THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

# HUMAN RESOURCE FOR HEALTH AND SOCIAL WELFARE STRATEGIC PLAN 2014 - 2019

Ministry of Health and Social Welfare
6 Samora, Machel Avenue
11478, Dar es Salaam

September 2014

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# List of Abbreviations

| | |
|---|---|
| AAS | ASSISTANT ADMNISTRATIVE SECRETARY |
| BCC | BEHAVIOUR CHANGE COMMUNICATION |
| BMAF | BENJAMIN MKAPA HIV/AIDS FOUNDATION |
| CHMT | COUNCIL HEALTH MANAGEMENT TEAM |
| CPD | CONTINUED PROFFESIONAL DEVELOPMENT |
| DHS | DISTRICT HEALTH SECRETARY |
| EPI | EXPANDED PROGRAM ON IMMUNIZATION |
| ESL | ENTERSOFT LIMITED |
| FBO | FAITH BASED ORGANIZATION |
| HIV/AIDS | HUMAN IMMUNE DEFFICIENCY VIRUS/AQUIRED IMMUNE DEFFICIENCY SYNDROME |
| HMTs | HOSPITAL MANAGEMENT TEAMS |
| HRHSP | HUMAN RESOURCE FOR HEALTH STRATEGIC PLAN |
| HRH&SW | HUMAN RESOURCE FOR HEALTH AND SOCIAL WELFARE |
| HRHIS | HUMAN RESOURCE FOR HEALTH INFORMATION SYSTEM |
| HRHDP | HMAN RESOURCE FOR HEALTH DEVELOPMENT PROJECT |
| HRHTWG | HUMAN RESOURCE FOR HEALTH TECHNICAL WORKING GROUP |
| HSSP | HEALTH SECTOR STRATEGIC PLAN |
| ITNs | INSECTICIDE TREATED NETS |
| JICA | JAPAN INTERNATIONAL COOPERATION AGENCY |
| NMCP | NATIONAL MALARIA CONTROL PROGRAM |
| MDAs | MINISTRY, DEPARTMENTS AND AGENCIES |
| MDGs | MILLENIUM DEVELOPMENT GOALS |
| MoF | MINISTRY OF FINANCE |
| MoHSW | MINISTRY OF HEALTH AND SOCIAL WELFARE |
| MoEVT | MINISTRY OF EDUCATION AND VOCATIONAL TRAINING |
| MMR | MATERNAL MORTALITY RATIO |
| MMAM | MPANGO WA MAENDELEO WA AFYA YA MSINGI |
| MVC | MOST VULNERABLE CHILDREN |

| | |
|---|---|
| NACP | NATIONAL AIDS CONTROL PROGRAM |
| NACTE | NATIONAL COUNCIL FOR TECHNICAL EDUCATION |
| NCPA | NATIONAL COSTED PLAN OF ACTION |
| NTLP | NATIONAL TUBERCULOSIS AND LEPROSY PROGRAM |
| OPRAS | OPEN PERFOEMANCE APPRAISAL SYSTEM |
| PHSDP | PRIMARY HEALTH SERVICES DEVELOPMENT PROGRAM |
| PMORALG | PRIME MINISTER'S OFFICE REGIONAL AND LOCAL GOVERNMENT |
| POPSM | PRISIDENT'S OFFICE PUBLIC SERVICE MANAGEMENT |
| PMTCT | PREVENTION OF MOTHER TO CHILD TRANSMITION |
| RHMT | REGIONAL HEALTH MANAGEMENT TEAM |
| RMO | REGIONAL MEDICAL OFFICER |
| RRH | REGIONAL REFFERAL HOSPITALS |
| SWTIs | SOCIAL WELFARE TRAINING INSTITUTIONS |
| TCU | TANZANIA COMMISSION FOR UNIVERSITIES |
| TIIS | TRAINING INSTITUTION INFORMATION SYSTEM |
| TI | TRAINING INSTITUTION |
| UDSM | UNIVERSITY OF DAR ES SALAAM |
| USAID | UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT |
| WHO | WORLD HEALTH ORGANIZATION |

# Glossary

Human Resources for Health (HRH - synonyms are health manpower, health personnel, or health workforce). HRH denotes persons engaged in any capacity in the production and delivery of health services. These persons may be paid or volunteers, with or without formal training for their functions, individuals engaged in the promotion, protection, or improvement of population health, including clinical and non-clinical workers.

Human resources planning "...is the process of estimating the number of persons and the kinds of knowledge, skills, and attitudes they need to achieve predetermined health targets and ultimately health status objectives" (WHO, 1978). Over the years this function has been broadened to include that of formulating human resources policy, in which the word "policy" refers to statements made by relevant authorities that are intended to guide the allocation of resources and effort. Health services and human resources policies constitute key instruments for implementing decisions affecting the delivery of health care.

Human Resources Production refers to "all aspects related to the basic and post-basic education and training of the health labour force. Although it is one of the central aspects of the health manpower (development) process, it is not under the health system's sole control" (WHO, 1978). The production system includes all the health system's educational and training institutions, which are increasingly the joint responsibility of service and educational institutions.

Human Resources Development (HRD) is the process of developing and improving the capacity, ability, skills and qualifications of an organization's staff to a level required by the organization to accomplish its goals. As applied to human resources for health (HRH), it includes the planning, production, and post-service training and development health personnel.

Human Resources Management has been defined as the "mobilization, motivation, development, and fulfilment of human beings in and through work" (WHO, 1978). It "... covers all matters related to the employment, use, deployment and motivation of all categories of health workers, and largely determines the productivity, and therefore the coverage, of the health services system and its capacity to retain staff" (Ibid). Typical HRM functions include recruitment, staff performance evaluation, work analysis and the development of position descriptions, remuneration policy and practice, and occupational health and safety policy and practice. Strategic HRM is the development and implementation of personnel policies and procedures that directly support the achievement of an organization's goals and objectives.

