United Republic of Tanzania
Ministry of Health, Community Development, Gender, Elderly and Children

Mid Term Review of the Health Sector Strategic Plan IV 2015 - 2020

Thematic Report
HUMAN RESOURCE FOR HEALTH

October 2019
Recommended Citation: MOHCDGEC. 2019, Mid Term Review of the Health Sector Strategic Plan IV 2015 – 2020, HUMAN RESOURCE FOR HEALTH, Technical Report, Ministry of Health, Community Development, Gender, Elderly and Children.
Mid Term Review of the Health Sector Strategic Plan IV
2015 - 2020

Thematic Report
HUMAN RESOURCE FOR HEALTH
Hadija Kweka
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<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>CHMT</td>
<td>Council Health Management Team</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Workers</td>
</tr>
<tr>
<td>CO</td>
<td>Clinical Officer</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuous Professional Development</td>
</tr>
<tr>
<td>DHFF</td>
<td>Direct Health Facility Financing</td>
</tr>
<tr>
<td>DHRD</td>
<td>Department of Human Resources Development</td>
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<tr>
<td>EN</td>
<td>Enrolled Nurse</td>
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<tr>
<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
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<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>HRHIS</td>
<td>Human Resources Information System</td>
</tr>
<tr>
<td>HRHSW</td>
<td>Human Resource for Health and Social Welfare</td>
</tr>
<tr>
<td>HSSP IV</td>
<td>Health Sector Strategic Plan IV</td>
</tr>
<tr>
<td>MD</td>
<td>Medical Doctor</td>
</tr>
<tr>
<td>MOHCDGEC</td>
<td>Ministry of Health Community Development Gender Elderly and Children</td>
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<tr>
<td>MTR</td>
<td>Midterm Review</td>
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<tr>
<td>NHIF</td>
<td>National Health Insurance</td>
</tr>
<tr>
<td>OPRAS</td>
<td>Open Performance Appraisal</td>
</tr>
<tr>
<td>PE</td>
<td>Personnel Emolument</td>
</tr>
<tr>
<td>PlanRep</td>
<td>Planning and Reporting</td>
</tr>
<tr>
<td>PNC</td>
<td>Post Natal Care</td>
</tr>
<tr>
<td>PORALG</td>
<td>President’s Office Regional Administration and Local Government</td>
</tr>
<tr>
<td>RHMT</td>
<td>Regional Health Management Team</td>
</tr>
<tr>
<td>RMNCH</td>
<td>Reproductive Maternal New-born and Child Health</td>
</tr>
<tr>
<td>TNC</td>
<td>Tanzania Nursing Council</td>
</tr>
</tbody>
</table>
Executive Summary

The MTR information was collected through document review, key informants interviews and survey. It started in March 2019 and finalised in August 2019. The review focused on the components of HSSP IV where progress and challenges were explored with regard to HRH planning, distribution, production and performance management. In addition progress on nursing and midwifery and professional regulatory councils were also assessed. The current progress indicates that the pace at which HRH shortage is reduced is unacceptably slow. The gap is expected to widen following construction of new facilities and HRH attrition which is estimated to be 3%. Production is progressing well exceeding the absorption capacity. Since 2015-2018, more than 10,000 middle level cadres were produced and only about 1500 were recruited. Following the current economic situation it is less expected that there will be a dramatic increase in hiring staff to abridge the current 52% gap.

The estimated gap is based on the static establishment which might have not indicated the real picture. Despite shortage (52%)- there is a recorded efficiency in output than previous years suggesting no linear relationship between HRH numbers and output if other factors such as medicines, infrastructure and equipment are improved. Whether the existing workforce is optimally utilised is still questionable due to the limitation of the existing performance appraisal system and lack of complete WISN report which was implemented countrywide in public health centres and dispensaries.

While celebrating the increased enrolment and output as well as the power of private sector involvement in training, quality issues have been aired out. The application of outdated curriculum, shortage of tutors, poor quality skill labs and dilapidated buildings are some of quality limitations identified in this MTR. The following are recommended to address the HRH challenges;

1: Rationalisation of the current gap and deploy innovative solution to abridge the current gaps

   a) Enforce Policy for more rational and evidence-based posting and redistribution decisions. Information technology should enable more adequate planning of human resources and a move from static establishment is recommended.

   b) Further elaboration of task sharing and task shifting as innovative solutions of critical shortage.

   c) Where technology can replace human presences or can enable task sharing, it should be utilised optimally. For example with MRDTs the need for skilled lab assistant at dispensary level may be considered as an option in less crisis state. Nurses and clinicians can replace such roles where feasible.

   d) Innovative approaches in deployment of staff have to be created, e.g. employment in government institutions by foundations through franchising, employment by village government and flexible decentralised contracts.
e) Strengthen MOHCDGEC coordination with other government Ministries and agencies to improve transparency, effectiveness and sustainability in public health workforce recruitment.

2: Address Production and CPD challenges

**Adequate curriculum**
- A drastic innovation of the training approach in the health sector, making them more aligned with modern education methods, more adequate for practice

**CPD and Licencing MOHCDGEC to ensure that**
- CPD is embedded in a system of career development by linking CPD and re-registration of professionals.
- All CPD activities are accredited in order to be allowed in the health sector,
- Promote Mentorship of health workers using variety of ways including digital media, etc.

**Innovation and e-learning**
- Facilitate continuous support to e-learning centre, development and maintenance of e-learning tools.
- Mechanisms for regulating e-learning development should be established including things like licencing products before they are made available on the market, and before they can be integrated in blended learning curricula

**Management of institutions**
- MOHCDGEC to promote Public Private Partnership in training for the health sector
- Concentration in zonal multidisciplinary training institutions is an option for innovation.
- concentration of curriculum development in one educational centre may contribute to better quality and more investments in the training sector in health

3: Performance and career development
- Performance management has to be implemented, as intended in OPRAS and performance-based management systems need to be reinforced, together with adherence to incentive schemes.
- Supervision should be geared more to coaching and mentoring for developing leadership skills.
1. Introduction

This is the Human Resources section of Health Sector Strategic Plan Four Midterm review. The assignment required the consultant to track progress made so far regarding the implementation of HSSP IV, identify success factors, challenges and lessons learned in order to suggest improvements to the final period of HSSP IV implementation and inform the design and formulation of the Health Policy and Health Policy Implementation Strategy, as well as the formulation of HSSP V. Specifically the HRH thematic group was expected to:

- Assess the progress in production of new staff
- Assess progress made in deployment and distribution of HRH as
- Establish any information regarding HRH utilisation and productivity including task sharing
- Establish strengths and challenges in HRH policy and programming including – definition of needs and staff projection
- Recommend HRH focus on the remaining period of implementation of HSSP IV and
- Recommend what should be considered in the forthcoming strategic plan (HSSP V)

