MINISTRY OF HEALTH AND SOCIAL WELFARE

# HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN 2008-2013

## MIDTERM EVALUATION DRAFT REPORT

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# Executive Summary

*Objectives*

The Mid Term evaluation of the Human Resource for Health Strategic Plan (HRHSP) was carried out between December, 2011-January, 2012. The evaluation objectives are:

- To review Human Resource for Health Strategic Plan accomplishments and challenges for the midterm period 2008-2013.
- To document successes, challenges, lessons learnt during the implementation.
- Recommend way forward for the remaining period of the strategic plan taking into account challenges, constraints, lessons and current priorities.

The evaluation employed qualitative methods where key informants interviews were conducted and key relevant documents reviewed. The data was collected from the Ministry of Health and Social Welfare, Development Partners and from sampled regions and districts. In total 29 Interviews were conducted.

## Key findings

***Continued relevance of the strategy, strengths and challenges of strategy development process***

The HRHSP is still a relevant strategy in the current Health System at all levels. The development process of the strategy was highly participatory involving variety of actors- training institutions, the academia, development partners, councils and regions. The process also attempted to use the generated evidence to inform the strategy development process. It clearly stipulated how the strategy will be monitored and learning will be disseminated. Although the strategic objectives are comprehensive encompassing key strategic issues in HRH, they looked ambitious given the uncertainty on funding and also the time frame. Nevertheless, they are logically linked and key in addressing HRH challenges in Tanzania. The strategy is silent regarding the mechanisms to which the lower levels (regions and districts) will implement the strategy in a systematic manner. It was not clear on how annual operational plans will be developed. Another limitation of the design was failure to project income at least for one year.

***Organisation of implementation of HRHSP***

The structure (the Technical Working Group) to coordinate all actors who participate in implementation of the strategy exists and goes beyond the public sector. To ensure that all strategic objectives receive adequate attention, strategic objective teams are formed that oversee and track progress. The use of Technical Working Group is effective but seems to paralyse the monitoring function of the strategy as this has been used as the main avenue for tracking progress.

***Monitoring Evaluation and Learning***

Although the design stipulated the use of the existing information systems to track progress of this strategy, there was no clear indication of how for example HMIS is used to provide this. It was noted

that the existed system needed additional inputs in terms of key indicators for it to be able to report on HRH issues. It was also learnt that HRHIS was developed, piloted and rolled out country wide.

Use of pilot programs such as Mkapa Fellows initiatives are seen as important platform for learning regarding deployment, retention and management of human resources. However, it is not very clear how lessons from these kinds of initiatives inform policy, plans and practise at all levels

***Financing HRHSP***

Resource mobilisation was found to be well planned and continued to improve. It takes both proactive and reactive mode. For example the application of global fund is a commendable initiative that had contributed to realisation of recruitment objectives through the emergency hiring program. The progress regarding the strategy financing includes:

- PEs /salaries for HRH have been increasing year after year and seem sustainable.
- Concept for investing in HRH is acknowledged and supported at Ministerial level through financial allocation. For example Post Graduate training allocations has increased from 1.5 TS Billions in 2007/08 to 5.4 Billion for 2011/12 period.
- Basket Fund commitment has been stable.
- General Development support has been stable.
- Global Fund Round 9 has committed to support through HSS III rehabilitation of Training institutions.

***Achievements in implementation of the Strategic Objectives***

Given the resource constraints the current achievements regarding strategic objectives is commendable. Implementation of all Strategic Objectives has been attempted by the Ministry of Health and Social Welfare, RHMTs, CHMTs and Development Partners and the implementation is still ongoing for almost all planned activities, despite of the fact that at the beginning there was no operational plan and no targeted funds for implementation. Implementation could not start at the very beginning of 2008, it started rather later in the 2009/10 period.

HRH issues have gained adequate attention especially with the need of attaining the MDG targets that stimulated the financing of this strategy. The partnership base in implementing the strategy has expanded and is having a great contribution to the recorded achievements.

Implementation of the strategic objectives at district and regional levels is equally good although the achievements seem to happen as a matter of routine actions rather than deliberate efforts targeted towards HRHSP objectives accomplishments.

***Challenges***

The majority of challenges encountered in implementing the strategy are contextual and systemic as listed below.

- The HRHSP faces inadequate finances and untimely disbursement.
- Not all strategic Objectives activities have been implemented.
- HRHSP Dissemination and advocacy are very low.
- Difficult to acquire staff despite having employment clearance due to POPSM HR ceiling.

- HRH shortage in the market especially specialists and other cadres.
- Inadequate mechanism for tracking compliance to Posting of new employees between MOHSW, RAS, DED and other agencies.

***Lessons Learned by the respondents***

- The HRHSP has been a good reference to guide employers such as RAS on staff development matters which have enhanced slight improvement on supporting HRH in training and PE issues, which was not the case before.
- HRH issues need wider advocacy / communication between Ministries, Employers (PMOLARG, RAS, and DED) and supervisors. Sometimes an employer can receive HRH who were not needed and therefore budgeted for.
- Leadership , and Teamwork ability capacity is important in implementation of HRHSP
- Introduction course/ orientation course /programme for new employees at District Hospital before locating them in peripheral health units has assisted to improve workers' morale and mind –set and expectations to District situations.
- Quick inclusion of new employees in the payroll is instrumental in attracting new employees to their new stations.
- 14 days Subsistence allowances for new employees is a motivator and retaining strategy
- Budgeted transfers for long working staff is a motivation for them even if transferred to distant remotely located health facilities
- Follow-up of HRH issues physically at the MOHSW /POPSM yield better results in securing new HRH.

## *Conclusions and Recommendations*

| Assessment Area | Conclusion | Recommendations |
|---|---|---|
| Strategy relevance | The evaluation concludes that HRHSP (2008-2013) is still a relevant strategy in the current Health System context at all levels; the contents are relevant and comprehensive. | Development of the next strategic plan should reflect much on what has been planned in the current strategy |
| Strategy Design | The design of the HRHSP was good, the strategic areas were well thought of and process involved a range of relevant stakeholders in HRH | 1. There is a need to revisit the HRHSP Strategic Objectives and activities so that priority is assigned to those which can be implemented in line with foreseeable resources and levels within the Health system.<br>2. |
| Organisation of Strategy implementation | 1. Implementation of the strategy is well organised in terms of structures for coordination and reporting of the progress.<br>2. The lack of formal annual plans have probably influenced how much is achieved in implementations as there are no deadlines for accomplishing task and the extent to which the strategy is financed and distribution of actors to addressing all strategic objectives.<br>3. Tracking progress is concluded to be less robust as the key forum for tracking progress is the HRH technical working group. Less is done outside this forum<br>4. Financing: The strategy received due attention from actors and the financing though not enough but much has been done in this area and this is positive and commendable. | 1. There is a need to recast the implementation plan for the remaining period taking into account of priority activities, abilities of actors , resources availability and time<br>2. Devise mechanism for tracking progress other than TWG<br>3. The strategy needs more support financially so as to realize envisaged milestones.<br>3. |

| Assessment Area | Conclusion | Recommendations |
|---|---|---|
| | | |
| Achievement of strategic objectives | 1. The implementation of all Strategic Objectives has been attempted by The Ministry of Health and Social Welfare, RHMTs, CHMTs and Development Partners and the implementation is still ongoing for almost all planned activities.<br>2. The fact that at the beginning there were no operational plan and no targeted funds for implementation, implementation could not start at the very beginning of 2008, rather later in the 2009/10 period. However the implementation status of most of the strategic objectives is impressive especially those having a booster from Development Partners' funding. | 1. There is a need for the Strategic Objectives teams to link with Districts CHMTs, Regions-RHMTs so as to decide on which activities need to be implemented at which level in priority order. Otherwise there will be duplication and efforts will bear no tangible results.<br>2. Improve coordination among MOHSW and POPSM /POMLARG on HRH Information System, ceiling and funding<br>3. Research priorities be identified by involving more actors in the Districts where HRH variety of problems are being faced<br>4. Efforts should be devoted in strengthening Distance learning areas by also taking advantage of the expanding E-learning programmes so that more health workers can access learning without necessarily relying on Institutionalized learning programmes |

## List of Abbreviations

| | |
|---|---|
| BMAF | Benjamin William Mkapa Foundation |
| CCHP | Comprehensive Council Health Plans |
| CHMT | Council Health Management Team |
| CIDA | Canadian International Development Agency |
| DC | District Council |
| DHS | District Health Secretary |
| DMO | District Medical Officer |
| GIZ | Deutsche Gesellschaft für Internationale Zusammenarbeit www.giz.de |
| HMIS | Health Management Information System |
| HRD | Human Resource Development |
| HRH | Human Resources for Health |
| HRHIS | Human Resources for Health Information System |
| HRHSP | Human Resources for Health Strategic Plan |
| JICA | Japan International Cooperation Agency |
| MDGs | Millennium Development Goals |
| MOH&SW | Ministry of Health and Social Welfare |
| OPRAS | Open Performance Appraisal System |
| PMORALG | Prime Minister's Office Regional Administration and Local Government |
| RHMT | Regional Health Management Team |
| RMO | Regional Medical Officer |
| R-RHMT | Regional Referral Hospital Management Team |
| SO | Strategic Objective |
| TWG | Technical Working Group |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

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We acknowledge the value of rich information provided by respondents from MOH&SW, development partners, regional and district key informants. We appreciate their cooperation especially agreeing to meet the evaluation team during the hectic times of Christmas and New Year holidays. To all we are grateful.