Labour Market is an informal market where workers find paying work, employers find willing workers, and where wage rates are determined. Labour markets may be local or national (even international) in their scope and are made up of smaller, interacting labour markets for different qualifications, skills, and geographical locations. They depend on exchange of information between employers and job seekers about wage rates, conditions of employment, level of competition, and job location (Business dictionary. com)

Operational Planning: is related to the implementation of the strategies on a day-to-day basis for example, if training more staff is the strategy selected for improving staffing in remote facilities; the operational planning would include the start date for training courses and the number of tutors needed. (Martineau and Caffrey, 2008) Workforce plan: is an integral part of the strategic plan, it enables senior managers to scan and analyse human resources (HR) data routinely, determine relevant policy questions and institute policies to ensure that adequate numbers of staff with appropriate skills are available where and when they are needed. Workforce planning supports the overall HRH strategic plan within the constraints of available resources. This usually has significant implications for training and the planning for training institutions or recruitment campaigns if suitable prospective staff exists in the labour market (King and Martineau, 2006)

Health Workers Productivity: percentage of observed time spent doing one of the eight "productive" activities including: Direct patient care; Indirect care; Outreach; Administration; Meetings; Training; Cleaning, preparation, Maintenance; and Personal hygiene (The Zanzibar Health Care Worker Productivity Study, 2010)

# Foreword

Human Resource for Health (HRH) is a key component for delivery of quality health and social welfare services to all the people wherever they are. Yet, most countries suffer serious shortages of this important component. In Tanzania, the shortage of HRH&SW is now considered and dealt with as a national crisis requiring continuous and collaborative attention.

This strategic plan provides a framework and clear path toward the attainment of adequate and competent health and social welfare workforce that is motivated and equitably distributed to all parts of the country. Five core values identified in the document require serious attention if this plan is to be turned into a reality which will benefit the people of Tanzania. These are:

- Production of quality workforce with competence and skills mix that commensurate with demand of the time
- Distribution of health workers equitably to all levels in right numbers, with right skills at the right time
- Ensure continuous provision of incentives to all health workers at the right time to stimulate work commitment and performance
- Ensure constant supportive supervision and performance monitoring and evaluation for skills improvement and rewards
- Guaranteed working environment that promote attraction, retention and performance of health workforce at all levels and all places

This Strategic Plan has been developed with a view to creating an enabling environment to promote participation of key Human Resource for Health and Social Welfare stakeholders in addressing human resource crisis in the health sector. It categorise HRH&SW issues and challenges into the six key areas to facilitate the measurement of expected results. These are: HRH planning and policy, HRH&SW research, Leadership and Advocacy, HRH&SW management, Production and Quality of HRH&SW, and Partnership. It is the hope of the government that effective intervention and inputs to the aforementioned areas will enable attainment of the expected HRH targets identified in this strategic plan.

Moreover, it is important to notice that this strategic plan is based on what we know today. Since change is constant, we can only hope for the better given our current situation. Nevertheless whatever these changes will bring in, we must be prepared and determined to adjust our plan so that it will continue to be a guiding light for the effective and efficient production and use of our health workforce to provide better health and social welfare services to all the people we serve.

*Dr. Donan W. Mmbando*

Chief Medical Officer

# Acknowledgement

The government through the Ministry of Health and Social Welfare (MoHSW) extends its outmost appreciation for the generous contributions, support, commitments and efforts put forth by all involved institutions and individuals to ensure success in the development of this Human Resource for Health strategic plan. Indeed, their tireless involvements in the open and participatory processes have made possible the accomplishment of this strategic plan. Though the space does not permit to mention them all, we are thankful so much to all of them.

Specifically, the government is indebted to JICA for their financial assistance, guidance and support provided throughout the process. It is worth to mention Mr. Hisahiro Ishijima- Chief Advisor, HRH Development Project, Nobuko Yamagishi- the project coordinator, Violeth Solomon- the project technical assistant for their time and dedication to this work.

Special appreciations are extended to all MOHSW staff for their valuable contribution in providing and facilitating access to very useful information and technical guidance. In particular we would like to thank you Mr. Martin Mapunda-the acting assistant Director Human Resources Planning, Hussein Mavunde-Coordinators of Human Resources Planning, and Renatus Mashauri-coordinator of Quality assurance for Health, for their tireless involvement in the interpretation and processing of most important HRH data.

The government wish to acknowledge the contribution of experts from WHO Country Office Dr. Martins Ovberedjo, MS Jennofer Macais from Intrahealth capacity project, CDC, I-TECH, GIZ, APHFA, SIKIKA, CSSC, USAID and Mkapa foundation for their time and dedication to this work. Their support was given at an opportune moment when validation, rationalization and critical analysis of the contents of the Draft Strategic Plan were being conducted.

Last but not least, we would like to express our sincere gratitude to our consultants Dr. Henry A. Mollel and Mrs. Hadija Kweka from Ifakara Health Institute for their technical expertise. Their immeasurable contribution and guidance throughout the process have greatly added value to the quality of this strategic plan.

It is our strong belief and conviction that the strategies set out in this Human Resource for Health Strategic Plan will effectively address the human resource crisis in the country for the improvement of health and social welfare of Tanzanians.

*Dr. Otilia F. Gowelle*

Director of Training and Human Resource Development

# Executive Summary

This Human Resource for Health and Social Welfare Strategic Plan sets out strategies and options for implementation from 2014 to 2019. The strategies focus on moving the country from the HRH&SW crisis to the improved HRH&SW situation in the country. Overall, the Plan guides the health sector in proper planning, development, management and effective utilization of human resources.

There has been much achievement in the implementation of the previous HRH strategic plan 2008-2013. The remarkable achievement includes expansion of health and social welfare training institutions, increasing enrolment, transformation to competence based curriculum by health training institutions, opening of the closed down training institutions, and reduction of the HRH&SW shortage to the current 52%, just to mention but a few. However, as the shortage level indicates, there is still much to be done to increase the quantity, quality, and utilization of HRH&SW. As geographical distribution favours urban areas, special attention is required in rural areas.