HRH review of progress focused on the areas outlined in table 1

Table 1: The focus areas of HRH Thematic Area

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>The specifics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6.1 Strategic Direction</strong></td>
<td>Adequate staffing of health facilities and social welfare institutions at all levels is the most critical success factor in achieving quality health and social welfare services. Equitable staff distribution, retention and maintaining high performance standards for employed professionals will be at the heart of quality improvement in health and social welfare services. Human Resources production will follow HSSP IV priorities</td>
</tr>
</tbody>
</table>
| 6.1.1 HRHSW planning and management| A. Capacity Building leadership, HRH planning and HR management practices such as induction and coaching of new staff  
B. Staff distribution: Equitable distribution of staff over the country in the context of the BRN strategies  
C. HRH Planning |
| 6.1.2 Distribution of staff        | Focuses on  
A. Distribution of skilled HRH based on priority service delivery areas and prioritise underserved areas  
B. Improved systems of recruitment, career development and retention of HRH- LGAs using incentives for retention of health care workers.  
C. Private providers providing professional health services in public facilities through innovative PPP contractual arrangements in at least 25% of identified Councils |
| 6.1.3 Performance Management       | A. Collective Performance Management promoted(Star Rating, certification or accreditation)  
B. Operationalization of individual performance management systems (OPRAS AND RBF) |
| 6.1.4 Information and research     | A. Use of human resource for health applied research for planning and advocacy |
### 6.1.5 HRHSW development

| A. | Develop and maintain high quality HRHSW production, to meet the demands of the health sector with emphasis on increased production of middle level cadres (AMO, CO, nurses midwives, SWOs) as per HRHSW production plan |
| B. | Engagement in public-private partnerships for increasing training of health staff |
| C. | Community Health Workers (CHW) formalized and standardized |
| D. | Quality and effectiveness of Continuing Professional Development (CPD) Programmes enhanced and fragmentation reduced. |
| E. | Zonal Health Resource Centres (ZHRCs) position reflected in the MOHCDGEC organizational structure, the linkage to national, regional and Councils level clearly stipulated |

### 6.1.6 Nursing and Midwifery services

| A. | Improved skills for nurses and midwives in reaching public expectations by providing quality services. |
| B. | Orientation plan to newly and relocated staff and employees introduced to facilitate the understanding of the new working environment |
| C. | Creation of a clinical instructors’ programme for students and interns |
| D. | Certification towards Accreditation |
| E. | Clients’ Charter |
| F. | Pay for Performance |

### 6.1.7 Professional Regulatory Councils

| A. | A system of re-registration for health professionals introduced |

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**1.1 Methodology**

Given that the TOR requires the consultant to provide an analysis of what has facilitated or impeded progress to date, a critical analysis approach was used for this assignment. This is because this approach provides an opportunity for evaluator to understand the overall context, expectations and processes that determines implementation performance. The approach to this assignment followed the methodology stipulated in the inception report of the overall HSSP IV MTR exercise. Figure 1 summarizes the process.
Both qualitative and quantitative information were collected. The following methods of data collection were used. A desk review was conducted to generate a description of the implementation and evaluation of the achievement of HSSP IV in Human Resources for Health. The output of this part was to gather what was planned and the extent to which the planned activities were implemented, lessons learned and challenges encountered. The existed secondary data (where feasible) were used to establish quantitative change in relevant areas of focus. The consultant and the technical team worked together to identify appropriate documents for review. Documents reviewed included operational plans and report of HRH TWG, partners report, HRH profile, policies, guidelines and health sector profile. Meeting reports and joint field visit reports as well as publications on HRH issues in Tanzania and outside Tanzania were used. HRH electronic database were consulted to gather information on production, deployment as well as attrition. Reports from RBF and other collective performance management were used to establish bases for exploring their influences on HRH performance and motivation. Further this component also drew findings from the two preparatory studies- Gender in Health and Mid-term analytical report.

Field visit was conducted where Key informants were consulted to understand the status of HRH availability, success stories and challenges. Questions were administered using the ODK and also further probes were made to clarify the situation in a better way. In total, 24 councils were included in the study whereby in each council HRH related questions were sought from Regional and Council Health Management Teams, Health facility in-charges and heads of training institutions as well as Health Facility Governing Committees. Further national level interviews were conducted to gain more insight on the development made so far, challenges as well as future plans in total 108 respondents were interviewed

<table>
<thead>
<tr>
<th>Table 2: Respondents Consulted</th>
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</thead>
<tbody>
<tr>
<td>HMT</td>
</tr>
<tr>
<td>CHMT</td>
</tr>
<tr>
<td>RRH</td>
</tr>
<tr>
<td>Facilities</td>
</tr>
<tr>
<td>Training institution</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

The information was analysed using excel and STATA tools. This study also consulted the WISN report shared, however, the report did not clearly indicate the workload analysis hence it was not used to inform this MTR.
2. Strategic Directions and Specific Issues Findings

This section presents findings of the HSSP IV MTR - the HRH section. The findings focus on: progress on production of new staff, deployment and distribution of HRH, utilisation and productivity including task sharing as well as retention and staff satisfaction. In each assessment area strengths and challenges are identified and recommendations regarding HRH focus on the remaining period of implementation of HSSP IV and what should be considered in the forthcoming strategic plan (HSSP V) are highlighted.

2.1 HRHSW planning and management

In this component, the health sector planned to do the following:
- To strengthen leadership and management capacities of HRH officers for adequate planning at all levels
- To improve recruitment policies
- To promote and formally enhance task shifting of medical and other related professionals
- To formalize current untrained Ward Attendants to skilled Health Attendants, by taking them through competency-based training and
- To build capacity of LGAs to plan their local human resources needs based on the revised staffing norms for health facilities and institutions and to manage human resources adequately, including induction and coaching of new staff.

2.1.1 Building HRH Planning Capacity

Efforts to ensure planning skills is enabled at all levels were noted. For example it was noted that health secretaries have been employed in district and hospitals visited and in some areas they are more than the required number. Furthermore use of HRHIS and DHIS2 were mentioned amongst interventions to improve planning. Efforts to integrate HRHIS to DHIS2 are ongoing to ensure that HRH data is routinely available. At council level Health secretaries are the ones working on HRH planning.

Challenges of HRH Planning

However, it was noted that HRH planning did not receive the required attention and was seen to be used interchangeably with budgeting for personnel emolument. The review noted existence of HRHIS which is not updated. It has been a challenge to find information on HRH availability easily. From HRD department it was possible to get the database of who is available but was not tied with the requirement which again made the analysis difficult. Table 2 summarizes HRH planning challenges.
Table 3: HRH planning challenges

<table>
<thead>
<tr>
<th>Bottlenecks</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data generated not up to date</td>
<td>Limited update of HRH information systems</td>
</tr>
<tr>
<td>Limited data use</td>
<td>Inefficient modes of data transmission, Insufficient knowledge of health staff on computer as well as limited capacity to analyze and utilize the information at all levels of the system</td>
</tr>
<tr>
<td>Limited integration of HRHIS with other management with other management information systems and planning tools</td>
<td>HRHIS and TIIS are not integrated with other systems such as NACTE, WISN, PLANREP something that contributes to little utilization of information generated in subnational and national level planning</td>
</tr>
<tr>
<td>Limited HRH financing</td>
<td>Attributed to limited and targeted efforts to mobilize resources for financing HRH activities at all levels aggravated by lack of robust monitoring and evaluation framework and effective mechanisms to comprehensively manage HRH activities</td>
</tr>
<tr>
<td>Limited HRH Planning at subnational levels</td>
<td>Limited integration of HRH planning into subnational level planning has lowered HRH focus to HRH agenda and hence limited local initiatives in addressing HRH issues in sustainable way. There is a high dependency to centrally provided grants that has always been enough to meet PE commitments. Hence making the focus of HRH planning at subnational level inclined to annual projection of PE only</td>
</tr>
</tbody>
</table>

2.1.2 Task shifting of medical and other related professionals

Due to HRH shortage task sharing has been happening and it was the intention of the ministry then to formalize it. HRH Task Sharing Policy Guideline and Implementation Plan (2014 – 2019) exist. Task sharing is seen in all levels and prominent at lower level health facilities especially at dispensary and health center level where HRH shortage is higher. It has been noted in PMTCT and RCH there are vivid examples of task sharing and task shifting with clear guidance on how to do the tasks. There are guidelines and training package for implementation of tasks that are shared or shifted. For Medical attendants task sharing seemed motivating and part of job enrichment. Task shifting promotes on job coaching and mentorship. It was learned that MDs said they learn a lot from senior AMOs who did caesarean sections. Medical attendants and CHWs reported to get engaged in PMTCT and RCH activities and to them this is a very important learning platform. On the part of nursing several efficiency increase were identified which enhance more rational scope of practice (Mboineki and Zhang 2018). Little is known as to whether the training systems consider the task shifting components to improve curriculum development.
2.1.3 Leadership, induction and coaching of new staff

Leadership and management training were also reported by CHMTs, facility in-charges and RHMT- the training include hospital management, 5S Kaizen, DHFF implementation orientation and PlanRep. It was established that in all council’s staff induction is not conducted. The new recruits are given on job orientation only. Benjamin Mkapa Foundation spearheaded the development of staff induction guide that simplifies the complex induction process to something that is simple and doable by LGAs given the resource constraints.