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To all, we say “Thank You Very Much”

# SECTION ONE: INTRODUCTION AND BACKGROUND

This is the midterm evaluation report for the Human Resource for Health Strategic Plan 2008-2013, conducted between November and January 2012. The midterm evaluation has been called upon three years down after initiation and implementation of the HRHSP.

The report is divided into six sections. While section one provides a background information regarding the strategy and the focus of the midterm evaluation, the second section describes the methodology used to conduct the evaluation. The third through fifth sections provide the findings of the evaluation. The sixth section presents major conclusions and recommendations

## 1.1. Human Resources for Health Strategic Plan (HRHSP) 2008-2013

The HRHSP 2008-2013 was developed by the Ministry of Health and Social Welfare as a response to the human resource crisis it was facing. The HRHSP sets out strategies and options for the period from 2008 to 2o13 to tackle the human resource crisis within a framework of National Development Plan and National Health Sector Strategic Plan. The purpose of HRHSP is to guide the health sector and other stakeholders in proper planning, development management and effective utilization of human resource. Key areas stipulated in this strategy include:

- Human resource planning and policy development capacity.
- Education, training, and development.
- Workforce management and utilization.
- Partnership among key stakeholders.
- Research in HRH
- Promotion of adequate financing for HRH.
- Promoting leadership and stewardship.

## 1.2. HRHSP Midterm Evaluation

**Aim and Specific Objectives**

According to the Terms of Reference (see annex 1) the aim of this evaluation is to provide recommendations for improved implementation of the strategy in the remaining period of its milestone. The specific objectives are:

- To review Human Resource for Health Strategic Plan accomplishments and challenges for the midterm period 2008-2013.
- To document successes, challenges, lessons learnt during the implementation.
- Recommend way forward for the remaining period of the strategic plan taking into account challenges, constraints, lessons and current priorities.

**The Scope and focus of the evaluation**

The midterm review covered the implementation period of 2008 -2011. The focus of the assessment is most on the accomplishment of the planned activities between the mentioned periods. In order to be able to translate the status of accomplishment and explore the probable contributing factors, some contextual and organizational issues were explored. To achieve the objectives, the evaluation looked into the four parameters in order to be able to link the current status with the context as well as the strategy design to enable proper translation of the results. The four areas are:

- Strategy Relevancy in relation to the prevailing HRH needs and general Health systems context
- Strategy Design in terms of involvement of actors ,coverage of needs, prediction of processes for implementation
- Strategy implementation in terms of initiation, dissemination, coverage of planned strategic objectives and activities.
- Lessons learned; how they are documented and disseminated to influence decisions and changes

The approach used for evaluating the strategy was selected based on the fact that, outcomes of the implementation depend entirely on how the strategy was designed. The hypothesis is that design leads to how the strategy was implemented which leads to outcomes which when measured may necessitate redesigning of the strategy (Figure 1)

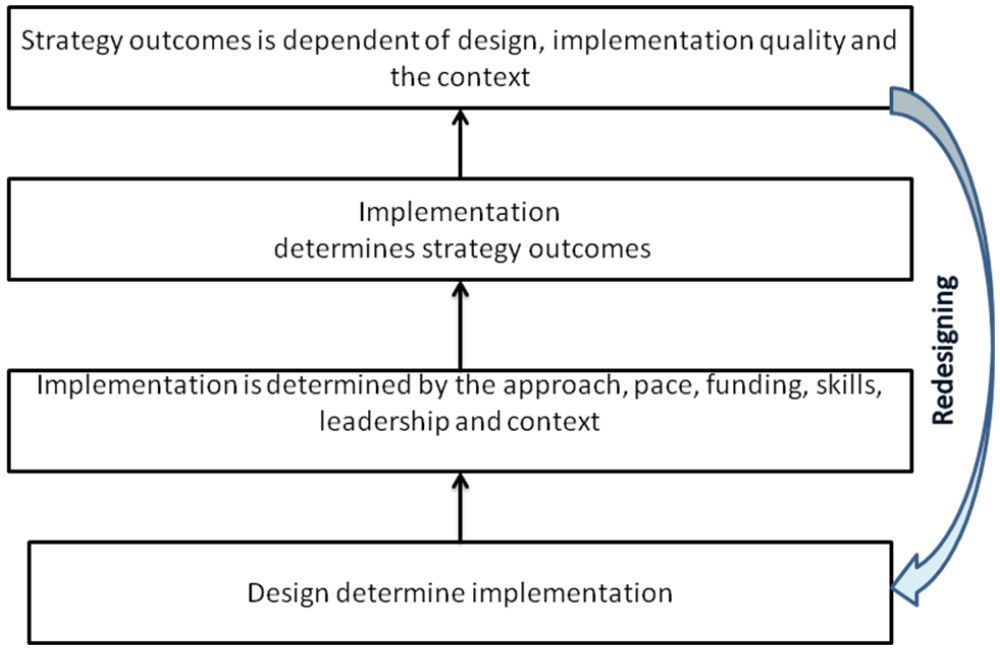


Figure 1: Hypothesis used in designing the strategy evaluation

# SECTION TWO: EVALUATION METHODLOGY

## 2.1. The evaluation Approach

This evaluation used qualitative approach into larger extent. Quantitative approach was only used in gathering the achievements in some areas such as number of trainees, people recruited, financing of HRHSP, salaries trends since 2008 to date as well as coverage of some HRH intervention such as human resources information system rollout.

## 2.2. Data collection method

Data collection methods included key informant interviews and documentary review.

**Key Informant Interviews**

Interviews were conducted at national, regional and district levels. At national level interviews were conducted with development partners and Ministry of Health and Social Welfare Officials. At regional and district level, some key informants from RHMT and CHMT members were interviewed. Where possible a training institution was included. In total 29 Interviews were conducted.

**Documentary Review**

Relevant documents were reviewed this included reports and strategies.

## 2.3. Study areas

Study Areas included :Ministry of Health and Social Welfare, Coast, Morogoro, Mtwara ,Kilimanjaro, and Tanga Regions and Kisarawe, Mkuranga, Kilosa, Kirombero and others are Mtwara DC, Muheza, Lushoto, Same and Moshi DC, Districts. Development Partners included JICA, CIDA and BMAF.

## 2.4. Data Analysis:

Data was analyzed manually using a thematic and subject grouping technique.

## 2.5. Data validation:

Data validation was done through presentation of preliminary results to some national stakeholders. Ideally it would have been good to validate with regional and district respondents too, practically this was not possible.

# SECTION THREE: EVALUATION FINDINGS ABOUT THE DESIGN OF THE STRATEGY AND ITS RELEVANCE

## 3.1. Introduction

In order to meet the midterm evaluation objectives as stipulated in the Terms of Reference (see annex 1), the evaluation categorized the information gathering into four thematic areas. First information was sought on whether stakeholders interviewed feel that the strategy is still relevant given the existing context, this was furthers qualified from documentary reviews. Second the evaluation explored what happened in the designing of the strategy with thinking that some implementation challenges and success are in some way attributable to the design of the strategy. Issues of focus in this category include i) who participated in the design ii) what were the strategic focuses iii) what were the roles of actors with regard to the strategic focuses iv) what plans were there to finance the strategy, coordination of actors, tracking progress and disseminating the lessons learned.

## 3.2. Relevance of HRHSP 2008-2013

The HRHSP is perceived by respondents as a document to assist on making basic decisions to solve the HRH problems (see box 1). The seven strategic of objectives are seen to address key issues that when implemented as planned will address the crisis. The respondents commented that the strategy is well structured the activities highlighted are quite exhaustive and interrelationships between different strategic objectives are clear in the document. Most of what has been stipulated in the strategy aligns well with other MOH&SW strategic documents and policies. However, the inter-linkages of the seven strategic objectives become fade at implementation due to reasons that are stipulated section 3.3 of this document.

**Box 1: Reasons for Developing HRHSP**

The reasons for developing the HRHSP (2008-2013) were:

- The previous HRHSP had expired.
- Development partners ,MOHSW, POMLARG, and other agencies PFP ,PFNP needed to know what to guide them in HRH planning, training and management
- There was a need to align HRH to the bigger MOHSW HSSP III
- To regulate partners who were having small HRH projects
- Assist to implement MAMM. As a means to meet MDGs
- It was needs based especially to overcome problems such HIV/AIDS,MMR,IMR
- Push Based on Global HRH assessment on comprehensive Health systems strengthening
- Among top political priorities agenda issues like MMAM.
- As a response to deal with acute HRH shortage

The relevancy of the HRHSP is further augmented by the fact that; all respondents asserted that HRHSP is used as a reference material in fulfilling their HRH Roles which were stated to include:

- Ensure that the staffing level is adhered to in the entire Council Health facilities.
- Prepare budget for Personnel Emoluments
- Ensure that vacant HRH posts are established budgeted for.
- Prepare request for HRH from POPSM
- Deploy / allocate new HRH to their appropriate posts / health facilities.
- Organize training and HR development
- Targeting of HRH support ( DPs)

It was also gathered from other respondents that though what is stipulated in the strategy is relevant, the strategy is too ambitious as it is not easy to accomplish all what was highlighted in the strategy. They had a feeling that the next strategic plan needs to map what will not be accomplished at end of this strategy and carry it forward.

**Conclusions**

From the above findings the evaluation concludes that the HRHSP was, and is still a relevant strategy and most strategic focus of the strategy needs longer time to realise.