The development process of this plan followed participatory and interactive approaches for purposes of ensuring comprehensiveness and wider ownership. It involved reviews of various relevant documents, series of consultations and interviews with key informants, and working sessions with multi-level stakeholders, including key staff from the Ministry of Health and Social Welfare (MoHSW), Prime Minister's Office Regional Administration and Local Government (PMORALG), Ministry of Finance (MoF), and President's Office Public Service Management (POPSM). Other stakeholders were from Development Partners, Major Programs, Governmental and Non – Governmental Institutions, Professional Councils and Associations, Private Sector, Regional and Councils Health Management Teams (HMTs/CHMTs) and health workers. The Plan had finally to incorporate the HRH Production Plan 2014-2024, which was developed using the Supply, and Requirements Projection Model developed by WHO.

The plan identifies six Strategic Objectives that will be the focus of achievement in the next five years. These are:

1. Strengthen HRH&SW policy development and planning at all levels
2. Strengthen HRH&SW research and utilization at all levels
3. Promote leadership and advocacy for HRH&SW at all levels
4. Strengthen HRH&SW recruitment, retention, career development and utilization at all levels
5. Increase and standardize production and quality of HRH&SW
6. Strengthen/promote partnerships and coordination of HRH&SW interventions among stakeholders at all levels

These strategic objectives are translated into a number of operational strategies, long-, medium- and short-term targets and activities for accomplishment. Performance indicators are further established for measuring performance of the program and progress against the set objectives and targets as part of ongoing monitoring and evaluation.

The successful implementation of the strategic plan will highly depend on continuous commitments and collaborative efforts of key stakeholders from government sector, non-governmental sector and development partners. It also requires dedication and focus of staff and managers of relevant ministries and the health sector in particular to stimulate, energize and coordinate the incoming efforts to produce results in the short-, medium- and longer-term. Creating demand to improve utilization by end-users, including individuals, households and communities will be a crucial part of measuring success of implementation.

# Chapter One:

## Introduction

Human Resources for Health (HRH) are a very important component of the health sys¬tem in any country. Recently HRH has received much attention because of challenges associated with obtaining, maintaining and managing health workers for effective and efficient functioning of the health system. The global shortage and crisis in HRH has been increasingly recognized as a factor crippling health systems and jeopardizing curative, rehabilitative, preventive and health promotion efforts.

Health workforce is also known to absorb a great share of the health budget. This fact provides ground for giving more focused attention to HRH issues. Therefore, human resource planning is regarded as an entry point to define and address health workforce issues. This third strategic plan for HRH&SW in Tanzania is introduced with the aim of guiding the efforts and further work in developing human resource plans at different levels of the health system in a comprehensive approach that considers all dimensions of HRH&SW. The plan defines the priorities of HR issues; and accordingly recommends strategic goals and objectives to improve HRH&SW policies, planning, production, distribution and HR management systems to improve individual performance and training services.

The United Republic of Tanzania was highly committed in addressing HRH issues in the previous strategic plan. However, alleviating HRH crisis is a long-term endeavour needing clear milestones and addressing the health systems issues holistically. Tanzania still records a serious shortage of Human Resources for Health and Social Welfare (HRH&SW). The levels of shortage varied over time since independence in 1961, with the sharp increase of the crisis being observed between 1994 and 2002 when the government implemented the civil service reforms policy of 1990s. Such policy reforms involved the retrenchment and employment freeze that focused on cutting down public expenditure. It also resulted to strict adherence to the wage bill, which restricted the amount of fund that can be allocated to most activities including the workforces' related issues. As a result of the policy reforms, the country's national health systems suffered extensively from loss of experienced and skilled health workers.

Other contributing factors to the sharp decline included: weak planning and forecasting of Human Resources for Health (HRH) requirements; inadequate involvement of key stakeholders, including end-users of the health care system in HRH planning and brain drain within and outside the country. The Ministry of Health and Social Welfare (MoHSW) acknowledges that the problem of brain drain is not well understood and thus calls for an urgent need to put in place a mechanism to monitor health professional's movement within and outside the country.

The severity of the problem made the government to announce the shortage of HRH- as national crisis; with intention to express its commitments and call for collaborative effort. The announcement stimulated development of strategies and intervention that focused on increasing production, quality and recruitment of HRH graduates. As a result a number of health training institutions were expanded to double the intake; enrolment of health cadres was increased almost to double; teaching and learning materials such as skills laboratories were equipped and improved; health curricula were changed from non to competence based; some of the closed down training schools such as Nachingwea Nurse Training School was opened also; Emergency Hiring Project was implemented. Despite such development HRH crisis remains a distant dream. In 2005-Joint Annual Sector Review Meeting, the Ministry of Health (MoH) reported the HRH crisis to have reached an emergency proportion. This is an indication that the shortage of HRH is still high- for reasons associated to higher demands on the health sector and higher attrition rates. To date, it is estimated that the shortage of Human Resources for Health is about 56%. The shortage varies across regions, districts and facilities. According to the MoHSW data, the shortage of HRH is more severe in rural areas.

Similarly, the Social Welfare commission, which was moved to the Ministry of Health in 2005, is also suffering the same human resource crisis. The extreme shortage of the social welfare staff is caused mainly by three factors: Retrenchment Policy of 1993, Decentralization Policy which required Social Welfare services to be rolled out to the lower levels which was previously rendered at Central and Zonal level. Similarly, the scheme of services does not allow employment of lower level Social Welfare cadres such as certificate and diploma holders. Since most of the graduates from the Institute of Social Work Dar es Salaam, the only institute that produces the degree level of social welfare cadres, are either absorbed in the private sector or unwilling to work at the lower levels, made the problem more complicated. Such, situation underscores the urgent need for appropriate strategies to address the problem.

