do you have standard data or set of HRIS reports that you provide to HR managers at district and national level regularly? Describe and show some reports you have generated.
2	In what format do you produce the report?
3	Who are principle users of the data and/or reports you generate?
4	How many reports were requested by data users in the past three months?
5	How many HRIS reports have you generated in the past three months? (Verify in HRIS Logs)?
6	Have HRIS system helped you in meeting data demands from HR managers? Please describe
7	I am interested in knowing about technical capacity for collecting and using information. Does your organization have technical capacity to analyze data and produce reliable reports in the format requested by data users?
8	What specific challenges have you experienced among staff when it comes to using data?  ( probe respondents for the following items following their response: awareness of data source, technical skills, motivation, time, workload, lack of incentive or knowledge on using data for program decision
9	Do you have any suggestions or recommendation for improving the current system in order to meet the user's requirements?

**TOOL 3.B: Data Use for Decision Making**

Date:	
Interviewer Name:	
Title of Respondent:	
Specialization:	
Responsibilities:	

**About this interview – and why your participation is so important**

The ultimate purpose of developing a Human Resource Information System is to collecting and analyzing HR data is to improve to improve HRM systems by enabling more informed decisions based on facts. However, information is always used to make decisions.

This tool should be completed by District manager ( DMO, DHS, DNO or DHRO) to enable the program to determine successes and challenges in using HRIS data for informing decision making process.

HRIS Use: Planning and priority setting		YES	No	Unsure
1	Do you use HRIS data for practical decision making (such as set resource allocation in annual budgets, advocating for funding or influencing policies)?			
	Please give two practical examples of HR decisions you made which were informed by HRIS data this year:			
2	How do you access the HRIS data?			
3	Does the HRIS data meet your information requirements in making HR decision?			
	Please Describe:			
4	Has there been any occasion when data quality or local capacity made it difficult for you to use information in making a decision?			
	Please describe:			
5	How does your organization support training staff in skills for using information for decision making?			

**HRIS Data Quality Checklist:**

<b>A: Review HR data Source Documents (Personnel files)</b>		
	<b>Number</b>	<b>REVIEWER COMMENTS</b>
<b>Availability</b>		
1. How many staff are employed by the organization		
2. How many personnel files are available?		
3. How many staff data have been entered in the system ( verify in the system)		
4. Review available source documents for the reporting period being verified. Is there any indication that source documents are missing? If yes How many?		
5. If yes, determine how this might have affected data use		
<b>Completion</b>		
6. Review completeness of HR data source documents complete? Are all documents complete? If not how many?		
7. If no, determine how this might have affected reported numbers.		
<b>Regular updates</b>		
8. Review the dates on the source documents. Do all dates fall within the required updates period? If not how many?		
9. If no, determine how this might have affected reported numbers.		

**B : Cross-check Paper based HR data and Electronic Based HR data**

<b>Cross-check</b>	<b>REVIEWER COMMENTS</b>
<b>Randomly select 10% of paper based HR data and cross check against electronic HR data to see if the data is accurate.</b>	
10. List the HR files used for performing the cross-checks.	
11. Describe the cross-checks performed?	
12. What are the reasons for the discrepancy (if any) observed?	