## 3.3. Strategy Design

### Involvement of actors in designing HRHSP 2008-2013

The evaluation has established that during the strategy development stage efforts were made to involve a range of actors. The coordinating point for this strategy development was the Directorates of Human Resource Development. The involvement of other actors started from within the Ministry of Health and Social Welfare by engaging other directorates such as personnel and Administration, Policy and Planning, Other Ministry of Health and Social Welfare Programs. Other sect oral ministries were also involved these include Prime Minister's Office Local Government Administration and Presidents Office Public Service Management. Others who were involved include Private for Profit Organizations, Private Non for Profit organisations, Ministry of Health and Social welfare Training Institutions, development partners such as WHO, JICA, Capacity Project who supported the process both financially and technically. Councils and universities were also involved. A highlight of who did what in the strategy development stage is outlined below.

- MOH –Provide general policies ,Advocacy and dissemination
- WHO- Technical aspects
- JICA –Finance ,Technical assistance
- USAID-Technical assistance
- Others – Technical expertise and practical experience

It was noted that the HRHSP 2008-2013 was developed after assessing the situation see the existing gaps, contributing factors and mapping of who is where doing what in addressing HRH issues. In addition there were series of consultative meetings to translate the assessment findings and gather more ideas. The process was found to be highly participatory.

### Strategy Coordination

The strategy clearly stipulates how different actors will be coordinated. It highlights coordination mechanisms under strategic objective number five such as expanding the working group, mapping of HRH activities and conducting annual reflection meetings to assess the implementation of the strategy.

### Monitoring, Evaluation and Learning

The strategy has a whole section that explains the objectives of monitoring and evaluation. It explains that the existing information system will be used this include HMIS, OPRAS analysis for staff performance and where possible field visits will be conducted. However, much should not be expected with regarding to tracking the information in relation to progress as most of the activities in this section involve building the M&E system and developing capacity of DHR staff to handle the function. The fact that the strategy also planned to use the existing system there are potentials of this being hampered by inherent weaknesses of these systems. The strategy was also silent on how other levels will be engage in the M&E progress.

Regarding documentation of lessons learned, it was planned that through monitoring and evaluation process good practices will be identified, retained, and strategies will be identified to improve weaknesses. It was asserted that identified good practices will be documented and shared with other stakeholders to improve practices across the country:

### Strategy operationalization

It was planned that the strategy will be financed through government own source from both central and also at Local Government Authority (LGA) level. Centrally the plan was to incorporate into MTEF and at LGA level to advocate for its incorporation into Comprehensive Council Health Plans (CCHP). To ensure the later is happening, HRD departments participated in developing the reviewed CCHP guideline to incorporate specific indicators such as attrition, gap and capacity building. Another envisaged source of funding for this strategy was development partners. It was envisaged that other supporters will join the implementation and this will be achieved through dissemination of the strategy. The dissemination of strategy mostly depended on integrating it with other activities within the ministry due to financial constraints. The practice has been slotting a time in fora such as DMOs, RMOs meetings to disseminate the strategy. The snag of this kind of mechanism is limited dialogues between the intended targets and disseminators of the strategy regarding what are expected and how can it be achieved. The evaluation has established that the inception, and dissemination issues were not adequately planned for. Although the strategic plan indicates also operational plan, it was not clear how other levels will be operationalizing the strategy. It was also not clear at this stage who was potential funders for the strategic objectives.

# SECTION FOUR: EVALUATION FINDINGS ABOUT STRATEGY IMPLEMENTATION, MONITORING AND LEARNING

## 4.1. Introduction

This sub section presents findings about the strategy implementation where information on issues such as translation of plans into action, assignment of roles, resource mobilization, what was achieved, what was not achieved, contributing factors and recommendations on what to be improved were gathered. In addition it presents information about how progress is tracked, lessons are gathered and disseminated to inform implementation of the strategy itself and of other relevant plans both at macro and micro level.

## 4.2. Organization of the implementation of HRHSP

The assessment of the implementation of the strategy focused on issues such as translation of plans into action, assignment of roles, resource mobilization, what was achieved, what was not achieved, contributing factors and recommendations on what is to be improved.

### Translating the strategic Plan into Action

It was learnt in this evaluation that the strategic plan document highlighted activities to be conducted under each objective in which year. It further indicated list of quick wins in each strategic objective. This is a list of key activities envisaged to produce rapid and significant results. However as mentioned earlier in this report, annual action plans were developed. It was learnt also that the SO teams are in the process of developing the action plans.

### Assignment of roles in implementation and coordination of actors

**Actor's roles**

The roles to implement the strategy were considered to be a shared responsibility. The key actors are government - MOH&SW in collaboration with other relevant ministries and Local government authorities as well as development partners. For example MOH&SW was to coordinate the implementation as well as incorporating the activities of this strategic plan into MOH&SW plans for funding. In addition MOH&SW disseminates and advocates for support in implementing the strategy including writing proposals for funding. It was learnt that the strategy got support from Global Fund round nine where emergency hiring program is implemented as it will be discussed in the later sections of this report. The role of other actors in implementing this strategy includes:

- Training and curriculum development
- Deployment and retention
- Systems development and testing e.g. Information systems
- Leadership development
- Situation analysis e.g. Touch foundation and McKenzie
- Private sector engagement in accelerating training- CIDA
- Research/assessments

Assumption of the mentioned roles have been both in terms of financing and actual implementation

**Actor Coordination**

Coordination mechanism in application is the use of Technical Working Group (TWG). The working group is divided into teams. These teams are responsible for following up the progress and also they take part in implementation of the strategic objectives. The division of teams are listed in table 1.

**Table 1: SO Teams and their Focus**

| Team | Strategic Objectives | Team Members /Progress made so far |
|---|---|---|
| **Team 1.** | **SO 1:** Human Resource Planning and Policy Development and **SO 6:** Human Resource Research and Development | • The team was formed since 2009.<br>• The team did not develop an operational plan at the beginning , instead each member chose an area of interest<br>• Just of recent i.e. 2011 , the team has developed an operational plan on both SO 1 and 6.This plan is intended to be implemented in partnership between MOHSW and JICA , THRP(Tanzania Human Resource Project funded by INTRAH-HEALTH) , BMAF,ECSA/CDC,GIZ,CIDA/HWI-CT,NIMR/IHI |
| **Team 2.** | **SO 2:** Strengthening Leadership and Stewardship **SO 4:** Workforce Management and Utilization | • The team currently has no operational plan for the SO 2 and 5. The team has a meeting plan.<br>• Team members include: Representatives from MOHSW ,CIDA, BMAF,INTRAH-Health, SIDA, Holland, CSSC and GIZ. |
| **Team 3** | **SO 3:** Education ,Training and Development **SO 5:** Partnership in Human Resource | **Team members**<br>• I-TECH, CIDA, GIZ, APHT, USAID |
| **Team 4.** | **SO 7:** Human Resource Financing. | **Team members comprise**<br>• Policy planning staff<br>• Chief accountant Office representative<br>• CIDA<br>• APTHA<br>The team has operational plans on SO 7 for Jan 2010 to June 2011 and July -Dec2011, Jan 2012 Jun 2012 and Jan -Jun to 2013. |

**Roles and responsibilities of SO teams are:**

- Develop bi-annual implementation plans of the respective strategic objective s of the national HRHSP
- Coordinate the effective implementation of identified priorities within their respective SO.

- Prepare and submit to the Health Work Force Secretariat monthly and quarterly progress reports.
- Liaise and involve relevant stakeholders on specific HRH areas in the respective so.
- Present updates on specific operational issues and challenges, and opportunities0 emerging in the SO and provide practical suggestions.

Other coordinating and reporting structures include:

- Health Workforce Secretariat
- TC-SWAP

The implementation phase faced some coordination challenges which include:

- Lack of comprehensive forum to involve every actor.
- Long chain of command
- Lack of transparency among actors especially on finances.
- Multiple actors on the same HRH area.

The evaluation team felt that the use of SO is good and is easy but probably team seven would have difficulties in doing sound activities as fundraising is cross-cutting and it should be embedded to all other remaining SOs .

## 4.3. Monitoring and evaluation

The mid-term evaluation has established that the implementation of monitoring and evaluation along with documentation and sharing of lessons learned has not been taking place as planned. Some stakeholders had documented lessons learned, but had never shared them with other actors, some actors could only retrieve from their individual memory the lessons learned when asked to do so.

Together with the M&E framework that was designed for the strategy, the evaluation team found that, the framework and indicators cannot answer some of the questions (See box below) which may input into having in place a strong informing component of the strategy.

- How research component is managed: is it proactive – reactive – utilization to inform programs, practice and Policy?
- How strong is the link between research in HRH and the HRH M&E systems
- How strong is the whole process of learning
- How HRH experiences influence policy-what are the pathways?

**Conclusion**

The Monitoring and learning has not been implemented to the expectation of the planned intentions. Most respondents seemed not to be aware of this role. It is hoped that the Mid-term evaluation would be a stimulus for actors to be proactive to implement this function.

**Recommendation**

- It is recommended that SO teams at the Ministry and Development Partners document lessons learned and use them in forum where decisions are made.
- The Regions and Districts Health Management teams are a fountain of practical lessons which could influence Central level decisions on HRH management and planning, therefore mechanisms for tracking these lessons be enhanced and used in making crucial decisions on HRH.

## 4.4. HRH Strategic Plan Financing

The strategy is highly donor dependent. However, it is learnt that government have been increasing the staff salaries annually. On the other hand it was also learnt that given the existing context where the government aims at ensuring each village has a dispensary and each ward has a health centre, concurrently this plan went hand in hand with the plan of increasing the enrolment of health cadres in the training institutions. The financing of the training institution is noticed though in a small scale. Concept for investing in HRH is acknowledged and supported at Ministerial level through financial allocation. For example Post Graduate training allocations has increased from 1.5 TS Billions in 2007/08 to 5.4 Billion for 2011/12 period.