2.1.4 Private providers providing professional health services in public facilities through innovative PPP contractual arrangements

Efforts to strengthen and promote PPP are ongoing although the most developed area of the PPP was public providers serving on secondment in FBOs’ facilities. This MTR noted that PPP in service delivery is more advanced compared to other arrangements of PPP

2.2 Distribution of staff

2.2.1 Distribution of skilled HRH based on priority service delivery areas and prioritise underserved areas

The implementation HSSP IV and the HRHSP 2014-2019 benefited much from the assessment and strategic options set during the BRN lab. The product of this lab was the improvements made on how MOHCDGEC used employment permits and managed distribution of staff. These include: Prioritized allocation of employment permits to regions with critical shortage, strengthened central guidance on HRH planning in terms of production and recruitment plan as well as conversion of permits to increase ability to recruit critical cadres which are in critical shortage. In 2016 it was projected that if all permits are utilized and rationalized as planned in 2018 the situation will look as in part B in the - figure 3.

Figure 2 : Projected improvement as of 2018 if employment permits were used as planned

Source: BRN Report
It was noted that there was employment freeze for 2015-2016 followed up by the removal of ghost workers and those with fake certificates from the payroll. In 2017 permit for recruiting 3,152 was issued to replace those who were taken out of the systems because they did not have proper certificates. The outcome of these efforts include the filling of gaps to 334 health facilities which had only MA and 1,505 which had no Clinicians at all. There is a clinical officer and an enrolled nurse in all dispensaries visited. It was noted all upgraded health centers have Medical Doctors. Effective partnerships with DPS on HRH were mentioned as one of the key success factors for HRH attraction in hard to reach areas. Currently all health facilities have at least one trained staff. Employment focused on middle level cadre to ensure that the primary facilities are staffed and the regions with high burden of maternal mortality were prioritized. Permit absorptions increased for two consecutive years- the utilization of permits was reported to be 100%. Majority of health professional who were posted reported with the exception of Katavi where the last batch of employees who were posted more than 50% did not report-

Figure 3 presents the current status of HRH availability. In terms of meeting the HSSP IV target a good progress is seen on medical officer and AMO density per 10,000 populations, whereas nurse midwives per 10,000 populations increased but did not meet the estimated target- figure 3.

<table>
<thead>
<tr>
<th>Indicator HSSP IV</th>
<th>Baseline (Year)</th>
<th>Target 2020</th>
<th>Achievement</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officer/ Assistant Medical Officer per 10,000</td>
<td>MO=0.4 (2011) AMO=0.4 AMO+MO=0.8</td>
<td>NA</td>
<td>MO=0.61 / 1,000 population AMO=0.27 AMO+MO=0.88 (2018)</td>
<td>Increased density medical doctors</td>
</tr>
<tr>
<td>Nurse midwives per 10,000</td>
<td>4.0 (2011) 5.0 (2014)</td>
<td>7.0</td>
<td>6.2 (2018) 4.7</td>
<td>Increased yet below the target</td>
</tr>
</tbody>
</table>

Figure 3: Improvement of HRH density per 10,000 populations as per the HSSP IV indicators
Source: HSSP IV MTR Analytical report

There is overall increase in HRH density 10,000 populations (figure 4) for all cadres. BUT still regional disparities exist (figures 5). There were large regional differences, with the 5 highest density regions having 5 times more core health professionals than the 5 lowest density regions.

Figure 4: HRH Per 10,000 population all cadres
Figure 5: number of core professional per 10,000 population
Source: MTR Analytical
The density of nurses and midwives per 10,000 populations indicate decreasing trend. However, major gaps remained and the core health professional’s density per 10,000 populations hardly increased (figure 6 and 7).

![Figure 6: Clinicians per 10,000 population](image)

Source: MOHCDGEC report

At regional referral hospitals shortage of specialist ranges between 62% - 100%

![Figure 8: Status of Availability of specialist](image)

2.2.2 Quantity of Human Resources and Productivity

The current pace of addressing HRH shortage is half of the required pace – figure 4. 11,469 middle level cadres graduated and 730 MD (from MUHAS) since 2015, only 1, 505 providers were employed making it hard to bridge the existing gap to an acceptable pace. HRH demand continues to increase following construction of new facilities and upgrading of existing ones to higher levels of care. The gap will continue to widen in next year following the plan to construct 67 district hospitals.
There have been discussions among HRH stakeholders to align the staffing needs with workload. This review noted that the staffing level is reviewed basing on workload indicator. However, what is not known is whether other factors such as transitions, emerging and re-emerging diseases, technology development and the focus on UHC are taken into account to define the HRH requirement. Actors are now calling for forward looking strategies in addressing HRH. This has to start from how the health sector defines its HRH requirement and how it includes innovative, feasible and sustainable solution to address the challenge. In May 2019, DHRD in collaboration with partners convened high level meeting to redefine the focus on HRH and see how finance can be mobilized to implement strategic policy options.

Despite huge shortage of staff, compared to the establishment (around 52%) productivity has increased: the output of health services is considerably higher than 5 years ago as indicated in service delivery statistics. Indicating increased efficiency. This is attributable to improved availability of medicines (95% tracer medicines) although there are instances where out-of-stock of other essential medicines are reported. Facilities indicated improvement in terms of STAR rating in second assessment (20% three star) though below target of 50%. These findings suggest that, there is no always linear relation between production of services and numbers of staff when other inputs are strengthened. Probably it is high time to reflect back on the existing staffing norms in the context of improved service delivery and technology development in health. For example with the introduction of MRDTs does the country still need lab assistants at dispensary level? With task sharing policy does the country need pharmaceutical assistants at dispensary level or nurses can do the work with additional orientation of inventory management. Focus on workload-based distribution of staff together with increased decision space to allow other recruitment arrangements at council level may probably be the way to go.
The team was informed that Workload Indicators of Staffing Need (WISN) was conducted through support of partners. It was also established that MOHCDGEC is reviewing the staffing level based on work load indicator which will inform further the HRH planning system. It was established that WISN was conducted in all regions covering clinicians and nurses working in public dispensaries and health centres. There have been challenges in redistributing staff despite the conduct of WISN. In most of the LGAs where WISN was conducted could use the information to redistribute staff due to financial constraints as redistribution also require budget. Transfer of health workers from one district to another or within the council is not only bureaucratic but also very expensive and makes it difficult councils to implement WISN recommendations. This MTR accessed the raw data which was not easy to interpret. When this report was finalised the team could not accessed any narrative providing the actual findings and recommendations of WISN exercise.

2.2.3 Improved systems of recruitment, career development and retention of HRH-LGAs using incentives for retention of health care workers

2.2.4 Recruitment policies

It was established that the DHR department developed Health Workforce Requirement and Recruitment Plan for the Public Health Sector in Tanzania Mainland- 2018-2022. This plan was expected to guide recruitment of HRH at all levels. It was also established that HRH recruitment focused much in middle level cadres for the purpose of ensuring that all facilities have at least one trained personnel.