## **Annex D**

### **HRIS Customized Reports**



## CSSC HRIS Reports

Report	Description
<b>Facility Report</b> Facility List ( RIPOTI YA VITUO VYA AFYA, ZAHANATI NA HOSPITALI)	List of all facilities.
<b>Filled Positions</b> Filled Positions Export (VYEO VILIVYO NA WATUMISHI)	List of historical filled positions for exporting.
<b>Establishment Report</b> IKAMA Report	Standard Establishment of facilities
<b>Staff Reports</b> Staff Promotion Age Distribution Classification Breakdown Hires per Year ( RIPOTI YA WATUMISHI WALIOAJILIWA KWA MWAKA) Job Breakdown Nationality Breakdown Retirement Planning (RIPOTI YA MPANGO WA WATUMISHI KUSTAAFU) Salary Scale Report -- Orodha ya Scale za Watumishi Tange Report (Jinsi na Kada) -- Orodha ya Ripoti ya Jinsi na Kada Leave Report (Likizo) -- Orodha ya Likizo kwa Watumishi Tange Report (Elimu) -- Orodha ya Watumishi Elimu Tange Report (Ripoti ya Kuajiliwa) Tange Report (Ripoti ya Kustaafu) Designation by Employer Designation by Facility and Employer Emergency Contact List Home Contact List Salary List ( RIPOTI YA MISHAHARA KWA WATUMISHI) Staff Directory ( RIPOTI YA TANGE KWA WATUMISHI)	List of promoted staff Total of all staff by age range Total of all staff by classification Hire totals by year Total staff by job List of all staff by nationality Staff totals by retirement year Scale List of Employees List of How to cadres Report List of Holidays for Employees Education Staff List List of Hired Employees List of Retirement Year Totals of designation by employer Designation by Facility and Employer List of all staff with emergency contact details List of all staff with home contact details List of all employees with salary details List of all current staff with work contact information
<b>Position Reports</b> Position List (ORODHA YA VYEO) Position Open Duration	List of all positions Time (days) each position was open before being filled
<b>Search</b> Search People(RIPOTI YA WATUMISHI NA VYEO VYAO)	Search all person records in the system

## **Annex E**

### **HRIS Data Utilization Log**



CHRISTIAN SOCIAL SERVICES COMMISSION (CSSC)

HRIS DATA UTILIZATION

Full Name: Mwingira, John E.

Title: Projects Agent

Organization Name: The Church of Jesus Christ of LDS

Department: Humanitarian Services

Type of Data requested: Contracts for Mission Owned Hospitals for HRB 2012 Training Project.

Purpose of the data: Inviting interested parties to attend a seminar and receive free medical equipments for transfer & use at respective hospitals.

Date requested: 03/07/2012

Issued by: John Jayce Signature: [Signature]  
Date: .....

Received by: John E. Mwingira Signature: [Signature]  
Date: 06/07/2012

Authorized by: ..... Signature: .....  
Date: .....

## **Annex F**

# **CSSC THRP Performance Management Plan Activity Record**

**PERFORMANCE MANAGEMENT PLAN (PMP) – FROM QUARTERLY PROGRESS REPORT**

**YEAR ONE October 2009 – September 2010**

***Qtr II January – April 2010***

<b>No</b>	<b>Indicator</b>	<b>Achievements Jan – March 10</b>	<b>Targets Jan – March 10</b>	<b>% Achieved based on annual targets</b>	<b>Program Area</b>
1	Number of workshops conducted to orient private sector stakeholders on HRH policy documents	5 workshops conducted	6 workshops	83%	THRP
2	Number of stakeholders receiving orientation on HRH documents	328 stakeholders attended	315 people	104%	THRP
3	Number of staff trained on iHRIS software application support	8 staff trained	8 people	100%	THRP
4	Number of people trained on iHRIS application	8 staff trained	11 people	72%	THRP
5	Number of CDs produced	70 CDs –film	400 CDs	17.5%	THRP
6	Number of CDs produced in workshops	278 CDs	368 CDs	75.5%	THRP

***Qtr III April – June 2010***

<b>No</b>	<b>Indicator</b>	<b>Achievements April – June 10</b>	<b>Targets April – June 10</b>	<b>% Achieved based on annual targets</b>	<b>Program Area</b>
1	Number of workshops conducted to orient	1 workshop	1 workshops	100%	THRP

	private sector stakeholders on HRH policy documents	conducted			
2	Number of stakeholders receiving orientation on HRH documents	51 stakeholders attended	60 people	85%	THRP
3	Number of staff trained on iHRIS software application support	10 staff trained	10 people	100%	THRP
4	Number of people trained on iHRIS application	83 staff trained	90 people	92%	THRP
5	Number of CDs produced	83 CDs –film	90 CDs	92%	THRP
6	Number of CDs produced in workshops	83 CDs	90 CDs	92%	THRP

**Qtr IV July – September 2010**

<b>No</b>	<b>Indicator</b>	<b>Achievements July – Sept 10</b>	<b>Targets July – Sept 10</b>	<b>% Achieved based on annual targets</b>	<b>Program Area</b>
1	Number of workshops conducted to orient private sector stakeholders on iHRIS System	3 workshop s conducted	3 workshops	100%	THRP
2	Number of stakeholders receiving orientation on iHRIS System	163 stakeholders attended	172 people	94%	THRP
3	Number of DVDs produced	0 CDs –film	350 CDs	0%	THRP