The resource mobilization for HRHSP implementation was through MTEF and marketing the HRHSP to Development Partners such as USAID, GIZ,JICA,CDC,WHO,GLOBAL FUND were given liberty to select areas of interest. Some areas in the HRHSP were not supported at all. SOs financing varies. Some are better funded and some are not. For example SO number seven and number two were found to have less progress see table 2: Table 2 Indicate the assessment of financing of the SOs by counting the partners who support different activities in the SO. The presentation of the financing status is not by amount of funding but numbers of activities that have a committed fund for 201/2011 and 2011/2012. This information is extracted for the mapping document prepared by MOH&SW annexed to this report

### Table 2: Table 2 Indicate the assessment of financing[1] of the SOs

| Strategic Objective | Better funded[2] | Moderately funded | Poor or not at all |
|---|---|---|---|
| SO 1: Human Resource Planning and Policy Development | X | | |
| SO 2: Strengthening Leadership and Stewardship | | | X |
| SO 3: Education ,Training and Development | X | | |
| SO 4: Workforce Management and Utilization | | X | |
| SO 5: Partnership in Human Resource | | X | |
| SO 6: Human Resource Research and development | | X | |
| SO 7: Human Resource Financing. | | | X |

The evaluation team felt that SO seven fitted as an outcome of SO two rather than a strategic objective in its own. SO two if achieved it means the funding and attention to HRH issues would have been aggravated in a way. It was also realised that the intervention logic along the result chain for SO number two does not match. This might have led to difficulties in translating the activities in some ill –funded SOs into meaningful result oriented activities. The team tried to assess the logic of the activities and their potential to contribute to the intended results see table 3

[1] It was not possible for the evaluation team to have access to any actual committed or spent funds that could have been used to analyze this financing trend and pattern.

[2] This classification is not based on actual funds but rather commitment from development partners (DP). It indicates areas where DPs were interested to participate.

**Table 3: SO two activities and their potential to yield the intended results**

| Activities under SO 2 | The potentiality of the activity to yield to the intended results | | |
|---|---|---|---|
| | High | Moderate | doubtful |
| Conduct training needs assessment in leadership and management | | | X |
| Conduct management and leadership training programs to central and RHMTs | | | X |
| Develop attachment, exchange programs and study tours for sharing best practices in HR planning, financing, development and development for HR responsible officers. | | | X |
| Train leaders on good governance and gender | | | X |
| Train leaders in communication and advocacy skills | | | X |
| Develop advocacy and communication strategy in HR | X | | |
| Advocate HR policies, guidelines, circulars and other issues at all level | X | | |
| Strengthen HRH Working Group at central level and establish HRH Working Groups at regional and district | X | | |
| Establish terms of reference of regional and district HRH Working Groups | X | | |
| Facilitate launching of regional and district HRH Working Groups | X | | |
| Orient the regional and district HRH Working Groups on their roles | X | | |
| Facilitate involvement of Social Welfare membership in RHMTs, CHMTs, HMTs and FMTs | | | X |
| Resource mobilization to facilitate work of the regional and district HRH Working Groups | X | | |

**Recommendation**

The evaluation team are of the opinion that an independent small study be conducted to assess the funding mechanisms of the SOs. This will enable to establish actual committed funds and expenditures against activities and thus help to demonstrate areas that are not well funded and motivate development partners to fulfil their commitments.

# SECTION FIVE: EVALUTION FINANDINGS ABOUT THE ACHIEVEMENTS AND CHALLENGES

## 4.1. Quick wins and achievements from 2008 to 2011 in each strategic objective at National level

The evaluation concludes that Quick wins as stipulated in the HRHSP have been fully implemented. The only worry is whether the dissemination of HRHSP has been conducted well to the peripheral actors like Districts. This is because the evaluation has established that the inception and dissemination issues were not adequately planned for. As such 10 copies of HRHSP were delivered to each Region, District, Institution and HRH working Groups. RMO's , DMO's and other MOHSW conferences were used to pass on HRHSP information. In addition it was noted that there were no funds for advocating for HRHSP apart from the fact that there were CCHP-HRH indicators through which to advocate for their involvement in the CCHP. The recorded achievements according to the strategic objectives are:

**SO1: To improve HRH planning and policy development capacity.**

Planned Quick Wins for strategic objectives 1 were: Training key HRH staff at Central level on HRH planning, undertake initial planning work for the design of a comprehensive HRIS, incorporate key issues outlined in the HRHSP into the Health Sector Strategic Plan III and launch and disseminate the HRH strategic plan at all levels. The following were achieved under SO 1:

- Training key HRH staff at MOHSW / BMAF /some RHMTs and about 54 CHMTs in 2011. The training included skills in HRH planning, communication, HRH data analysis. The training was funded by BMAF.
- Have developed software through HRH Working Group for all Training Institutions. The Information System software will track information on all aspects of the institutions such as logistics, HRH, and academic performance of students e.g. CATS. This is supported by JICA.
- Training on Planning and design of HRIS for MOHSW staff and rolled-out to Districts – this has been achieved by 100%. Currently all Districts have a HRHIS Software linked to MOHSW HRIS.
- Disseminated HRHSP through RMO/ DMO Conferences and Public exhibitions such as *SABASABA,NANENANE, and 50 years of independence exhibitions.*
- Have established HRH Newsletter .
- Have incorporated HRHSP issues into the HSSP III.
- Have started the exercise of Reviewing the Staffing Level guideline and this is ongoing under support of JICA and BMAF.
- Have facilitated Mid Term review of HRHSP with JICA support.
- HRH Mater plan software is being introduced and this is expected to ease HRH projection task

**SO 2 to strengthen leadership and stewardship in HRH**

**Planned Quick Wins**

The quick win for this strategic objective was :Run a leadership development programme (LDP) for key personnel. This was supported and Benjamin Mkapa Foundation and JICA. Where the former assisted in running supportive supervision training to CHMTs countrywide Where as the later supported training of R-RHMTs members countrywide on Leadership and Supportive supervision and soon they will embark on training R-HMTs on the same.

**SO 3: Education, Training and Development**

During planning stage it was envisaged that the following will be implemented in order to achieve Strategic Objective 3.

- Train HRH Focal Persons at District level on HR management.
- Review training curricula to shorten the courses duration while maintaining quality standards.
- Strengthen distance learning initiatives**.**

Most of the quick wins in The SO 3 have been achieved except the some areas on Distance learning **.**

- JICA has developed management / leadership training programme for R-RHMTs and conducted training for all R-RTHMTs the whole country.
- JICA is currently planning to run management courses for Regional –Referral Hospital personnel on management, planning and leadership for the whole country.
- BMAF has supported development and training of CHMTs with District HR officers on HR management and supportive supervision for the whole country.
- Increased enrolment from 5,365 in 2009/10 to 6,713 I 2010/11 and funds for expansion of health training institutions have been secured.
- 15 Training Institutions are Fully Accredited of which 6 are Private. 4 other private training institutions have Provisional accreditation.
- 16 Curricula have been reviewed and entrepreneurship added as one of curricula content.

**Recommendation**

The evaluation recommends that efforts should be devoted in strengthening Distance learning areas by also taking advantage of the expanding E-learning programmes so that more health workers can access learning without necessarily relying on Institutionalised learning programmes.

**SO4 to improve workforce management and utilization**

The quick wins for strategic objective four include:.

- Streamline recruitment bottlenecks.
- Track and monitor new recruited employees.

- Reallocate health workers to ensure equity in distribution.
- Develop and advocate an improved incentive package for health workers in hardship areas.

## Achievements

***Tracking Posted Employees***

Tracking of HRH postings from the MOHSW to Ministries Departments and Agencies (MDAs) such as RAS ,DEDs, Military ,Home Affairs, Education, and Parastatal has been the main focus of the implementation of this SO. This task has been funded and facilitated by BMAF using a developed guideline. In addition a consultancy was commissioned. This exercise was conducted between 2010-2011 the results are as indicated in table 4. It was realised that there is no a functioning mechanism that enables the tracking of human resources. When employees are posted from the central it is difficult for the personnel department central to establish whether these people have reported or did not report or reported and left. Regional health secretariat although in one its functions human resources management is mentioned but their roles in HRH tracking is not clearly evident.

There is a hope of easing the tracking task following the existing initiatives to improving the Human resources information system that is going on. This evaluation noted that there is several human resources information tracking initiatives going on. Some have been piloted and taken to scale (JICA/MOH system) and some are tried in certain areas example Intrahealth project in Nanyumbu. This is a commendable improvement. However, the team feels that if these are left uncoordinated and unharmonised it will add more burden to health workers and may stagnant the process of having one system that is used for generating information country wide. It is also important for these initiatives to take into account how they will be linked to the existing health information system such as DHIS to avoid having parallel systems where critical indicators of progress can be sourced from.

**Table 4: General status of deployment of staff 2007-2010**

| NO | Financial Year | Permit | Posted | Tracked | Variation (Permit-Posted) |
|---|---|---|---|---|---|
| 1 | 2007/2008 | 6,437 | 4,812 | 3,204 | 1,625 (25%) |
| 2 | 2008/2009 | 5,241 | 3,010 | 2,998 | 2,231 (43%) |
| 3 | 2009/2010 | 6,257 | 4,090 | 3,673 | 2,167 (35%) |
| **Total** | | **17,935** | **11,912 (66% of Permit)** | **9,875 (83% of Posted)** | **6,023 (34% of Permit)** |

***Sources draft tracking report 2011***

## Salary situation

It was noted that government despite economic challenges is trying to improve employee salaries. There has been a considerable increase of salaries since 2006 see table 5. In addition there are promising efforts to try to address salary delays for government staff. It was noted that MOHSW, POPSM with BMAF support have developed a mechanism for handling payroll management system using a

SOFTWARE-LAWSON. BMAF facilitated training of staff on the software use, purchase of Software, and Computers. This software is linked from the Districts to the MOHSW/POPSM and so far by the time of this evaluation has covered 75% of the Districts in Tanzania.