---

1.1.1 1 WHO | Workload Indicators of Staffing Need (WISN) – is amethod is a human resource management tool. It provides health managers a systematic way to make staffing decisions in order to manage their valuable human resources well.
2.2.5 LGAs’ incentives for retention of health care workers and Career development

75% of the CMTs visited reported to have retention mechanisms for staff—though not written. The mechanisms included provision of entitlement on time, provision of mattress and gas cocker for new recruits. It was noted the focus was to enable the new recruits stay after reporting. This did not work much for Medical Doctors who needed more than this to stay in rural facilities. Complaints regarding lack of support for further education were raised and the difficulties are faced mostly by those in rural areas due to limited training opportunities in the rural areas. The promise of career support is one of the government incentives to convince MDs to take up posts in periphery regions and districts (Sirili, Frumence et al. 2018, Sirili, Frumence et al. 2019). Some doctors avoid to go to remote areas because once they go districts councils administration are sometimes reluctant to allow doctors to go for specialized training, knowing that there is no position for a specialized clinician in the district according to the health sector staffing norm and by so doing they think they will lose them for good. In almost all councils visited staff entitlements such as leave payment claims have not been paid for several years and it has been very difficult to pay on call or extra duty due to financial deficit. Delays in re-categorisation after training were amongst the cries of employees visited. Results from discrete choice experiments in Malawi, Mozambique and Tanzania indicated factors such as access to continuing professional development and the presence of functioning human resources management (transparent, accountable and consistent systems for staff support, supervision and appraisal) significantly influence job preference (McAuliffe, Galligan et al. 2016).

2.2.6 Capacity Building of HRH

Generally, there are several on job training going on conducted by Disease Control Programmes and NGOs. Efforts to accredit these programs need to be established through national level interviews. Majority of the trainings are managed by NGOs who implement vertical programs such as HIV, TB, Malaria and RMNACH. Leadership and management training were also reported by CHMTs, facility in-charges and RHMT- the training include hospital management, 5S Kaizen, DHFF implementation orientation and PlanRep. The capacity building initiatives do not seem to be coordinated and are reported to contribute to the official absenteeism. For example when the team visited Goima dispensary –met a medical attendant who was providing all services alone. The MA was well knowledgeable of what she was expected to do. It was noted that the on job training have been one of the mechanisms that made task sharing and task shifting a reality for almost all vertical programs. It was noted that changes in regimen for example for HIV care and treatment and PMTCT has been made a reality through high degree of task sharing. It was established that one of the best mechanism to enhance task sharing is to embed the process of adaptation of new regimen with training package, job aid, guidelines and continuous tracking. All councils and even the RHMTs did not receive any training on gender. Despite the growing burden of NCD staff train only 30% reported to have received training on NCDs.
Table 5: Challenges on recruitment and distribution of HRH

<table>
<thead>
<tr>
<th>Existing bottlenecks</th>
<th>Contributing Factors</th>
</tr>
</thead>
</table>
| Difficulties to deploy required number of HRH, normally the permits are lower than what was requested | • lengthy and unwieldy recruitment systems  
• Financial constraints to creating new posts and incentive packages |
| Maldistribution has been a longstanding concern in the health sector and the deployment of health personnel to the rural and remote areas of the country | • Difficulties in deploying health workers to remote and underserved areas due to: Several request for further training and transfers and Unwillingness of graduates to work in remote areas |
| official absenteeism is a growing problem | • Uncoordinated CPDs |

2.3 HRHSW development

2.3.1 HRHSW production

The Directorate of Human Resource Development (DHRD) prepared a 10 years (2014-2024) production plan which guides the investments on Human resource for Health (HRH) development. In addition, the importance of aligning needs with HRH supply was amongst strategic initiatives emphasized in the previous Human Resource for Health Strategic Plan (HRHSP) and the Health Sector Strategic Plan IV (HSSP IV). Following this guidance the implementation of 2014-2019 HRHSP was aligned with national intention of strengthening health services provision at the primary health care level (inpatient and outpatient) by improving skills-mix and competencies to ensure quality services are closer to communities. More emphasis was placed on the production of middle level cadres and increasing supply of medical doctors whose production was also low compared to the future needs by then. The focus was to increase enrolment of students in order to reach production targets of 15,000 HRH by 2020. In academic year 2017/2018, 17,370 students were enrolled that increased to 18,539 in academic year 2018/2019. This achievement is attributed to government support to training such as joint public and private sector focused attention to the production of middle level cadre.
Table 6: Graduates Allied Health Section

<table>
<thead>
<tr>
<th>SN</th>
<th>PROGRAMME</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Advanced Diploma AMO Anaesthesia</td>
<td>3</td>
<td>3</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>2</td>
<td>Advanced Diploma in Clinical Dentistry</td>
<td>7</td>
<td>10</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>Advanced Diploma in Ophthalmology</td>
<td>10</td>
<td>5</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>4</td>
<td>Advanced Diploma in Clinical Medicine</td>
<td>130</td>
<td>145</td>
<td>97</td>
<td>372</td>
</tr>
<tr>
<td>5</td>
<td>Advanced Diploma in Vector Control</td>
<td>12</td>
<td>3</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>6</td>
<td>Diploma in Clinical Medicine</td>
<td>700</td>
<td>810</td>
<td>793</td>
<td>2303</td>
</tr>
<tr>
<td>7</td>
<td>Diploma in Dental Laboratory Technology</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>8</td>
<td>Diploma in Clinical Dentistry (Dental Therapy)</td>
<td>47</td>
<td>46</td>
<td>48</td>
<td>141</td>
</tr>
<tr>
<td>9</td>
<td>Diploma in Diagnostic Radiotherapy</td>
<td>55</td>
<td></td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>10</td>
<td>Diploma in Environmental Health Sciences</td>
<td>136</td>
<td>78</td>
<td>58</td>
<td>272</td>
</tr>
<tr>
<td>11</td>
<td>Diploma In Medical Laboratory Sciences</td>
<td>194</td>
<td>148</td>
<td>228</td>
<td>570</td>
</tr>
<tr>
<td>12</td>
<td>Diploma in Health Personnel Education</td>
<td></td>
<td></td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>Diploma in Occupational Therapy</td>
<td>12</td>
<td>11</td>
<td>13</td>
<td>36</td>
</tr>
<tr>
<td>14</td>
<td>Diploma in Optometry</td>
<td>184</td>
<td>192</td>
<td>103</td>
<td>479</td>
</tr>
<tr>
<td>15</td>
<td>Diploma in Pharmaceutical Sciences</td>
<td>830</td>
<td>1907</td>
<td>1543</td>
<td>4280</td>
</tr>
<tr>
<td>16</td>
<td>Diploma in Physiotherapy</td>
<td>506</td>
<td>910</td>
<td>624</td>
<td>2040</td>
</tr>
<tr>
<td>17</td>
<td>Certificate in Clinical Medicine</td>
<td>48</td>
<td>37</td>
<td>56</td>
<td>141</td>
</tr>
<tr>
<td>18</td>
<td>Certificate in Medical Laboratory Sciences</td>
<td>150</td>
<td>221</td>
<td>266</td>
<td>637</td>
</tr>
<tr>
<td>19</td>
<td>Certificate in Health Record Technology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Certificate in Pharmaceutical Sciences</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>TOTAL</strong></td>
<td><strong>3060</strong></td>
<td><strong>4543</strong></td>
<td><strong>3866</strong></td>
<td><strong>11469</strong></td>
</tr>
</tbody>
</table>

2.3.2 Engagement in public-private partnerships for increasing training of health staff

Private providers have been engaged in training for various levels of certification. This arrangement has had positive contribution in achievements realized to date. Quality management of training is exercised right from selection of students where NACTE manage the selection. Further there are supervision visits which are conducted by MOHCDGEC staff – DHR section. Still there are limitations in achieving the required numbers of specialists to serve RRHs and the few critical cadres for primary care service delivery such as lab technicians, radiology and pharmaceuticals middle level cadres whose outputs are low. Also there are claims that such arrangements somehow jeopardizes the quality of training (Sirili, Frumence et al. 2019)

According to Global Health Workforce 2030- policy options, HRH production has to be aligned with population needs and health system demands. The HTIs conduct 17 training programs – Box 1. These programmes are cautioned in such a way they produce cadres that are relevant for service portfolios at primary care level. This show the alignment of the country’s production focus to the production of cadres needed for internal use rather than production for international market; the focus which aligns well with recommendations on Global workforce strategy 2020.