## 1.1 Rationale for the Plan and Strategic Objectives

To date, the shortage of Human Resources for Health and Social Welfare remains a crisis in Tanzania. It has seriously impinged on various health initiatives and attainment of health goals. This strategic plan is therefore developed to call for more collaborative effort to address HRH crisis in the country. It provides guidance on key issues to be addressed in relation to HRH production, planning, development, management, utilization and monitoring of HR within the Health Sector and Social Welfare. The Strategic plan is also used as a coordinating and integrating instrument among various HRH&SW stakeholders. In overall, this plan facilitates the extension and sustainability of results obtained from implementation of previous HRH strategic plans. It is expected to contribute to the improvement of human resource financing by providing comprehensive budgets and identifying ways of mobilizing adequate resources from all stakeholders. As such it will assist the country to achieve the right number of health and social welfare workers, with the requisite knowledge and skills that are effectively managed and are equitably distributed to ensure that national health goals are attained. Currently, the health status of the country is as shown in the health indicators below;

***Table 1: Health Indicators***

| Indicators | Both sex | Male | Female | Source and Year |
|---|---|---|---|---|
| Life expectancy at birth | 55 | 53 | 56 | National Bureau of Statistics 2010 estimates |
| Crude Mortality rate | 38.1/1000 | - | - | National Bureau of Statistics 2010 estimates |
| Under-5 mortality rate | 81/1000 | - | - | DHS 2010. |
| Maternal mortality ratio (deaths per 100,000 live births) | - | - | 454 | DHS 2010. |
| HIV/AIDS prevalence rate (15-49 years) | 5.7% | 4.6% | 6.6% | 2011/12 Tanzania HIV/ AIDS and Malaria Indicator Survey |
| % with access to safe water | 81.4% urban<br>46.7% rural | - | - | Tanzania in Figures 2010 |
| % with access to improved sanitation | 29.3% urban<br>8.7% rural | - | - | Tanzania in Figures 2010 |
| Infant mortality rate | 51/1000 | - | - | DHS 2010 |

Source: MoHSW

## 1.2 Burden of Disease and Main Causes of Death

High burden of disease remains a major challenge facing the health sector. The life expectancy has remained below 55 years on average. In spite of a decline in infant and under five mortality, overall Maternal Mortality Ratio (MMR) and prevalence of other major diseases like HIV/AIDS, Malaria and Tuberculosis remain high. New interventions such as Prevention of Mother to Child Transmission (PMTCT), Counselling and Testing, distribution of Insecticide Treated Nets (ITNs) has significantly increased health staff workload. In addition local and international governmental and non-governmental agencies and Programs involved in research and implementation of these interventions continue to take away staff from traditional health service delivery. The workforce requirements of most of these Programs are not provided for in the current staffing levels. The country also faces high incidence of non-communicable conditions such as cancers, diabetes, malnutrition and cardio-vascular diseases. Table 2 shows the main causes of morbidity and mortality in the country. The causes suggest the need for more health and social welfare workforce with skill mix.

*Table 2: Main causes of morbidity and mortality*

| Condition | Under five years (%) | | Condition | Five years and above | |
|---|---|---|---|---|---|
| | Outpatients attendances | Deaths among admissions | | Outpatients attendances | Deaths among admissions |
| Peri-natal and Neonates Conditions | | 15.5 | Vitamin A Deficiency/ Xerophthalmia | | 42.8 |
| Cardiac Failure | 0.1 | 14.0 | Hepatitis | 1.4 | 23.0 |
| Severe Protein Energy Malnutrition. | | 11.9 | Cardiac Failure | | 14.9 |
| HIV/AIDS | | 11.4 | GUD | 0.4 | 8.9 |
| Congenital Diseases | | 10.9 | Other Cardiovascular Diseases | 0.5 | 8.8 |
| Haematological Diseases | | 8.9 | Tuberculosis | 0.1 | 8.1 |
| Other Nutritional Disorders | 0.1 | 7.2 | Severe Protein Energy Malnutrition | | 7.7 |
| Neoplasm | | 7.2 | Hypertension | | 6.5 |
| Diabetes Mellitus | | 5.9 | Nutritional Disorders | | 5.2 |
| Tuberculosis | 0.3 | 5.0 | Anaemia | 2.0 | 5.2 |
| Anaemia | 1.7 | 4.7 | Pneumonia | | 4.9 |
| Non-Inf. Gastrointestinal Diseases (Others) | | 4.6 | Bronchial Asthma | | 3.9 |
| Other Cardiovascular | | 4.4 | Sickle Disease | | 3.5 |
| Sickle cell Disease | | 4.3 | Neuroses | 0.2 | 3.4 |
| Poisoning | 0.1 | 3.9 | Respiratory Disease | | 3.2 |
| Burns | 0.3 | 3.9 | Malaria-Severe, Complicated | | 2.6 |
| Pneumonia | 9.5 | 3.2 | Ear Infections | 1.3 | 2.1 |
| Snake and Insect Bites | | 3.2 | Psychoses | 0.7 | 2.0 |
| Malaria- Severe, Complicated | 34.6 | 2.7 | Epilepsy | | 1.9 |

Source MoHSW

## 1.3 Social Welfare Issues

There has been a rapid increase of social problems in Tanzania stimulated by a number of factors such as high population growth, socio-cultural changes, HIV/AIDS pandemic and poor socio- economic trends. The situation today is such that Social Welfare services are in great demand due to these increasing social problems, which are exacerbated by poverty, and the effects of HIV/AIDS. To date, the specific problems which need social welfare services interventions include child labour, early pregnancies, child abuse, child neglect and family rejection, alcohol and drug abuse, increasing levels of destitution, commercial sex (prostitution), cases of sexual assault, number of households headed by children and or elderly people. Other increasing social problems include family disintegration, marriage breakages, number of street children, number of orphans, vulnerable children, widows/widowers, elderly and human trafficking especially children, increasing number of children in conflict with the law, child truancy and single parenting.

Despite the fact that Social Welfare Commission has been in existence for many years there has not been much success in dealing with the identified social problems due to inadequate resources including human resource, infrastructure, finance and working facilities. This HRH&SW Strategic Plan provides a platform for improving Human Resources for Social Welfare, which is one of the key components for reduction of social stress contributing to poor health and, therefore, the plan contributes to attainment of better health for all.