**Table 5: Salary increments trend for some selected cadre**

| Cadre | 2005/2006 | | 2006/7 | 2007/8 | 2008/9 | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|---|---|
| Doctors | TGS E1 | TGS G4 | TGS G4 | TGS G.4 | TGHS E1 | TGHS E1 | TGHS E1 | TGHS E1 |
| Increments | 201,100.00 | 403,120.00 | 523,950.00 | 561,670.00 | 658,400.00 | 687,440.00 | 886,800.00 | 957,700.00 |
| Nursing Officers | TGS C1 | TGS D4 | TGS D4 | TGS D4 | TGHS B1 | TGHS B1 | TGHS C1 | TGHS C1 |
| Increments | 120,300.00 | 167,390.00 | 245,900.00 | 263,660.00 | 315,750.00 | 329,680.00 | 614,210.00 | 682,000.00 |

*Sources MOH&SW report*

***Addressing Geographical imbalance while providing choices for new recruits***

The MOHSW has developed a guideline for new employees to choose from a range of three possible Districts to be posted. This is a strategy to reduce the tendency for some workers not reporting to their new stations.

## Challenges facing SO 4 implementation

- HR Ceiling from POPSM e.g. scaling down HR recruitment from 9,000 to 4500 in 2011/2012 for the whole country also affects the MOHSW efforts to increase HRH posting to fill gaps.
- Inadequate funding has led to failure to absorb HRH into Government payroll that were earlier paid by–BMAF – Global fund HRH projects.
- The team has NOT dealt with the Incentives for HR instead this is done by POPMS for the whole country.
- Also there are Districts initiatives on incentives but are not well coordinated to document how they work.
- The Team has not been able to act on most of the quick wins namely: Streamline recruitment bottlenecks, Reallocate health workers to ensure equity in distribution and Develop and advocate an improved incentive package for health workers in hardship areas.

It was learnt that BIMAF tested innovative ways of attracting highly qualifies employees to rural areas and the program proved successful and the same mechanisms were used to implement the emergency hiring program which also shows good results. Mkapa fellowship program is highly appreciated for its ability to attract highly qualified staff to areas where historically that was not easy BIMAF (2011), End of program evaluation report.

It was also established that fellows have been co-opted to take leadership and management posts in district health department. I was further evident that 1st and 2nd batch of fellows did not take long to be mainstreamed (see figure 3). The mainstreaming need emanated from the districts. The necessitating factor for this was qualities portrayed by fellows in service provision, technical support in district health planning and implementation of programs including HIV/AIDS services.

Surprisingly majority of fellows over age 45 opted to be mainstreamed regardless of their age. The drivers for being mainstreamed to the government service were mostly related to employee welfare, see figure 2.

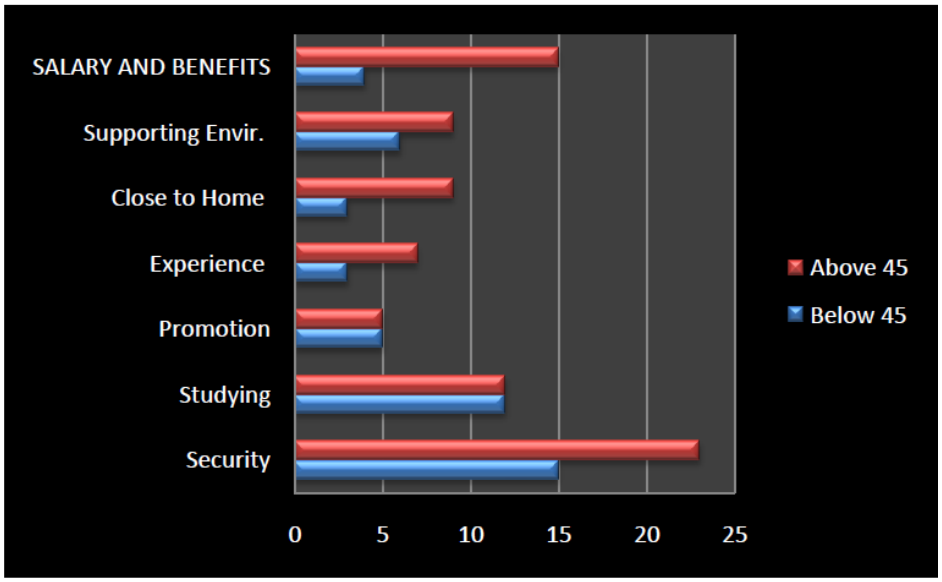


**Figure 1: Reasons for being mainstreamed:** ***Source: BIMAF***

However, there have been challenges in this program. There were some un intended effects recorded such as De-motivation of the existing, Clash in personalities and transfer of fellows from rural areas to towns. Other challenges of this program were systemic these include:

- Human resources management capacity at district level is low
- Structurally it is expected that there should be an active link between health secretaries, hospital secretaries and Council Human Resources Officer, but in practice this link was found weak.
- Most councils do not have clearly stipulated retention strategies
- Human Resources information system in MOHWS is weak
- Mainstreaming challenges
    - Old age
    - High salary and allowances from Mkapa Foundation and low salary from Public service. Though following the mainstreaming analysis that was done by the program the difference between what was offered by the program and what government offers is insignificant in terms of salaries. The attracting bit on the part of the program was the

consideration of duration of service of recruit and previous experience to determine the entry scale and Other allowances like communication

- Payroll system and procedures create delays in salaries for new recruits

### SO 5: To build and strengthen partnership in HRH .

Assess capacity of private institutions in training and service delivery, Support private sector to scale up training of health workers in line with PHSDP and Involvement of business companies in supporting HRH training and retention were set as quick wins for strategic objective 5.

### Achievement in SO5

CIDA being a Focal Point for Technical Working Group for Human Resource Workforce comprising of Government, Donors and Civil Society Organizations is planning to support the Government to increase HRH production targeting middle cadres at Health Centres and Dispensary. The emphasis will focus to supporting non government training institutions because they do not receive Government financial support. This initiative will be coordinated through an Executing Agency who will sort out Proposals from PFP & PNFP and advice on whom to be supported. Currently the following have been done

- MOH&SW has signed the agreement
- The work plans and budgets have been approved

Other achievements include

- Formulate committee to strengthen coordination and linkages among sectors in addressing HRH issues
- Expansion HRH working group to incorporate private and other government institutions
- Mapping of HRH stakeholders was done
- Annual meetings to assess implementation of HRH strategy- HRH day done in 2011
- Introduced entrepreneurship in training institutions curricula

**Conclusion**

The move taken by CIDA to invite proposals from the PFP/PFNP institutions to bid for support is welcome but it should be noted that some institutions with no abilities to write Technical proposals might be left out.

**Recommendation**

The evaluation recommends that the CIDA approach is good BUT should also seek to identify weaknesses in some private institutions in proposal writing so that they are not unnecessarily be left out in this important exercise.

### SO 6 to strengthen HRH Research and development

Planned Quick Wins in SO 6 include identifying the priority areas for HRH research and make use of research findings. GIZ is working with the Team on SO 6 conducted research synthesis on HRH. The focus has been what has been done, how, findings and possibility of applying it in Tanzania. The report has been circulated. The team has not been able to develop HRH priority areas for Research.

### SO 7: To promote adequate financing of HRH strategic Plan

The task of the team is to find sustainable financing for HRH through finance mobilization from Government and Development Partners and disseminate the HRH strategic plan to relevant government ministries and Development partners to get their buy in and financial support. Various mechanisms were used to advocate for funding and support to accomplish the strategic objectives such as:

- Advocacy for expansion of training institutions through construction of new ones and rehabilitation of old ones.
- Supporting HRH proposals from Technical departments e.g. nursing for support in the general budget.

### Achievements

- PEs /salaries for HRH have been increasing year after year and seem sustainable.
- Concept for investing in HRH is acknowledged and supported at Ministerial level through financial allocation. For example Post Graduate training allocations has increased from 1.5 TS Billions in 2007/08 to 5.4 Billion for 2011/12 period.
- Basket Fund commitment has been stable.
- General Development support has been stable.
- Global Fund Round 9 has committed to support through HSS III rehabilitation of Training institutions.

### Challenges

- Scarcity of Finances from Government for example in the period 2011/12 The actual Budget estimates for HRH was / is 66.3 Billions BUT Actual Allocation is 13.2 Billions and Actual release by Jan 2012 is 20 % of the actual release
- Development partners funding health NGOs in the field on HRH issues without informing the MOHSW. This is leading to Fragmentation of coordination to track actual resources released to HRH in the country.
- Having no clear ways of tracking donor inputs at different levels of care.

### Conclusion

The efforts for resource winning has been solely targeting traditional means i.e. Government and Development Partners, it seems no efforts have been put into winning resources/ finances from non-

traditional sources such as the blossoming private companies . Also the efforts have been routed through the Central level such that local potential financial sources at District level have been left out.

**Recommendation**

- The efforts in future should involve more the private sector such as building companies who can alleviate chronic housing problems in rural settings.
- Decentralize financial winning efforts so that local companies in the Districts could respond to problems of their relevance.

## 5.2. Achievements from 2008 to 2011 in each strategic objective at Regional and District level

The HRHSP has been taken as one of the reference material in the development of Hospital plans and CCHPs in the Regions and Councils respectively. All Regions and Councils visited by the evaluation team have the HRHSP copy, BUT they lament not to have been sensitized on how to use it. However they have been able to align most of the SO activities in their annual plans. The following is an outline on the status of implementation of each SO as mentioned by Regional and Council Health Secretaries/ RMOs and DMOs.