**BOX 1: Allied Health Sciences Courses**
Clinical Medicine, Nursing, Pharmaceutical Science, Medical Laboratory, Health Records, Health Information Science, Environmental Health Science, Community Health, Clinical Dentistry, Dental Lab Tech, Optometry, Physiotherapy, Assistant Medical officer and AMOs Specialties (Radiology, Ophthalmology, Anesthetics, Dermatology), Assistant Dental officer, Occupational Therapy and Prosthetics

19
2.3.3 Formalization of untrained Ward Attendants to skilled Health Attendants

It was found that formalization was achieved where POPSM issued a scheme of service for health assistants that formalises the Untrained MAs. The scheme of service categorises the cadres into various sections of health delivery including those who will do the outreach – (CHWs). CHW training curriculum were developed and training of CHWs was conducted. 11,924 CHWs have graduated since 2015 and some have been deployed through partners support. The health sector has been struggling on how best to promote Community Based Health Care Services within the existing resource constraints.

There are varieties of Community Based Health Care Services models which are implemented. There are those who are trained using the competence based curriculum and the usual CHWs used by vertical programs who are supported by NGOs given short training on site. In Kigoma for example it was noted CHWs stay in health facilities (Kakonko) and are given 50,000 TKS monthly from facility own sources and they work in RCH units. In another village -Vigwanza in Kakonko CHWs are paid by the village government, this has been possible because the village has a broader revenue base compared to others. In Dodoma, Chemba there are CHWs who are paid through Mkapa foundation who co-exist with the ones who operate through old system (working for programs or for facilities and receive token amount of money for the work usually ranging between 10,000- 30,000 per quarter). According to providers they are all useful, helpful and good performing. It was found that CHWs that work in communities are the ones which receive short training for particular purpose.

It is high time for the national level actors to revisit the policy decision regarding the “Formalized model of CHWs” and see what was the thinking behind, feasibility and what policy options exist to realize the original intention in a manner that feasible and sustainable. The fact that CHWs have a great role to play is undisputable (Larson, Geldsetzer et al. 2019). There is a huge body of evidence confirming this. The current focus is to use the modified Uturo model and put it to scale. This is a strategic policy issue needing a close attention and effective deliberation to guide the forthcoming HRH strategic plan and HSSP V in terms of training, deployment and performance management of CHWs.

2.3.4 Quality and effectiveness of Continuing Professional Development (CPD) Programmes enhanced and fragmentation reduced.

Professional councils continued to focus on which competencies are relevant to various cadres and raising importance of CPD in managing licensing of the professionals. The nursing council indicated proactive efforts in promoting CPD as compared to other councils. Efforts in improving access to CPD for health staff through use of distance learning is again amongst the important achievement. MOHCDGEC has opened a center for distance learning in Morogoro. There have been varieties of initiatives implemented by government in collaboration with HRH stakeholders. One of the important initiatives in this area was to ensure that all councils and
hospitals have health secretaries with appropriate qualifications. Further through partners support, CHMTs and RHMTs reported to have been trained in leadership and management. However, it was not easy to establish what was meant by strengthening leadership and management in practice and how implementers were guided in achieving this strategic focus. Equally it was not easy to get a comprehensive report on this partly due to the fact that most of the trainings were implemented by partners and there is no a good way to capture what has been done and to what extent. During this review it was learnt that UNICEF is planning a district strengthening program where the main focus will be to enhance evidence based planning and management capacity to execute the plans.

2.3.5 Zonal Health Resource Centres (ZHRCs) position reflected in the MOHCDGEC organizational structure

Despite intentions to use the ZHRCs as MOHCDGEC technical arms, the centres are still virtual, they are not clearly stipulated in the structure. The zones are not in equal capacity and less is done to improve their capacity despite their growing relevance.

Challenges in HRH Training and Development

It has been noted that many programmes ran using old curriculum systems. For example out of existing 19 programs only 4 programs have been approved and their curricula are validated, 8 programs have outdated Curricula and 7 programs don’t have proper curricula to support competence based training. **Thus increased production of cadres whose training is outdated is somehow a lost investment.**

Availability of teaching staff is another big challenge. It was noted that the shortage of teaching staff is 62% and 68% for support staff.

Training institutions under MOHCDGEC are constrained in almost all aspects. This MTR noted a huge difference between the status of infrastructure in public and private training institutions. The private institutions were found to have good structures and ensured that the minimum standard requirements are met. This is done to ensure they get registered and continue in business. The situation was found different in some government institutions where students leave in dilapidated dormitories with poor water supply and have ill-equipped skill labs. One of the private training institution respondent was quoted to say “When government official come to us they will be so bitter if we have not met the standards, but we wonder why they do not do the same in their institutions. We were expected to learn from them”

Further there are incomplete or abandoned buildings/projects, poor staff houses and teaching and learning materials
The summary of challenges in in-service and pre-service trainings are presented in Table 1.

**Box 1: Infrastructure Challenges**

![Image of outdated buildings]

The summary of challenges in in-service and pre-service trainings are presented in Table 1.

<table>
<thead>
<tr>
<th>Existing bottlenecks</th>
<th>Contributing Factors</th>
</tr>
</thead>
</table>
| Mismatch between market requirements and supply leading to Oversupply of some cadres and under supply of others- less strategic investment in training | • Limited enrolment capacity compared to demands due to inadequate and dilapidated buildings as well as teaching and learning materials  
  • shortage of staff (Shortage is 62% teaching staff and 68% support staff) contributed by  
    o Permits provided allows recruitment of few staff  
    o Poor retention mechanisms  
    o Unconducive working environment  
    o High staff turn over  
  • Poor prioritization of investments in HRH production  
  • Limited strategic engagement of private sector in production |
| Out of the existing 19 programs only four have 4 approved and validated curricula, 8 have outdated curricula and 7 programs don’t have proper curricula to support competence based training and existence of dormant but relevant training programs | • Lack of clear mechanism within MOHCDGEC to continuously follow up the existing training program curriculum status in terms of their relevance to the health service provision needs  
  • Low coverage and less effectiveness supervision of training institutions due finance constraints |
| Weak Continuous Professional development system                                        | • Low coverage of distance learning eLearning  
  • Lack of centralized and standardized CPD  
  • Lack of CPD guidelines to some of the professional councils  
  • Lack of modality for achieving CPD without getting out of working environment |
| in adequate adaptation of technology in managing information in training institutions | • Users of the systems do not have full capacity of using the systems  
  • The electronic system deficiencies  
  • Lack of clear and effective supportive supervision and mentorship on the system utilization |
2.4 **Performance Management**

Health workers’ motivation is a key determinant of the quality of health services, and poor motivation has been found to be an obstacle to service delivery in many low-income countries. Public Service Act defines OPRAS as a compulsory performance appraisal in the public sector. The current status show that there is no serious application OPRAS as it is intended to be. This is because of:

- Understanding of the mechanism itself. Majority of health worker and their managers were found not conversant with intentions of OPRAS
- Even if OPRAS is institutionalized the process ends after filling the forms. The process is not tied with either negative or positive reward. OPRAS is unpopular for employees who have reached end line in the promotion (those who have reached what is called bar)

Generally OPRAS is not seen to have an influence to the individual and systems performance. It has been a challenge to link OPRAS with individual performance in the health sector especially at facility level. This is because majority of the targets are disease based and less management oriented. Leaders need to focus on how best they can stimulate performance culture in service delivery, especially at primary care facilities where majority of population go to. Globally, 20–40% of all health spending is wasted, with health workforce inefficiencies and weaknesses in governance. It was noted that performance management initiative is ongoing at Makole health center in Dodoma spearheaded by PORALG. This improvement is done under the slogan promoted by the newly appointed Deputy PS Dr. Doroth Gwajima- termed “**Moto wa mabadiliko**”– The Fire of Change”. The performance improvement intervention under the “**Moto wa mabadiliko**” focuses mainly on enforcing the existing management practices which are not enforced and stresses on increasing attention to the forgotten details-figure 12

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**Figure 11: Interventions implemented to promote individual accountability at Makole health center**

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The limited attention to the basics is attributable to several factors. One is poor induction and orientation system to new recruits, hence creating a loophole for inculcating poor work practices to new recruits. Secondly, some of the CHMTs and HMTs are less experienced hence provide weak oversight of the service provision. For example in regions visited during MTR only 60% of the CHMTs have required qualifications - figure 13

![Figure 12: % of CHMTs having all positions filled](image)

![Figure 13: % distribution of available cadres forming CHMTs with minimum required qualification](image)

### 2.5 Nursing and Midwifery services

From the key informants it was established that the department is aiming at one single platform for e-learning and for registration of all courses. If the system of renewing licences every 5 years is applied, and if health workers need to get sufficient accreditation points for training, it is easy to maintain the system. Tanzania Nursing and Midwifery Council (TNMC) already has introduced an electronic system for registration of nurses and renewing licences. Every organisation that provides CPD must register centrally to get accreditation. The quality of training can be checked and mushrooming of courses can be controlled. Introduction is delayed due to resource constraints, but a team is working on the system and the e-learning platform. Further the department has established onsite mentorship for improving quality of Nursing and Midwifery Services, short courses and upgrading as well as establishment of formal Clinical Instructors to improve clinical teaching. Department has developed several guidelines and standards such as standards of nursing and respective compassionate care (ethical behaviour). The nursing and midwifery department works with schools and TNCA in improving curricula in schools. The training programs focus to increase the output of diploma level nurses which is a follow-up after certificate training. The department has developed courses and standards for clinical instructors (who work on the wards and guide nursing students during internship) in order to improve the practice of training in 103 hospitals where nursing student are placed. On CPD the department has worked on modules that will enhance the operationalisation of task shifting and task sharing. Further it works on mentorship for young staff entering into the sector. More than 900 people have been trained. It is working on e-learning modules. Future plans include; development of leadership course. This is because often nurses are in charge in peripheral dispensaries and are responsible for planning, budgeting and quantification.
Knowing that OPRAS is not working as intended, their department stresses CPD as a motivation. The emphasis will be on promotion of the client charter and improve patient satisfaction; because too often programmes concentrate on technical capacity building, but patient satisfaction is less emphasized. The department aims at promoting respective and compassionate care.

2.6 System of re-registration for health professionals

It was established that there are several professional councils, Medical, pharmaceutical, laboratory, nursing, environmental and radiology. These professional councils differ, some are active and some are not. All have introduced licensing of professionals. However, with regard to emphasis on CPD the councils are in different development stages, nursing leading the way.

2.6.1 Pay for Performance

Pay for performance is implemented in selected region and has indicated improvement in service delivery as well as staff motivation. In councils where RBF is implemented it was learnt that facilities considered as an additional source of financing and would struggle to make sure that they earn what was set. The utilisation of RBF funds was said to include employee motivation, facility improvement such as construction of walk ways as well installation of electronic systems. It was learned that since April RBF stopped and health providers were not aware as to whether it continues or not

2.7 Cross Cutting Issues Findings

Private Public Partnership

It was learnt that there is an information system for managing student information. Three actors are supposed to work in this system – NACTE- The training institution and the ministry. In practice there have been challenges of the ministry to update the system on time. Such delays create frustrations to training institutions and students. The team received recommendation in writing and it is attached in this report

Another issue raised is the supervision modality. The private institution requests the ministry to use supervision as a tool to strengthen and increase bond with the private training institutions. On their perspective, the private institutions visited consider the current practice being inspection oriented.

Unintended effect of DHFF

There was no unofficial absenteeism except staff attending short training. Official absenteeism was reported to be prominent for health centres and dispensaries in-charges (who report to be absent for between 2-3 days a week) to attend administrative issues following the implementation of DHFF
NIHF policy
NHIF policies on reimbursements seem to lag behind the changes made on the current recruitment policies. Services provided by MDs who are in health centres and specialists who are in regional referral hospitals are underpaid by NHIF because the payment calculations are not made based on qualifications of provider but by type of facility.

Gender
The gender study found that there is insufficient knowledge on gender at all levels. This is because gender is not included in curricula thus both old and newly trained staff do not have information in this area.

Financing
There has been chronic under-investment in education and training of health workers. This was compounded by difficulties in deploying health workers to rural, remote and underserved areas. Despite significant progress made in addressing rural-urban divide, there is a need to boost political will and mobilize resources for the workforce agenda as part of broader efforts to strengthen and adequately finance health system in Tanzania. Past efforts in health workforce development have yielded significant results. The implementation of the previous plan was guided by the development of HRH recruitment and Production plans whose implementation was unacceptably low. The investment in the previous strategy was lower than is assumed. For example out of 129 activities only 42 activities had funding- Table 7.

Table 8: Funded and Unfunded HRH activities of HRHSP 2014-2020

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Number of activities</th>
<th>Activities with support</th>
<th>Activities with support</th>
<th>% of Supported per SO</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO1: To Strengthen Policy development and Human Resource Planning at all levels</td>
<td>30</td>
<td>7</td>
<td>23</td>
<td>23.3%</td>
</tr>
<tr>
<td>SO2: To Strengthen HRH Research and Utilization at all levels</td>
<td>12</td>
<td>1</td>
<td>11</td>
<td>8.3%</td>
</tr>
<tr>
<td>SO3: To strengthen leadership and stewardship in Human Resource</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>25%</td>
</tr>
<tr>
<td>SO4: To Strengthen HRH recruitment, retention, career development and utilization at all levels</td>
<td>22</td>
<td>10</td>
<td>12</td>
<td>45.5%</td>
</tr>
<tr>
<td>SO5: To Improve Production and Quality of HRH</td>
<td>41</td>
<td>17</td>
<td>24</td>
<td>41.5%</td>
</tr>
<tr>
<td>SO6: To Strengthen Partnership and coordination of HRH stakeholders at all levels</td>
<td>16</td>
<td>5</td>
<td>11</td>
<td>31.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>129</td>
<td>42</td>
<td>87</td>
<td>33%</td>
</tr>
</tbody>
</table>
The challenge has been; the plan was not disseminated and there was no resource mobilization plan. For example in 2018/2019 financial year up to February 2019 DHRD received only 15.3% of the budget (excluding salaries) and there was not a single cent that was received for development activities. This contributed to continued dilapidation of buildings in training institutions- Exhibit 1

Exhibit 1: 2018/2019 Funds disbursement status for DHRD

Exhibit 2: 2018/2019 Funds disbursement status for DHRD

The DHR department has prepared financial need to deploy HRH as presented in table 4 from 2018/19-2022/2023 in which advocacy is needed to mobilize such resources