## 1.4 Brief Overview of HRH Strategic Plan in Tanzania

In Tanzania, the first HRH Strategic Plan was developed 1996 and implemented between 1996 and 2001. The focus of the plan was mainly to elevate HRH issues to be recognised in the health sector reforms and decentralization. One of the major results of the plan has been the devolution of primary health services (i.e. district hospitals, health centres, dispensaries and other community based health services) including management of HRH to the local government authorities.

The second HRH strategic plan was developed in 2008 for the period 2008-2013. Unlike the previous strategic plan, the 2008-2013 HRHSP received attention of many stakeholders from government, nongovernmental institutions and international communities. It reinvigorated and complemented the efforts of the government through the Ministry of Health and Social Welfare (MoHSW) in addressing the crisis. The accomplishment of planned activities was about 70%. This success is the product of strong partnership of HRH actors- Table 3 illustrates accomplishment of activities by strategic objectives.

***Table 3: Accomplishment status of activities planned in HRHSP 2008-2013***

| Strategic Objectives | No of Strategies | Number of Planned Activities | Activities Implemented | Activities not implemented |
|---|---|---|---|---|
| SO 1: To improve Planning and Policy Development Capacity | 4 | 38 | 27 | 11 |
| SO 2: To Strengthen Leadership and Stewardship in Human Resources | 2 | 12 | 7 | 5 |
| SO 3: To improve Education, Training and Development for Human Resources | 5 | 53 | 52 | 1 |
| SO 4: To improve Workforce Management and Utilization | 9 | 36 | 22 | 14 |
| SO 5: To build and Strengthen Partnership in HRH | 3 | 10 | 4 | 6 |
| SO 6: To Strengthen HRH Research and Development | 1 | 8 | 2 | 6 |
| SO 7: To Promote Adequate Financing for HRH Strategic Plan | 1 | 5 | 1 | 4 |

Thus, the development of HRH&SW strategic plan 2014-2019 builds on the two previous plans. It is enriched from the lessons learned and experiences gathered from implementation of the two HRH strategic plans.

## 1.5 Process for Development of HRH&SW Strategic Plan 2014-2019

The development of this strategic plan was interactive and participatory. It began with the assessment of the current situation to identify the existing HRH gaps and key issues that required new strategies. The situation analysis involved stakeholders' consultation and review of relevant literature. The stakeholders were drawn from three levels, namely: local government levels, regional level and national level. The selected informants comprised of health services providers, implementers of various health and social welfare initiatives, Health and Social Welfare managers, beneficiaries, health and social welfare development partners, and policy makers. The information of the current situation was analysed and categorised into six thematic areas, namely: HRH Planning and Development; Education, Training and Development; Leadership and Advocacy; Management and HRH utilization; Research and Development; Partnership for Human Resource for Health. Each of the thematic areas covered four consistent information regarding strengths, weaknesses, opportunities and threats.

To ensure ownership and comprehensiveness of the plan, the situational analysis was conducted with the aid of the Core Group formed to undertake the process. The core group comprised of the key relevant staff from the MoHSW. Figure 2 illustrates the process for development of the 2014-2019 HRH&SW strategic plan.

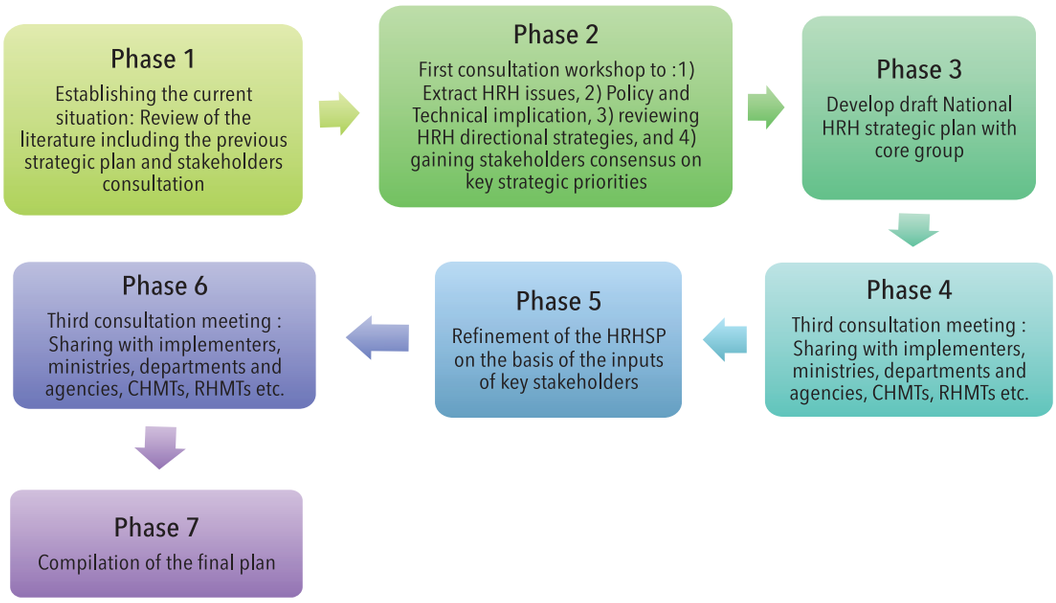



***Figure 1: The Process of Development of 2014-2019 HRH&SW Strategic Plan***

As shown in figure 1 the process involved seven phases. Each phase was interactive with either the core group (members from MoHSW) or with identified HRH key stakeholders. The involvement of stakeholders in all stages provided a broader spectrum for identification of HRH issues at all levels. As such, HRH&SW strategic plan 2014-2019 is more evidence-based and comprehensive.