The evaluation has established through interviews that Regions and Councils have translated the HRHSP into their respective annual plans. The evaluation has put together what is done per Strategic Objective. Due to the fact that most responses per SO have been similar.

**Strategic Objective 1:To improve HRH Planning and Policy Development Capacity**

The regions and districts are operational levels and most of their activities are operational. In this strategic objective they reported to be doing the following things:

- Plan for retirees and how to fill their positions.
- Plan and propose HRH promotions.
- Increased recruitment through proper planning.
- Estimation of HRH requirements.
- Plan for new construction of new health facilities.

Most of these activities are done through government financing allocated to regional secretariats the accounting officer being Regional Administrative Secretary (RAS). The regions and councils appreciate the efforts by the ministry for funding postgraduate trainings. However, there is obstacle in operationalising the mentioned human resources management functions because of financial constraints which is evident either in terms of delayed disbursement or budget cuts. With regard to filling the existing gaps it was reported that apart from the challenges of getting permission to hire on time, there are challenges of attracting specialist to remote regions.

It was learnt that some development partners directly support the regions in addressing HRH problems either through paying salaries for staff who are not yet in government payroll or by direct financial support. The mentioned organisations providing this kind of assistance include ICAP, CHAI, GIZ and CDC

**Strategic Objective 2: To strengthen leadership and stewardship in HRH.**

Apart from the initiatives that support all regions and districts from national level, there are other local initiatives that are geared towards leadership development. These are in terms of both local and trainings abroad. Some are accredited courses leading to a diploma award and some are just tailor-made short courses. The local arrangement was found to be either through budgeting in the plans or getting funded by the development partners see box two.

**Box 2: Leadership development activities in regions and districts**

- Department / section in charge got Orientation training on Leadership.
- Matron trained in Germany in Leadership and Management ( TANGA).
- Sponsored heads of departments for short courses in management .
- Conduct meetings to review progress ; this is guided on rotation by different cadres in order to enhance their leadership skills ,promote participatory leadership ,and transparency ( PWANI).
- Planned in 2011/12 to train more personnel in management. ( PWANI)
- Included budget for CHMTs and co-opted members for District Health Management course at Zonal Training Institutions ( Morogoro, CEDHA, Mtwara ). Some members have graduated with Diploma award

**Strategic Objective 3: To improve Education ,Training and Development for HRH**

The evaluation noted that upgrading the health workers to high levels along their career ladder is becoming more prominent. This is because of the existing opportunities that enable them to get sponsorships. The mentioned opportunities include.

- Demand from sensitized health workers
- MOHSW support
- Local Government ( RAS/DED)
- Training plan in place
- University Board of Loans

It was also noted that not all who wants to go for upgrading get the chances on time this is because of financial constraints and Some Health workers cannot be assisted to be trained further due to their basic education and age. See box three for patterns of upgraiding.

### Box 3: Health workers upgrading

- Medical Doctors have been facilitated to pursue postgraduate courses, Lab Tech to degree programme, Nurses to degree courses.
- Provided medical attendants to join O level Certificate through attending evening classes.
- Nurse Assistants have been upgraded through sponsorship to Nurse Midwives.
- Clinical Officers have been sponsored for AMO programmers.
- Clinical Officers have been assisted to join Medical Officer Degree courses while their salaries are paid while on studies.
- MCHA have been assisted to join Distance learning programme to upgrade to Nurses II.

**Strategic Objective 4: To improve workforce management and utilization.**

This evaluation noted that, there are local initiatives that are regional specific and emanated from the regions that aim at motivating health workers. For example the piloting of Pay for Performance (P4P) though CHAI funds in Coast region are amongst the initiatives

Apart from the famous award for Best worker being practiced in all Regions /Districts as means for motivating workforce there are other mechanisms such as:

- Provide 200,000/= per month as house allowances to MDs/ Specialists who do not have Government houses as means to retain them.( TANGA)
- Quality Improvement has been established to improve workforce performance. Quality Improvement Team made of 15 heads of departments has been established. This has been possible through GIZ support and North –South Partnership between GIZ/France Hospitals collaboration and Bombo Hospital in Tanzania. Also there is South-South collaboration in Quality Improvement between Bombo Hospital in Tanzania and Bamenda North-West Provincial Hospital in Cameroon funded by Charity Berlin in Germany which sponsors staff exchange programme between these hospitals to share experiences in Quality Improvement.( TANGA ).
- QI –Establishment of Hospital Quality teams –through support of EGPAF, and JICA /MOHSW ( Kilimanjaro)
- Contract HR hiring after retirement through Presidents' Office is being practiced as means to utilize retired BUT not tired health workers (TANGA).
- Formed Hospital/Health Centre/Dispensary management teams .
- Absorption of BMAF paid staff into the Council Payroll.
- Hiring of OG Specialist from Muhimbili Once a week paid by the Council ( Mkuranga).
- Sourcing for of houses in private housing sector for new staff.

Improvements in human resources management processes have been mentioned also as part of local initiatives to improve health workers' morale. Examples of these are:

- HRH Promotion information is processed timely.
- HRH Employment Confirmation is processed timely.
- Provide staff Uniforms.
- Conduct OPRAS
- Overtime allowances and other PEs paid timely on merit.
- Leave Rights paid.
- Renovation of staff houses.
- Early posting of Check numbers in the payroll.

**Strategic Objective 5: To build and strengthen partnership in HRH**

The following are experiences from the Regions and Districts that promote partnerships these include:

- Provide Supportive Supervision by RHMTs/CHMTs to PFP/PNFP.
- Guide them on staffing level.
- Temporarily Hiring of Doctors from Private (e.g. Urologist Surgeon on 2 days per week -400,000. = is set aside for hire per month (TANGA).
- PFP/PNFP staff is invited in training opportunities whenever they arise.
- PFP/PNFP Involved in CCHP planning sessions.

**Strategic Objective 6: To strengthen HRH research and development**

Nothing has been done regarding this strategy. Most respondents assert that it has not been a priority among their burning problems.

**Strategic Objective 7: To Promote adequate financing of HRH strategic Plan**

Some Regions and Districts have been able to secure alternative financial resources through collaboration with International Agencies working in the country and specifically in their Regions and some have used advantage of Health Insurance institutions. Examples of these practices are:

- GIZ funding support on Quality Improvement ( TANGA)
- AIDS Relief funds Salaries of HRH working in CTCs (TANGA)
- CDC has awarded a Grant to Coast Region Health Team after winning a bid through proposal writing. These funds are used to pay Rapid recruitment of Accountant and Administrator, and strengthening Health management system of the Region (Coast).
- Some have used NHF and CHF.

## 5.3. Challenges in implementation of the strategy:

The evaluation has established from respondents at different levels (Ministry, Region, District, and Development Partners that the implementation faced a number of challenges as listed below:

- The HRHSP faces inadequate finances and untimely disbursement.
- Not all SOs /activities have been implemented.
- HRHSP Dissemination / advocacy was very low.
- Delay of Salaries is de-motivation factor and at times cause of attrition.
- Difficult to acquire staff despite having employment clearance due to POPSM HR ceiling.
- Coordination problems between Ministries of MOHSW, PMOLARG, POPSM on HRH manning level and Ceiling / or acceptance of a new cadre.

- HRH shortage in the market especially specialists and other cadres.
- Inadequate mechanism for tracking compliance to Posting by new employees between MOHSW, RAS, and DED and other agencies.
- Government especially the MOHSW has not adequately assumed leadership role to facilitate implementation of HRHSP.
- Poor coordination of Ad hoc projects on HRH by some actors
- Duplication of efforts for example HRIS by MOHSW/JICA and POPSM HRIS
- Funding of MTEF for HRH coming from donors this negates sustainability

## 5.4. Participants recommendations

The following is the list of respondents' (Ministry, Region, District, and Development Partners) recommendations that would improve future implementation of HRHSP:

- More emphasis should be put on HRH just as emphasis is put on MDGs
- More efforts should be put in increasing training institutions outputs for HRH in order to realize HRHSP/MAMM
- Emphasis on infrastructure financing for health facilities to include Staff Houses
- Involve stakeholders in HRHSP design and implementation
- Improve coordination among MOHSW and POPSM /POMLARG on HRH ceiling.
- Introduce Risk allowances for HRH for those working for example in Psychiatric wards (some workers are beaten by psychiatric patients), other risky environments.
- Increase advocacy for HRHSP 2008-2913 so that it is known at lower levels, and Partners.
- Improve leadership on HRH at MOHSW and other levels.
- Decentralize through devolution some HRH functions to Regions and Districts/Zonal Resource centres.
- Plan for sustainability through mobilization of funds from Non-traditional funders.
- Improve coordination of SO Teams through having a person overseeing all activities of each team.

## 5.5. Lessons learned by MOHSW, Development Partners, Regions and Districts/ Councils.

- The HRHSP has been a good document to guide employers such as RAS on staff development matters which has enhanced slight improvement on supporting HRH in training and PE issues, which was not the case before.
- HRH issues need wider advocacy / communication between Ministries, Employers (PMOLARG, RAS, and DED) and supervisors. Sometimes an employer can receive HRH whom were not needed and therefore budgeted for.
- Leadership , and Teamwork ability capacity is important in implementation of HRHSP
- Introduction course/ orientation course /programme for new employees at District Hospital before locating them in periphery health units has assisted to improve workers' morale and mind –set and expectations to District situations.
- Quick inclusion of new employees in the payroll is instrumental in attracting new employees to their new stations.
- 14 days Subsistence allowances for new employees is a motivator and retaining strategy
- Budgeted transfers for long working staff is a motivation for them even if transferred to distant remotely located health facilities
- Follow-up of HRH issues physically at the MOHSW /POPSM yield better results in securing new HRH.
- Availability of staff houses of good status as shown by TASAF housing schemes at health facilities help to motivate staff THUS retention
- HRH management is very important BUT has been underrated in favour of recruitment and training.
- HRH is a multispectral issue especially on areas of staff retention, motivation through improving working environment and infrastructure. Therefore there is a need to have a multi-sect oral forum on how to deal with these issues.