4	Number of CDs produced in workshops	163 CDs	180 CDs	91%	THRP
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**YEAR TWO October 2010 – September 2011**

***Qtr I October – December 2010***

<b>No</b>	<b>Indicator</b>	<b>Achievements Oct – Dec 10</b>	<b>Targets Oct – Dec 10</b>	<b>% Achieved based on annual targets</b>	<b>Program Area</b>
1	Number of workshops conducted to orient private sector stakeholders on iHRIS System, improve project performance and data collection review	3 workshops conducted	3 workshops	80%	THRP
2	Number of staff from different partner project shared the performance and challenges for Year I	All staff shared the achievement and challenges	51 people	68%	THRP
3	Number of stakeholders receiving status on iHRIS System use	stakeholders attended	27 people	62%	THRP
4	Number of key stakeholder shared the review of data collection tool	Stakeholders improved the data collection tool	17 people	88%	THRP

***Qtr II January – March 2011***

<b>No</b>	<b>Indicator</b>	<b>Achievements Jan – March 2011</b>	<b>Targets Jan –</b>	<b>% Achieved based on annual targets</b>	<b>Program Area</b>
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			<b>March 11</b>		
1	Number of follow up action plan was conducted	Three follow up was conducted to three zones	5 zones	60%	THRP
2	Number of staff was trained on Gender interventions in HRH	Two staff from CSSC attended the training	2 staff	100%	THRP
3	Coordinating Committee meeting	Eight Committee members attended and shared the progress of the project	11 people	72%	THRP
4	HRIS Support	11759 has all needed records when the reports are generated	18,272 employee records entered in the system	63%	THRP

**Qtr III April – June 2011**

<b>No</b>	<b>Indicator</b>	<b>Achievements April – June 2011</b>	<b>Targets April – June 11</b>	<b>% Achieved based on annual targets</b>	<b>Program Area</b>
1	Number of THRIS follow up action plan was conducted	Two follow up was conducted to three zones	3 zones	67%	THRP
2	Number of hospitals conducted dissemination follow up	Fifteen hospitals visited to all five zones	15 hospitals	100%	THRP
3	Coordinating Committee meeting	Seven Committee members attended and shared the progress of the project	9 people	78%	THRP
4	HRIS Support	13273 has all needed records when the reports	18,272 employee	73%	THRP



		are generated	records entered in the system		
5	Train APHFTA and BAKWATA data Clerks	Nil	Five data clerks	0%	THRP
6	Train HMT members on HRM skills by BMAF	Nil	92 members	0%	THRP
7	Conduct HRIS workshop to APHFTA owners	Nil	100 participants	0%	THRP

**Qtr IV July - Sept 2011**

<b>No</b>	<b>Indicator</b>	<b>Achievements July – September 2011</b>	<b>Targets July – September 11</b>	<b>% Achieved based on annual targets</b>	<b>Program Area</b>
1	Number of THRIS follow up action plan was conducted	Nil	1 zone	0%	THRP
2	Coordinating Committee meeting	Seven Committee members attended and shared the progress of the project	9 people	78%	THRP
3	Train APHFTA and BAKWATA data Clerks	Trained nine people	Five data clerks	180%	THRP
4	Train HMT members on HRM skills by BMAF	Trained 82 members	92 members	89%	THRP
5	Conduct HRIS	Conducted workshop to	100 participants	58%	THRP

	workshop to APHFTA owners	Coastal zone and 58 participants attended			
6	No of APHFTA zones and BAKWATA installed THRS	Five workstation installed	Five workstation	100%	THRP
7	No of CSSC Hospitals installed THRS	Nine hospitals installed	15 hospitals	60%	THRP
8	No of CSSC hospital staff trained THRS	Twenty six staff trained THRS	30 staff	87%	THRP