As the HRH&SW Plan 2014-2019 was being developed, the HRH Production Plan (HRHPP) 2014-2024 was also being developed. The HRHPP is a detailed plan developed on the basis of the supply and requirements projections made by applying the Supply and Requirements Projection Model developed by WHO. The projections are made basing on demographic and macro-economic projections and expected changes in the pattern of diseases and the vision, aspirations and expectations of policy makers of health services and health system of the future to meet the changing disease pattern and demands of the population in terms of access and quality of health care. The HRHPP has been incorporated into the HRH&SW Strategic Plan 2014-2019.

# Chapter Two:

# Operational Environment

## 2.1 Policy Context

The commitment by the government and international communities to address health problems is revealed in a number of policies and strategies. Such policies and strategies also call for optimal human resources to meet the envisaged strategic goals. These directional strategies and policies have been used to provide a framework and guidance for the development of this strategic plan. They provided not only a focus and key issues of concerns by various stakeholders that have been taken into account in the development of this plan but also a sense of commitment that facilitate implementation. Some of such policies and guidelines are outlined as follows:

### *Millennium Development Goals (MDGs):*

The Millennium Development Goals aim at reducing child mortality by two-thirds, Maternal Mortality rate by three-quarters, combat HIV/AIDS Malaria and other diseases by controlling them by 2015. Human Resource strategic Plan has been developed to ensure availability of the necessary resources such as adequate health workforce to provide health services.

### *National Strategy for Growth and Reduction of Poverty:*

The strategy advocates for improvement in the quality of life and well being of all Tanzanians. Human Resource for Health and Social Welfare Strategic Plan to a great extent has identified effective interventions that will have a direct impact on quality of life and well being such as immunization for children and control of diseases by ensuring availability of skilled workforce to provide quality services

### *Tanzania Development Vision 2025:*

Tanzania Development Vision 2025 is a wider government official roadmap and a dream towards sustainable human development through achieving high quality livelihood for all. The vision identifies health and social welfare as a priority, and therefore the Human Resource Strategic Plan for Health and Social welfare has been developed to reflect vision 2025 for macro-policy linkage.

### *National Health Policy 2007:*

The National Health Policy aims at implementing national and international commitments. These are summarized through policy vision, mission, objectives and strategies. The Health Policy vision is to have a healthy community, which will contribute effectively to development of individuals and the country as a whole. The mission is to facilitate provision of basic health services, which are proportional, equitable, good quality, affordable, sustainable and gender sensitive. The Human Resource Strategic Plan seeks to implement strategies related to human resource as outlined in the policy.

### *Primary Health Services Development Program (PHSDP), 2007 – 2017:*

PHSDP aims at having a dispensary at every village, a Health Centre at every ward and a District Hospital at every District. The program requires the establishment and staffing of an additional 5162 dispensaries, 2074 health centres and 8 district hospitals. The Human Resource Strategic Plan compliments the effort to implement the program comprehensively through aligning all strategic factors related to human resources. Inculcating a care seeking behavior and increasing demand for services among communities is key to the success of the PHSDP. Evidences around the African continent show that providing health facilities and HRH within reach of the communities does not necessarily mean the community will automatically utilize the services. The demand must be generated through effective BCC strategies and this must be factored in the pre-service education and training of HRH. There are serious steps taken currently to increased community based services where formalization of community health workers is one of the key policy agenda

The MMAM Programme will be implemented with the Managed Primary Health Care approach by undertaking a systematic development of dispensaries, health centres and district hospitals. That is, construction of new health facilities will be undertaken with care, by first ensuring that those already constructed are provided with competent staff with appropriate skills-mix, adequate medical supplies and equipment so that they function optimally, strengthening the referral system.

### *Human Resource Policy Guidelines – 2005:*

Human Resource Policy major goal is to have a well-planned, trained deployed and motivated workforce. The Human resource Strategic Plan has set strategic intervention to address the policy goals

### *Social Welfare Policies and Legal Frameworks:*

There are various policies and frameworks governing the provision of social welfare services in Tanzania. Both policies and frameworks demonstrate the government's commitment and political will to extend social protection to all vulnerable groups. One of the key strategies emphasised in policy and framework documents focuses on strengthening the social welfare workforce. They stipulate that for effective implementation of the NCPA II and sustained provision of welfare services to the Most Vulnerable Children (MVC), Persons with Disability and The Elderly in Tanzania; it is crucially important to plan, train, develop, support, and manage the social welfare workforce.

The available policies and frameworks for social welfare services include the National Costed Plan of Action for Most Vulnerable Children NCPA II 2013-2017, The Law of the Child Act No.21 of 2009, The Law of Person with Disability act No.9 of 2010. Persons with Disability Act 2010, Disability Policy 2004 and the National Ageing Policy 2003.

### *Health Financing:*

The HRH Production Plan 2014-2024 which is incorporated into the HRH&SW Strategic Plan is based on some macro economic assumptions and projections in funding for the health sector. The Government is expected to introduce new financing mechanisms that will raise the level of available finance for health personnel from 62% in 2014 to 66% in 2019. The share of the public sector budget as a percentage of the GDP is assumed to increase minimally to 14.4% by 2019. With the projected average annual change of GDP of 6%, this will give an average increase in personnel expenditure of 8.2%, which will allow for increase in staff numbers, staff pay and benefits and retention of staff in rural areas.

## 2.2 Institutional Arrangements of the National Health Systems

The national health system operates in a decentralized system of governance. It is organised in a referral pyramid, made up of three main levels namely, I) district level, II) regional level and III) National Level. The classification of private health facilities follows the criteria of the national health system.

### *District Level:*

According to the current arrangement, the Local Government Authorities have full mandate for planning, implementation, monitoring and evaluation of health workers within the districts. The responsible structure for services delivery at this level is the Council Health Management Team (CHMT). The District Medical Officer (DMO) heads the CHMT as in charge of all District Health Services. The CHMT follows guidelines for planning and management of district health issued jointly by MOHSW, PMORALG and Ministry of Finance and Economic Affairs. The DMO is accountable to the Council Director on administrative and managerial matters, and responsible to the RMO on technical matters. The District Health Secretary (DHS) aids the DMO. The HRH needs for the districts are established in support of the CHMT by the management of the relevant health facilities i.e. dispensaries, health centre and the district hospital (or designated district hospital where the government owned hospital is not available) and forwarded to the council to be incorporated into the Comprehensive Council Health Plan. Once the plan is approved, it is the responsibility of CHMT to execute.