# SECTION SIX: CONCLUSIONS AND RECOMMENDATIONS

In conclusion the evaluation team consider that the implementation of the strategy is largely on track. The conclusions and recommendations of the whole evaluation on the HRHSP is arranged according to the main themes: Relevancy, Design, and Implementation Monitoring and evaluation.

## Continued relevance of HRHSP 200-2013

**Conclusion**

The evaluation concludes that HRHSP (2008-2013) is still a relevant strategy in the current Health System context at all levels; the contents are relevant and comprehensive.

**Recommendations**

Development of the next strategic plan should reflect much on what has been planned in the current strategy

## The strategy design

**Conclusion**

The design of the HRHSP was good, the strategic areas were well thought of and process involved a range of relevant stakeholders in HRH. However, the only snag was a failure to project the income and outline clearly other lower levels will operationalise the plan. There was no any indication of having the operation plans.

**Recommendation**

4. There is a need to revisit the HRHSP Strategic Objectives and activities so that priority be assigned to those which can be implemented in line with foreseeable resources and levels within the Health system.
5. The strategy need more support financially so as realize envisaged milestones.

## HRHSP implementation

**Organisation of implementation of the HRHSP**

5. Implementation of the strategy is well organised in terms of structures for coordination and reporting of the progress. However the lack of formal annual plans have probably influenced how much is achieved in implementations as there are no deadlines for accomplishing task and the extent to which the strategy is financed and distribution of actors to addressing all strategic objectives.
6. Tracking progress is concluded to be less robust as the key forum for tracking progress is the HRH technical working group. Less is done outside this forum

7. Financing: The strategy received due attention from actors and the financing though not enough but much has been done in this area and this is positive and commendable.

**Recommendations**

4. There is a need to recast the implementation plan for the remaining period taking into account of priority activities, abilities of actors , resources availability and time
5. Devise mechanism for tracking progress other than TWG

## Achievements in Strategic Objectives

## Conclusions

3. The implementation of all Strategic Objectives has been attempted by The Ministry of Health and Social Welfare, RHMTs, CHMTs and Development Partners and the implementation is still ongoing for almost all planned activities.
4. The fact that at the beginning there were no operational plan and no targeted funds for implementation, implementation could not start at the very beginning of 2008, rather later in the 2009/10 period. However the implementation status of most of the strategic objectives is impressive especially those having a booster from Development Partners' funding.
5. Meeting the planned Milestones in 2013 will need more speed, financial commitment and change in some modus operandi as recommended hereunder.

## Recommendations

5. There is a need for the Strategic Objectives teams to link with Districts CHMTs, Regions-RHMTs so as to decide on which activities need to be implemented at which level in priority order. Otherwise there will be duplication and efforts will bear no tangible results.
6. There is a need for the Government to improve HRH funding
7. The PPP need more involvement so as to augment more resources in HRH production and deployment.
8. Improve coordination among MOHSW and POPSM /POMLARG on HRH Information System, ceiling and funding.
9. Capacity building on implementation of Strategic Objectives should be cascaded down to Regions and Districts were the HRH needs are more specific to health facilities and skills mix.
10. Research priorities be identified by involving more actors in the Districts where HRH variety of problems are being faced.
11. The SO 4 team should strive to work on issues of HRH equity distribution and advocating for incentive packages for various aspects of HRH situations taking into account of Districts experiences on lessons learned on what works best to motivate HRH based on different job context and content.

12. Efforts should be devoted in strengthening Distance learning areas by also taking advantage of the expanding E-learning programmes so that more health workers can access learning without necessarily relying on Institutionalized learning programmes.
13. The efforts for winning finances in future should involve more the private sector such as Estate Development Agencies who can alleviate a chronic housing problem in rural settings through construction of Low-Cost houses.
14. Decentralize financial winning efforts so that local companies in the Districts could respond to problems of their relevance.
15. The SO 4 team should strive to work on issues of HRH equity distribution and advocating for incentive packages for various aspects of HR situations taking into account of Districts experiences on lessons learned on what works best to motivate HRH based on different job context and content.
16. The SO 4 team should strive to work on issues of HRH equity distribution and advocating for incentive packages for various aspects of HR situations taking into account of Districts experiences on lessons
17. Research priorities be identified by involving more the actors in the Districts where HRH variety of problems are being faced.

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BMAF 2008, Revised strategic Plan 2008-2012

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BMAF Mainstreaming Mkapa fellows and Emergency hiring program

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# Annexes

## Annex 1: Terms of Reference

THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

TERMS OF REFERENCE FOR CONSULTANCE ANNOUNCEMENT

HUMAN RESOURCE FOR HEALTH STRATEGIC PLAN 2008-2013
MID-TERM REVIEW

JULY 2011

## 1.0 Introduction

The Ministry of Health and Social Welfare (MoHSW), invites applications from qualified consultants to undertake a mid-term review of the Human Resource for Health strategic plan 2008-2013.

The Human Resources for Health Strategic Plan has been developed with a view to creating and enabling environment to promote participation of key Human Resource for Health and Social Welfare stakeholders in addressing human resource crisis in the Health Sector. Specific focus is on planning and policy development capacity, leadership, education, training and development, workforce management and utilization, partnership, research development, and financing. Successful implementation of this strategic plan will lead to increased human resource capacity necessary for the achievement of quality health and Social Welfare services at all levels in the Country.

## 2.0 Background

The strategic plan 2008-2013 was developed in January 2008. This was then followed by implementation of activities laid down in the document. Generally the strategic plan is the basis for all activities of the Human Resource for Health, it provides the strategic direction that keeps the organization in tandem with its core mandate which is to promote and encourage efficiency and relevance in the provision of health services in the country. It is 3 years since the strategic plan was implemented, therefore there is a need of carrying out a mid-implementation which will presents an opportunity to consolidate lessons learnt and consider opportunities for improvement in the implementation of strategic objectives and activities.

## 3.0 Activity Purpose

A number of important factors make the mid-term review an important milestone event in the implementation of this strategic plan. These include;

- Changes in the organizational structure of the secretariat with deliberate movement towards a more business oriented approach and Monitoring & Evaluation of all activities within the Strategic Plan
- Evaluate the implementation status of Strategic Plan.

## 4.0 Approach

The mid-term review will be undertaken in a highly consultative process that aims to surface relevant information from stakeholders that will enrich the implementation process. An initial briefing meeting will be undertaken with senior management, after which an inception report detailing the approach will be submitted by the consultant prior to commencement of the assignment.

The consultant will be expected to work closely with the HRH Secretariat to identify relevant literature to be reviewed as part of the mid-term review. This will include, the 2008-2013 strategic plan, performance reports, annual reports, selected activity report's undertaken by different stakeholders.

Furthermore, the consultant will work with the secretariat to develop survey tools including interview questionnaires for key informant interviews and Focus group discussions. The approved tools will be

used by the team and other interviewees to collect information from key informants on the activities as they relate to the strategic plan 2008-2013.

Information collected from the various stakeholders and other interviewees, will be collated, analysed and presented in a preliminary report to be shared with the HRH Working Group. After incorporating inputs from various stakeholders, a final report with clear recommendations and way forward will be prepared by the consultant and submitted to the MoHSW management.

## 4.0 Objectives of the mid-term review

- To review Human Resource for Health Strategic Plan accomplishments and challenges for the mid-term period 2008-2013
- To document, successes, challenges and lessons learnt during the implementation of mid-term period documented
- To recommend way forward for the remaining period of the strategic plan taking into account challenges, constraints, lessons learnt and current priorities.

## 5.0 Expected Outcomes

- HRH Strategic Plan accomplishments and challenges for the mid-term period 2008- 2013 reviewed
- Successes, challenges and lessons learnt during the mid-term period documented
- Recommendations on way forward for the remaining period of the strategic plan taking into account challenges, constraints and lessons learnt developed

## Main activities for Consultant (refer to Table 1.)

- Initial briefing with management
- Literature review
- Survey tools development
- Field visits and interviews
- Compilation and presentation of preliminary report
- Sharing of findings in a Stakeholders workshop/meeting
- Refinement of report
- Presentation of Final report to the MoHSW

## 6.0 Main deliverables

- Inception report
- Survey tools
- Preliminary report (MS-Word and PowerPoint Presentation)
- Final report

## 7.0 Qualifications

- Advanced degree in social sciences, public Health or development
- Thorough knowledge and experience of the Health sector issues in Tanzania
- Excellent report writing skills
- Familiarity with strategic approaches and planning
- Experience with Monitoring & Evaluation of organizational plans

## 8.0 Work Days ordered

This assignment will be undertaken for three months (90 days) to be completed starting from 11th August to 10th November 2011.