**YEAR THREE October 2011 – Sept 2012**

**Qtr I October – December 2011**

No	Indicator	Achievements October – December 2011	Targets October – December 2011	% Achieved based on annual targets	Program Area/Comments
1	# of stakeholder participated in Year II sharing	43 participants attended the workshop and representative from CSSC Zones, APHFTA Zones and BAKWATA HQ presented the THRP(Objective) achievements, challenges, lesson learnt and the way forward.	56 participants	76%	Added addition input to improve data management.
2	Number of members attended Coordinating committee	Six members attended the meeting and went through the July – September 2011	Nine members	66%	BAKWATA missed representation

	meeting	Quarterly report			
3	# of equipments procured	29 ( PC, UPS, Scanners, Printers and Flash Disk), 11 External Hard Disk and 3 Laptops was procured	29 of (Computers, UPS, Scanners, Printers and Flash Disks) and 11 external hard disk equipments for CSSC(15 hospitals) , BAKWATA(1 laptop and 4 hospitals) & APHFTA(10 hospitals and 2 laptop)	100%	It was delivered December as was planned.
4	Number of staff trained THRIS at CSSC Southern Zone	8 HRIS focal person was trained on HRH update and reports export at Mbalizi, Tosamaganga and Ilembula Hospital.	6 Focal Person	More than the expected number was trained to manage the HRIS at facility level =133%	The challenges was internet connectivity
5	Number of participants attended APHFTA sensitization workshops	Owners of the health facilities was sensitized about HRIS and created awareness. 127 staff attended.	148 staff from facilities of APHFTA three zones	85% of staff attended	Strengthened cooperation between facility owners and APHFTA head office staff.

	conducted				
6	# of THRIS monitoring follow up is conducted	One site was visited for HRIS follow up to CSSC Western Zone and Sikonge hospital.	One Hospital was visited and action plan was agreed to solve the challenges in HRH data update and system bugs.	100%	This was Year II activities. The activity report was shared.
7	Number of IT Technicians to be trained	Five IT Technicians attended the training	Six staff to attend	83%	It was supported by CSSC ICT Core fund

**Qtr II Jan – March 2012**

<i>No</i>	<i>Indicator</i>	<i>Achievements January – March 2012</i>	<i>Targets January – March 2012</i>	<i>% Achieved based on annual targets</i>	<i>Program Area/Comments</i>
1	# of members attending the coordinating committee meeting	6- members attended the meeting.	9- members	67%	BAKWATA attended an emergence meeting with the Prime Minister.
2	Number of facilities distributed personnel form - APHFTA	167- facilities distributed personnel form	415-facilities	40%	Distribution is still in progress
3	# of facilities distributed personnel form -	7- facilities distributed personnel form	7-facilities	100%	

	BAKWATA				
4	Hosting sites	2 sites for APHFTA and BAKWATA.	2 sites	100%	
5	Distribution of Equipment	26 hospitals have access to equipments.	29 hospitals	89.6%	
6	Data utilization	CSSC HQ, CSSC Northern Zone and Sikonge hospital.	27 institutions	11%	Accuracy of data still hinders utilization.
7	HRIS follow up	4 hospitals accessing THRS	15 hospitals	27%	CSSC zones still undertaking HRIS follow up the remained hospitals

**Qtr III April – June 2012**

<i>No</i>	<i>Indicator</i>	<i>Achievements April - June 2012</i>	<i>Targets April - June 2012</i>	<i>% Achieved based on annual targets</i>	<i>Program Area/Comments</i>
1	# of members attending the coordinating committee meeting	5- Members attended the meeting.	9- members	55.5%	BAKWATA did not attend
2	System installation and training of 28 Health facilities (CSSC, APHFTA and BAKWATA)	42 focal person was trained	30 focal person	140%	Some of the hospitals trained more focal person or attended the training than it was arranged or perpeared
3	Training of HRM linking with HRIS to 13 health	Participants from 45 managers was trained	82 managers	54%	The approach of HRM training changed due to the

	facilities				comments and advice from IH, IMA and other stakeholders. Only health facilities accessing the HRIS system was trained instead of all health facilities in EZ which could have 82 participants
4	Conduct Preventive Maintenance to 5 CSSC zones	4 CSSC zones	5 CSSC zones	80%	
5	Conduct follow up of HRIS data quality to 15 CSSC hospitals	15 hospitals	15 hospitals	100%	
				78%	