### *Regional level:*

The regional secretariat plays a linking role and oversight for Health services delivery in the region. At this level, the responsible structure for the Management of HRH issues is the Regional Health Management Team (RHMT) headed by the Regional Medical Officer. The RMO is the Assistants Administrative Secretary (AAS) of Health and therefore reports directly to the Regional Secretariat (RS). The RHMT is responsible for scrutinising the health plans in the region to ensure that they correspond to the national priorities and providing oversight to local governments. Besides, the RHMT provides technical support and oversight to the respective Regional Hospitals. The HRH issues such as acquisition and management are addressed through the Regional Referral Hospital Plan. The plan for the regional hospital is developed by the Regional Referral Hospital Management Team (RRHMT) and submitted to the regional secretariat of which RHMT is part, for scrutiny before it is forwarded to the relevant ministries.

### *National Level:*

The MoHSW is charged with the responsibility of ensuring the provision of quality health services in the country. To accomplish this responsibility, the Ministry's functions are divided into seven directorates, which include: Curative Services, Preventive Services, Human Resource Development, Policy and Planning, Social Welfare, Procurement and Supply and Administration and Personnel. As indicated in figure 1, these departments are further divided into sections for a more effective implementation as reflected in the organizational structure. Each of the department plays a crucial role in the management of HRH in terms of recruitment, promotion, development, retention, and utilization. It is important however to note that, though the Organization and Management of HRH functions are undertaken within the parameters of the MoHSW mandate, the overall management of the health system is a collaborative process that involves the Ministry of Health and Social Welfare (MoHSW); Presidents' Office Regional Administration and Local Government (PMO-RALG); the Ministry of Finance and Economic Affairs the Ministry of Education and Vocational Training. The President's Office Public Service Management (POPSM) controls all public sector employment and is responsible for determining and approving the pay and compensation packages and terms and conditions of employment in the public sector, Figure 2 shows the ministerial linkages of the overall management of the health system.

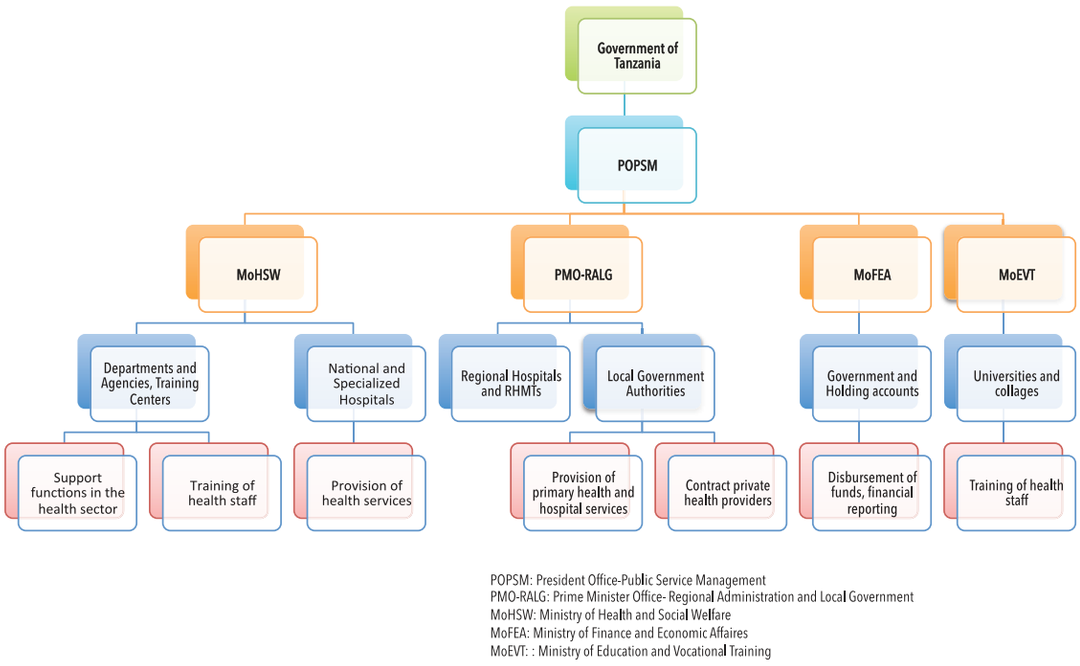



***Figure 2: Health System in the Overall Government Context (adapted from Health Sector Strategic Plan [HSSP III)***

Under the current arrangements, the MoHSW has oversight function for the collection and analysis of human resource information including provision of statistical estimates of present and future human resource requirements at all levels of the health system. In addition, the Ministry provides technical support to the local authorities and regions to achieve their human resources requirements. Also the Ministry formulates policies, regulation and standards. Within the framework of the ongoing local government reforms, the district authorities have responsibilities for delivering health services including full responsibility for human resource within their areas of jurisdiction. The human resource management framework involves an extensive process requiring multiple decision-making steps, which are occasionally, time consuming and slow.

Ministry of Health and Social Welfare through its Social Welfare Commission is charged with the responsibility of ensuring the enhancement of the provision of comprehensive, accessible, high quality social welfare services to the people. The department has set some strategic areas for intervention, among them are:- Enhancement of quality of life of vulnerable individuals, groups and families; Early childhood care and development; and facilitation of the transformation of social welfare services.

The Social Welfare Commission has been moved to the Ministry of Health since 2005, it is therefore necessary to realign and harmonize its direction and interventions to the ongoing reforms and the decentralization policy requirements. The functional activities will now be done under the following levels; Central (MoHSW), Regional Secretariats, Districts, and specialized institutions. The Social Welfare Commission works in close collaboration with Ministry of Home Affairs, PMORALG, Ministry of Education, and courts of law.