**Annex 2: Data collection tools**

## Human Resources Strategic Plan – Evaluation-Interview Guide for District Level Key Informants ( District Health Secretaries/Hospital secretaries/DMO/CHRO/ RMO)

### 1. A: Strategy Relevance in relation to the existed context

1.1. What are you roles in relation to human resources management in the council

1.2. What guides your actions regarding human resource for health management in the council ( HRH STRATEGIC PLAN,MAMM, STAFFING LEVEL GUIDE)

1.3. What do you know about Human Resource for Health Strategic Plan? Do you have a copy (2008-2013)

1.4. As far as you can remember, what were the reasons for developing the HRHSP?

1.5. What were the key strategic issues that were being advocated to be addressed by the plan? Why these?

### 2. B: The strategy design

2.1. Were you involved during Strategy development? ( If participated continue with the following question 2.2 It not go to section 3)

2.2How was Implementation designed – in terms of

2.1.1. Financing

2.1.2. The coordination private (PFP and PNFP) and public

2.1.3. Monitoring

2.1.4. Learning (How was it planned?) How could the lessons be communicated to other actors?

2.1.5. Communication and dissemination ( What was the strategy for communicating and disseminating the HRHSP to stakeholders?)

2.2. What were the

2.2.1. strengths and

2.2.2. challenges in relation to the design

2.3. Do you think the current plan is actually addressing the real HRH problems?

2.4. If not, what do you think have been left out and why?

### *3.* C: Strategy Implementation

3.1. How did you translate the national HRHSP into action in your districts.( Look for evidence CCHP/or other documents)

3.2. What did you plan to accomplish as part of implementing the national HRHSP?

3.3. What has been accomplished so far in each strategic area ***(use the implementation assessment matrix and implementation matrix)***

3.4. In your opinion, what are the short falls in implementation of the strategy?

*3.5.* What do you recommend to improve the implementation of the HRHSP ?

**4. D: Learning**

4.1. In the whole period that the strategy has been implemented, what are the lessons learned?

4.2. Do you document these lessons?

4.3. Do you communicate these lessons to mother stakeholders? ( Probe for examples )

***Thank you for your time?***

**INTERVIEW GUIDE FOR NATIONAL LEVEL MINISTRIES.**

**5. A: Strategy Relevance in relation to the existing context**

5.1. What do you know about Human Resource for Health Strategic Plan?

5.2. What were the reasons for developing the plan? Including the context (Probe for; local political will, external donor community push, local civil society push, government financial status etc.)

5.3. Do you think this strategy is still relevant? Why do you think so?

**6. B: The strategy design**

6.1. During Strategy development

6.1.1. Who (actors) got involved and why? (probe if there were also efforts to involve health providers, community through representative organs such as CHSB and HFGC etc).

6.1.2. How were they involved? (mechanism)

6.1.3. What were the actors' expected roles in implementation

- MOH
- Other Ministries
- Government departments and programs
- Regions and districts
- Development partners ( Bilaterals, NGOs, FBOs and Private)

6.1.4. How were you, / Directorate / department involved? (Ask Programs/other departments/Other ministries

6.2. How was the Implementation designed – in terms of

6.2.1. Financing ( strengths and weaknesses)

6.2.2. Mechanisms for coordination of all actors (Joint meetings, Reporting, working groups etc)- (Strengths and weaknesses)

6.2.3. Mechanisms for communicating and disseminating good practices Communication and dissemination (strengths and weaknesses)

6.3. Does this plan address the HRH problems: Yes why and No why?

*6.4.* What could have been done differently in designing this strategy to avoid the current shortfalls that you have pointed out? (Use stated weaknesses as a reference)

***7.*** **C: Strategy Implementation**

7.1. How was the HRHSP translated into actions?

7.1.1. Annual implementation Plans including all actors and their strategic areas

7.1.2. Were the various actors roles identified during strategy development reflected in the implementation plan?

7.1.3. Resource mobilization

7.1.4. Advocacy

7.1.5. Dissemination of the strategy Inclusion of pilot phase before national wide implementation (in terms projects)

***7.2.*** What is accomplished so far (Refer to the matrix assessment of implementation matrix and MOH HRHSP implementation matrix)

***7.3.*** Did each actor play their role as expected? If no why?

7.4. To your opinion, what are the short falls in implementation of the strategy?

7.5. What should be done differently to avoid the current shortfalls

**8. D: Learning**

8.1. (If there was a monitoring plan ASK) Did the monitoring plan include specific learning questions?

8.1.1. If yes, what are those learning questions?

8.1.2. In the whole period that the strategy has been implemented, what are the lessons learned base on those questions?

8.2. (If there was no monitoring plan mentioned ASK) How lessons are gathered in assisting decision making and/or policy change to fit well the strategic plans?

8.3. What lessons have been documented so far?

8.4. In both cases (4.1 and 4.2 – ASK)

8.5. How these lessons are communicated?

8.6. What actions have been taken based on the lessons (Probe if examples are available)

8.7. What was changed after those lessons were communicated?

8.8. How ere those changes incorporated to the existing strategy?

8.9. How were those changes communicated to various stakeholders and particularly to various levels of the health system? Has there been any follow up to see if the communicated changes are really being implanted? To your opinion, what are the

8.9.1. Strengths and

8.9.2. Challenges of the mechanisms laid down for tracking lessons learned from the implementation process of the strategy.

# Human Resources Strategic Plan – Evaluation- Interview Guide with Development Partner

**9. A: Strategy Relevance in relation to the existed context**

9.1. What do you know about Human Resource for Health Strategic Plan?
9.2. Do you have a copy
9.3. What were the reasons for developing the plan?
9.4. What was actually the context at that particular time? (Probe for; local political will, external donor community push, local civil society push, government financial status etc.)
9.5. What are the key strategic issues that were being advocated to be addressed by the plan? Why these?

**10. B: The strategy design**

10.1. Were you involved in the development of this strategy?
10.2. Why do you think you got/not involved?
10.3. How were you involved?
10.4. What role did you play in the development process?
10.5. Did you have specific strategic areas of interest?
10.6. What are these?
10.7. How was the Implementation designed – in terms of
  10.7.1. Financing
  10.7.2. Mechanisms for The coordination
  10.7.3. Mechanisms for communicating and disseminating good practices / lessons learnt Communication and dissemination
10.8. Does this plan address HRH problems? Yes Why or no Why
*10.9.* What do you recommend for improvement?

***11.* C: Strategy Implementation**

11.1. How was the HRHSP translated into actions?
  11.1.1. Annual implementation Plans including all actors and their strategic areas
  11.1.2. Were the various actors roles identified during strategy development reflected in the implementation plan?
  11.1.3. Resource mobilization
  11.1.4. Advocacy
  11.1.5. Dissemination of the strategy
  11.1.6. Inclusion of pilot phase before national wide implementation (in terms projects) Refer
11.2. Did each actor play their role as expected? If no why?
11.3. To your opinion, what are the short falls in implementation of the strategy?
11.4. What should be done differently to avoid the current shortfalls

11.5. What is accomplished so far (Refer to the matrix assessment of implementation matrix and MOH HRHSP implementation matrix)

11.6. To your opinion, what are the short falls in implementation of the strategy?

11.7. What should be done differently to avoid the current shortfalls

**12. D: Learning**

12.1. How lessons were gathered and communicated

12.1.1. By the Ministry

12.1.2. By other actors

12.1.3. By your organization

12.2. How lessons learned influence strategic decisions in implementation

12.3. What lessons have you documented so far?

12.4. How did you communicate and what was the influence?

12.5. What actions have been taken based on your lessons (Probe if examples are available)

12.6. To your opinion, what are the

12.6.1. Strengths and

12.6.2. Challenges of the mechanisms laid down for tracking lessons learned from the implementation process of the strategy.

## Annex 3: List of People Contacted

### Regional and District level

1. Dr. Beatrice Jane Byalugaba - RMO Coast
2. Ms Money Goodluck –Health Secretary Mkuranga
3. Ms Pili Ndauka –DNO-Mkuranga
4. Mr. Marcelino Pesambili-Health Secretary Mkuranga
5. Ms Tunu Abdallah - Health Secretary –Kisarawe
6. Mr Adam Lyatuu – Health Secretary Tanga Region Hospital
7. Dr Rajabu Malahiyo-medical Officer in charge Muheza DDH
8. Dr. Tom Mtoi- DMO Lushoto
9. Dr Salim Yaterti – DHIS Focal Person Lushoto
10. Dr. Waziri Juma Semarundu-Ag DMO –Same
11. Mrs Faustina Banduka –Health Secretary- Moshi DC
12. Mr. Leonard Msami-Regional Health Secretary Kilimanjaro Regional Hospital
13. Mr. Dia Ally District Health Secretary Kilombero District
14. Mbwana Abdallah Mbelwa -District Health Secretary Kilosa District Council
15. Zulkanaani Ikaji DMO Nanyumbu District
16. Salma Marijani District Health Secretary Nanyumbu District
17. Ibrahim Bulugu – District Nursing Officer Nanyumbu District

**National Level**

18. Ms Ziana Mlawa –Assistant Director Administration-MOHSW
19. Mrs Elikanaan Mwakalukwa-Assistant Director HR- MOHSW
20. Mr.Hussein Mavunde-Stastician/ Team Leader SO 1 and 6
21. Mr. Bernard Konga –Assistant Director Planning and Budgeting/Team Leader SO 7
22. Mr. Henry Makoi- Administrator/ Team Leader SO 2 and 4
23. Shizu Takahashi –JICA Project Coordinator
24. Hisahiro Ishijima-JICA Chief Advisor
25. Dr.Adeline Nyamwihura- Programme Manager Capacity Development –BMAF
26. Ms. Rahel Sheiza-Director of Programmes –BMAF
27. Dr Joseph Komwihangiro –Health 7 HIV/AIDS Advisor CIDA.
28. Dr. Gilles de Margerie- Senior Health & HIV/AIDS Advisor
29. Dr. Bjarne Olshoj Jensen- Health Systems Strengthening Advisor MOH&SW