Table 9: financial need to deploy HRH from 2018/19-2022/2023

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Specialist</td>
<td>1,490,764,828</td>
<td>2,113,441,696</td>
<td>3,664,170,451</td>
<td>3,950,874,741</td>
<td>4,387,029,532</td>
<td>15,606,281,249</td>
</tr>
<tr>
<td>Nurse and Midwives</td>
<td>23,869,795,200</td>
<td>25,252,720,019</td>
<td>21,457,466,998</td>
<td>21,707,920,190</td>
<td>23,268,846,282</td>
<td>115,556,748,689</td>
</tr>
<tr>
<td>Health Management Staff</td>
<td>1,054,636,800</td>
<td>1,110,144,000</td>
<td>1,124,020,800</td>
<td>416,304,000</td>
<td>832,608,000</td>
<td>4,537,713,600</td>
</tr>
<tr>
<td>Medical Attendant</td>
<td>1,187,174,400</td>
<td>1,585,920,000</td>
<td>2,174,976,000</td>
<td>1,404,672,000</td>
<td>2,174,976,000</td>
<td>8,527,718,400</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>-</td>
<td>2,619,033,600</td>
<td>9,130,368,000</td>
<td>19,117,132,800</td>
<td>15,619,046,400</td>
<td>46,485,580,800</td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>13,978,185,600</td>
<td>16,765,440,000</td>
<td>3,083,744,854</td>
<td>3,246,047,215</td>
<td>11,107,104,000</td>
<td>48,180,521,668</td>
</tr>
<tr>
<td>Allied Health Practitioners</td>
<td>30,808,775,760</td>
<td>33,924,281,326</td>
<td>34,837,990,025</td>
<td>21,053,182,304</td>
<td>28,622,765,050</td>
<td>149,246,994,467</td>
</tr>
<tr>
<td>Grand Total</td>
<td>72,389,332,588</td>
<td>83,370,980,641</td>
<td>75,472,737,128</td>
<td>70,896,133,250</td>
<td>86,012,375,264</td>
<td>388,141,558,873</td>
</tr>
</tbody>
</table>

3. Strategic Objectives

Table 10: HSSP IV Strategic Objectives

| Strategic Objective 1: The health and social services sector will achieve objectively measurable quality improvement of primary health care services, delivering a package of essential services in communities and health facilities. |
| Star rating second round assessment indicated improvement though the planned target has not been reached- the improvements have contributed to the increased productivity of the existing staff to some extent. All councils were found to have accessed the existing guidelines and procedures. Improvement in infrastructure as well as availability of medicine through MSD and prime vendor system are also factors contributing to improve quality. However, despite available guidelines, manuals and operational procedures, adherence to standards is still low. |
Both recently trained and experienced mid-level staffs are often not able to deal with medical diagnosis and treatment as required per standard. Curricula of mid-level staff in general are not competency-focused and not aligned with medical practices in the country. 70% were not trained in NCD despite the growing NCD burden.

Currently, there are many initiatives for continuing professional development (CPD); more than 50% of staff received some types of CPD last year. But it is fragmented, not-aligned, not integrated in a system of competency development and career advancement. It is too much vertical, and does not make sufficient impact on quality improvement of the health system. After in-service training, sometimes health professionals are not able to sustain new competencies trained because of lack of follow-up. Methods of mentoring and supportive supervision have shown to improve effects of CPD. A CPD framework is under development.

There is a wide variety of public and private training institutions with different enrolment capacities. Others are big and poorly equipped. Less than half of the training curricula have been validated. Capacities for training are not optimally used. The problems of sub-optimal training have been recognised in the MOHCDGEC. In many training institutions the infrastructure (buildings and teaching aids) or capabilities of training staff are inadequate to provide adequate modern training to students. This hampers quality of services in the health sector.

**Strategic Objective 2: The health and social welfare sector will improve equitable access to services in the country by focusing on geographic areas with higher disease burdens and by focusing on vulnerable groups in the population with higher risks.**

The HRH shortage of 52% is still huge. Posting of staff to regions with extreme shortage seems to work, despite continuing problems in certain remote areas. While in the past the HRH bottleneck was pre-service training, now absorption capacity is the main issue. Around 10,000 trained health workers could not be absorbed in recent years. It is unknown what they are doing (temporary jobs, volunteering, other sectors). Under the present political and economic conditions, dramatic increase of staff is not expected. Equitable distribution has not been achieved as foreseen in HSSP IV. Some local arrangements to hire staff were noticed. Councils were able to absorb accounts assistants who were employed centrally through DHFF arrangements.

**Strategic Objective 3: The health and social welfare sector will achieve active community partnership through intensified interactions with the population for improvement of health and social wellbeing.**

HFGC functionality is improving following the introduction of DHFF where the team is interacting more with facility in planning and implementation. Community support in construction of facilities was noticed in councils visited. Some council reported engaging village leadership in the reception of the new recruits.

**Strategic Objective 4: The health and social welfare sector will achieve a higher rate of return on investment by applying modern management methods and engaging in innovative partnerships.**

Motivation of staff is often a problem and the OPRAS, that measures and rewards performance, is not sufficiently operational. Alternative performance assessment systems are under trial. Client satisfaction is quite often limited ascribed to poor attitudes due to lack of motivation of staff. Staff often does not receive incentives and legally binding work-related compensation. It
has been noted that use of electronic systems in revenue collections, installation of biometric systems and existence of standard daily outputs for health providers are the starting point for initiating individual accountability. However, facilities lack modern management methods techniques, skills and tools to promote individual accountability that will lead to return on investment and improve workers’ morale. On the other hand unlike the service delivery part, the PPP in HRH is not well guided and lacks tools to govern the management of such partnerships
4. SWOC Analysis

This section illustrates key strengths, opportunities, weaknesses and challenges in the thematic area.

Table 11: Strengths Opportunities Weaknesses and Challenges

<table>
<thead>
<tr>
<th>Components</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR Planning</td>
<td>Improved system for generating planning information and guidance</td>
<td>• Data generated not up to date</td>
<td>• Limited HRH data use</td>
<td>• Plans to integrate information system</td>
</tr>
<tr>
<td></td>
<td>• Use of HRHIS/TIIS</td>
<td>• The HRH information not analytical enough to guide strategic investments in HRH</td>
<td>• Limited integration of HRHIS with other management with other management information systems and planning tools</td>
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<tr>
<td></td>
<td>• Development of production and recruitment plan</td>
<td>• Static establishment</td>
<td>• Limited HRH Planning at subnational levels used interchangeably with Personnel Emolument budgeting</td>
<td>• Existence of Data Use partnership promoting data use at all levels</td>
</tr>
<tr>
<td></td>
<td>• Strengthened central guidance on HRH planning in terms of production and recruitment</td>
<td></td>
<td>• Limited decentralisation on HR issues (hiring, firing)</td>
<td></td>
</tr>
<tr>
<td>Recruitment and distribution</td>
<td>Focused Distribution</td>
<td>• Difficulties to deploy required number of HRH, normally the permits are lower than what was requested</td>
<td>• Chronic underinvestment leading to low absorption capacity and difficulties to redistribute staff</td>
<td></td>
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<tr>
<td></td>
<td>• Prioritized application of employment permits to regions with critical shortage</td>
<td>• Maldistribution has been a longstanding concern in the health sector and the deployment of health personnel to the rural and remote areas of the country</td>
<td>• Low productivity and lack of mechanisms to promote individual level accountability at facility level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Conversion of permits to increase ability to recruit critical cadres</td>
<td></td>
<td>• Static Establishment</td>
<td></td>
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<tr>
<td></td>
<td>• Improving coordination between sectors in managing recruitment</td>
<td></td>
<td>• lengthy and unwieldy recruitment systems</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Several request for further training and transfers and Unwillingness of graduates to work in remote areas</td>
<td></td>
</tr>
</tbody>
</table>