**Qtr IV July – September 2012**

<b>No</b>	<b>Indicator</b>	<b>Achievements July – Sept 2012</b>	<b>Targets July - September 2012</b>	<b>% Achieved based on annual targets</b>	<b>Program Area/Comments</b>
1	# of members attending the coordinating committee meeting	8- Members attended the meeting.	9- members	88%	
2	Leadership and Management	33 Senior staff participated	36 senior staff	92%	

	training				
3	Training of HRIS to 12 health facilities 3 facilities from CSSC, 6 from APHFTA and 3 from BAKWATA	32 focal person were trained	24 focal persons	133.3%	Some of the health facilities trained more people than expected.
4	HRIS follow up to CSSC five zones(Five hospitals & Zonal offices) and Four APHFTA Zonal offices, BAKWATA health facilities	Follow up were conducted to 13 sites	15 sites	86%	
				88.4%	

**YEAR FOUR October 2012 – April 2013**

**Qtr I October – December 2012**

<i>No</i>	<i>Indicator</i>	<i>Achievements October - December 2012</i>	<i>Targets October - December 2012</i>	<i>% Achieved based on annual targets</i>	<i>Program Area/Comments</i>
1	# of HRIS documentary produced	300 DVD produced	500 DVD produced	60%	The achievement is very low due to the budget constraints as it was revised to produce HRIS documentary 300 DVD copies instead of 500 DVD copies

					as shown in PMP
2	# of for conducted	5 zones	5 zones	100%	
3	# of follow up conducted to HRM training performance to APHFTA-2, BAKWATA-2 and CSSC EZ - 4	2 follow up conducted(CSSC EZ – 2)	8 follow up(APHFTA-2, BAKWATA-2 and CSSC EZ -4)	25%	Due to the limited fund it was advised to choose only two hospitals should be assessed on the HRM trained in April 2012

**Qtr II Jan – March 2013**

<i>N o</i>	<i>Indicator</i>	<i>Achievements Jan – March 2013</i>	<i>Targets Jan – March 2013</i>	<i>% Achieved based on annual targets</i>	<i>Program Area/Comments</i>
1	# of HRIS documentary produced	300 DVD produced	500 DVD produced	60%	The achievement is very low due to the budget constraints as it was revised to produce HRIS documentary 300 DVD copies instead of 500 DVD copies as shown in PMP
2	# of new users of HRIS trained	49 new users trained to use HRIS	50	98%	Hospital Secretary was involved during HRIS training because is the one responsible on HRH at hospital level.



## **Annex G**

### **Performance Monitoring Plan Indicator Results Table**

**Performance Monitoring Plan  
Tanzania Human Resource Capacity Project, 2009-2013**

Expected Results	Indicator Source	Indicators and Benchmarks	Data Source	Reporting Schedule	Project Result	EOP Target
<b>Objective 1: HRH Strategy and the HR components of the HSSP III implemented</b>						
IR 1.1 HRIS functional and in use	Project	1. National HRIS functional	HRIS Function Checklist	Periodic	80 workstations	83
	Project	2. # instances in which use of HRIS generated-data in HRH strategic planning or other key decision-making has been demonstrated (by type of decision making/ planning)	CSSC, APHFTA and BAKWATA	Periodic	77 (HQ, Zones, Hospitals and Facilities)	83
<b>Objective 2: MOHSW Department of HR, PMORALG, and LGAs predicts, plans for, and recruits the required health and social welfare workforce</b>						
IR 2.0 District level HRIS functional and in use	Project	3. % of hospitals where HRIS is functional	HRIS Function Checklist	Semi-Annually Annually	100% (48 out of 47)	100%
	Project	4. % of hospitals with HRIS who are using HRIS data for HRH decision-making	CSSC, APHFTA and BAKWATA	Periodic	98% (46 out of 48)	100%
	PEPFAR H7.1N	5. National human resource information system in place with key elements	CSSC	Semi-Annually Annually	100% (Tange report)	100%
	PEPFAR H7.5N	6. Existence of national and sub-national databases that enable stakeholders to access relevant data for policy formulation and program management and improvement	CSSC, APHFTA and BAKWATA	Semi-Annually Annually	75%	100%