30
<table>
<thead>
<tr>
<th>Components</th>
<th>Strengths</th>
<th>Weaknesses</th>
<th>Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
</table>
| Pre and In-service training | Improved enrolment capacity in training                                  | • Low coverage of distance learning (eLearning)  
• Out of the existing 19 programs only 4 programs have been approved and validated Curricula, 8 have outdated Curricula and 7 programs don’t have proper curricula to support competence based training and existence of dormant but relevant training programs  
• Weak Continuous Professional development system | • Lack of clear mechanism within MOHCDGEC to continuously follow up the existing training program curriculum status in terms of their relevance to the health service provision needs  
• Lack of centralized and standardized CPD  
• Lack of CPD guidelines to some of the professional councils  
• Lack of modality for achieving CPD without getting out of working environment | • PPP policy  
• Existence of distance learning and e-learning mechanisms – needing upgrade and scale up  
• Decentralisation policy that can be defined further to expand decision space of managers  
• SWAP approach (TWG) – enhancing good HRH partnership |
| Performance management    | • Existence of compulsory performance appraisal in the public sector    | • OPRAS has lots of limitation making it difficult to work as intended  
• Pay for Performance is not implemented nationwide and is donor dependent hence sustainability challenges  
• Official absenteeism is a growing problem due to uncoordinated CPD  
• Poor employee induction | • Generally OPRAS is not seen to have an influence to the individual and systems performance. It has been a challenge to link OPRAS with individual performance in the health sector especially at facility level  
• Funding for induction | • Redesign OPRAS and align it with outcomes  
• Existence of simplified induction guide for LGAs |
| Management of staff welfare | • Stipulated entitlements of staff in HRH policy documents              | • Delayed payment of entitlements  
• Delayed promotion  
• Delayed re-categorisation and change of salary after health providers have gone for further training | • Financial constraints  
• Narrow decision space in financial management for facility level | • Decentralisation policy that can be defined further to expand decision space of managers |
5. Recommendations

Following the findings of the MTR, it is obvious that the future improvement in this area lies on addressing issues related Quantity, Quality and specifics on how the training institutions are managed. Quantity challenges will be addressed once i) appropriate mechanisms are set to guide how the country determines HRH shortage to inform the budget prioritization on absorption of workforce ii) how permits are utilised. In addition the future of HRH availability is dependent on how the performance management system is designed. The design of performance management determines whether it is responsive to accountability needs, employee growth and motivation or not. In addition the findings suggest that, quality of HR should be prioritised. The quality should focus on i) crafting innovative ways in which the existing workforce access training, ii) setting appropriate mechanisms for curricula update and iii) set systems in which the quality of the existing workforce is maintained. Specific recommendations are outlined in the following subsections

5.1 HRH Quantity

5.1.1 Rationalisation of the current gap and employ innovative solution to bridge the current gaps

The MTR findings suggest that the current shortage is less justifiable due to the base in which it calculated. Using static establishment provides a generic and standardized ways of calculating absolute number. However, not all facilities have the same workload. The feasibility of bringing the gap is as well unrealistic. Around 10,000 trained health workers could not be absorbed in recent years. The absolute shortages of health workers will continue to widen in the coming years following construction of more facilities in the current plan. Chances of gaining dramatic increase of staff are minimal due to competing priorities. On the other hand it was established that following the improvement in availability of other inputs despite the existing shortage the output of health services is considerably higher than 5 years ago. Implying no linear relation between production of services and numbers of staff; other factors play a role as well, when it comes to productivity. The following are recommended

a) Enforce Policy for more rational and evidence-based posting and redistribution decisions.

Information technology should enable more adequate planning of human resources and a move from static establishment is recommended.

b) Further elaboration of Task sharing and task shifting as innovative solutions of critical shortage.

c) Where technology can replace human presences or can enable task sharing, it should be utilised optimally. For example with MRDTs the need for skilled lab assistant at dispensary level may be considered as an option in less crisis state. Nurses and clinicians can replace such roles were feasible.

d) Innovative approaches in deployment of staff have to be created, e.g. employment in government institutions by foundations through franchising, employment by village government, flexible decentralised contracts.
e) Strengthen MOHCDGEC coordination with other government Ministries and agencies to improve transparency, effectiveness and sustainability in public health workforce recruitment

5.1.2 Performance and career development
Motivation of staff is often a problem and the OPRAS, that measures and rewards performance, is not sufficiently operational. Alternative performance assessment systems are under trial. Client satisfaction is quite often limited ascribed to poor attitudes due to lack of motivation of staff. Staff often does not receive incentives and legally binding work-related compensation. It is recommended that
- Performance management has to be implemented, as intended in OPRAS and performance-based management systems need to be reinforced, together with adherence to incentive schemes.
- Supervision should be geared more to coaching and mentoring for developing leadership skills.

5.2 Quality of HRH

Adequate curriculum
Quality of human resources is one of the bottlenecks for improving quality of the health services. Despite available guidelines, manuals and operational procedures, adherence to standards is still low. Both recently trained and experienced mid-level staffs are often not able to deal with medical diagnosis and treatment as required per standard. Curricula of mid-level staff in general are not competency-focused and not aligned with medical practices in the country. It is recommended that
- A drastic innovation of the training approach in the health sector, making them more aligned with modern education methods, more adequate for practice

CPD and Licensing
Currently, there are many initiatives for continuing professional development (CPD); more than 50% of staff received some types of CPD last year. But it is fragmented, not-aligned, not integrated in a system of competency development and career advancement. It is too much vertical and does not make sufficient impact on quality improvement of the health system. After in-service training, sometimes health professionals are not able to sustain new competencies trained because of lack of follow-up. Methods of mentoring and supportive supervision have shown to improve effects of CPD. A CPD framework is under development. The recommendation is that MOHCDGEC to ensure that
- CPD is embedded in a system of career development by linking CPD and re-registration of professionals.
- All CPD activities are accredited in order to be allowed in the health sector.
- Promote Mentorship of health workers using variety of ways including digital media

Innovation and e-learning
Initiatives for e-learning are many but often linked to specific programmes, projects or NGOs and not harmonised, not checked on quality. The effect of innovative learning is therefore not known. It is recommend that DHRD to
- Facilitate continue support to e-learning center, development and maintenance of e-learning tools. Mechanisms for regulating e-learning development should be established including things like licencing products before they are made available on the market, and before they can be integrated in blended learning curricula.
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5.4 Performance and career development
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- Performance management has to be implemented, as intended in OPRAS and performance-based management systems need to be reinforced, together with adherence to incentive schemes.
- Supervision should be geared more to coaching and mentoring for developing leadership skills.

5.5 Training Institutions
Management of institutions
At the moment there is a wide variety of public and private training institutions, some of which are small with few students. Others are big and poorly equipped. Less than half of the training curricula have been validated. Capacities for training are not optimally used. The problems of sub-optimal training have been recognised in the MOHCDGEC. It is recommended that
- MOHCDGEC to promote Public Private Partnership in training for the health sector
- Concentration in zonal multidisciplinary training institutions is an option for innovation.
- Concentration of curriculum development in one educational centre may contribute to better quality and more investments in the training sector in health
6. References


Reference (Ministry of Health Documents)
1. HSSP IV 2015-2020
2. HRH Strategic Plans (2014 – 2019)
3. HRH Production Plan (2014 – 2024)
7. BRN Report 2016
8. BRN Presentation
9. HRD presentations on High level HRH meeting on 6 May 2019