The MoHSW also oversees autonomous agencies, such as the Tanzania Food and Drugs Authority (TFDA), Medical Stores Department (MSD), the Government Chemical Laboratory Agency (GCLA), National Institute for Medical Research (NIMR), Tanzania Food and Nutrition Centre (TFNC) and National Health Insurance Fund (NHIF). The MoHSW collaborates with donors and nongovernmental organizations on the implementation of public health programmes such as the Immunization for Vaccine Development (IVD), Reproductive and Child Health (RCH), National AIDS Control Programme (NACP), National Malaria Control Program (NMCP) and the National Tuberculosis and Leprosy programme (NTLP). The MoHSW also oversees National Hospitals, Consultant and Specialized Hospitals.

Health Services Boards and various community health committees (Health Facility Governing Committees, Community Health Fund Committees etc) have been formed to ensure community involvement in health service delivery and also contribute to the formulation, monitoring and evaluation of health plans.

## 2.3 Relationship between the Public Health System and the Private Sector

The organization and management relationship between public and private sector is not well developed. Within the context of HRH management, the private and public sectors operate separately with minimal coordination. Planning, research, regulation, training, career path and compensation issues are also undertaken separately. The public sector staff has been seconded to support institutions providing Faith Based health services. In such instances, contracts have been managed within short-term parameters with government continuing the payment of salaries. Critical issues such as welfare benefits and related entitlement and tenure are often not clearly defined. Furthermore, the government provides grant in aid to FBO on contractual basis to support the running of the health facilities and training institutions depending on the priority needs. In addition, the government provides opportunities for in-service training to staff in both public and private/FBO sectors.

The training of health graduates professionals is done by Institutions of Higher learning under the Ministry of Education and Vocational Training. It involves working relationship between the institutions, MoEVT and the MoHSW. The contribution of non-governmental institutions in this area has been significant. As indicated in table 4, the institutions in the non-government sector have been providing a range of services that has largely complimented the government capacity to deliver health services in the country. Yet, the existing partnership between government and non-governmental institutions are inadequate to harness potentials of existing non-governmental institutions in the country. It is therefore crucial that partnership between the government and non-governmental institutions are strengthened to contribute more to the improvement of HRH&SW situation in the country.

***Table 4: Contribution of the private sector to the national health systems***

| Areas of Contribution | Facility |
|---|---|
| Service delivery | Hospitals |
| | Health Centres |
| | Dispensaries |
| Training | Universities |
| | Allied Health Training Schools |
| | Nursing Training Schools |
| | Institute of Social Works |
| | Day Care Training Institute |
| Research | Institutions |
| Social Welfare | Retention Homes |
| | Approved School |
| | Children's Homes |
| | Homes for Elderly |
| | Day Care Centres |
| | Drug/alcohol abuse counselling centre |
| | Marriage Reconciliation Boards |
| | Centres for Street Children |
| | Vocational Training and Rehabilitation Centres for Person With Disabilities |

***Source: MoHSW – HRH profile 2013.***

In addition to what is indicated in table 4, there are other facilities provided by the private sector as complementary to the government. Such facilities include: pharmaceutical shops and industries, laboratories, radiological centres, physiotherapy, Dental services, Waste management, ambulance and logistics, laundry, and catering, just to mention but a few. For effective and efficient function, these facilities require adequate available health workers.

# Chapter Three:

# Current Situation

## 3.1 Human Resources for Health Policy and Planning

### 3.1.1 HRH Planning

Considerable development is recorded in the area of HRH planning. This includes capacity development at national level, employment of health secretaries in all councils, as well as strengthening of information system. In an effort to ensure the production of human resources is focused and is in line with national priorities, a production plan has been developed. The plan is meant to guide HRH production in terms of numbers and cadres. Despite these successes there are several challenges. First the devolution of HRH planning role to other levels is limited. Councils concentrate more on Personnel Emolument budgeting rather than HRH planning in general. Therefore more emphasis is given to projection of staff numbers and less attention is given to issues like succession plan and staff retention. Another challenge is the limited collection and sharing of human resource information from the private sector. Furthermore, there is limited technical capacity for analyzing human resource demands and supply projections and forecast.

### 3.1.2 HRH Policy

The MoHSW has the mandate for coordinating policy formulation, guidelines, standards and the identification of priorities in the health sector. The MoHSW also regulates the activities of private health sector through setting and monitoring standards for quality of care and training. In the last five years several policy guidelines focusing on training, career pathways and staffing norms were developed and introduced. The challenges in this area include delays in finalising drafted policies and guidelines which have had negative effect in dissemination, limited emphasis on evaluation of existing policies and guidelines and low utilization of existing evidence in the development process of new policies. Furthermore harmonisation, cross-referencing and analysis of influence of these policies to HRH are limited.

### 3.1.3 HRH Information System

To better inform HRH policy and planning, efforts were made by HRH development partners recently to obtain sensible HRH data and information. With support from Japan International Cooperation Agency (JICA), two information systems have been developed called Human Resource for Health Information System (HRHIS) and Training Institution Information System (TIIS). The former is for health facilities and the later is for training institutions. HRHIS is installed in all regions, councils and referral hospitals, and TIIS in all training institutions and universities that produce health professionals. The systems are capable of assisting users to collect quality information and help them generate varieties of reports from individual staff reports to country aggregate. However the system is not without challenges. Some of the existing challenges in executing the systems include:

- Difficulties in collecting HRH data from private and Faith Based Organization's facilities
- Since the system is computerised- it is still challenging to some councils, which have not yet been connected to electric power supply.
- Familiarity of these tools by HR managers is minimal
- Motivation to utilize the system is low.

## 3.2 Health Workforce Profile and Distribution

In 2013 there were a total of 6,876 Health facilities in the country. Out of these 5,913 are dispensaries, 711 are Health centres, 219 district level hospitals, 25 are Regional Referral Hospitals and 8 National, zonal and specialized hospitals. According to the new Staffing levels guideline (2014), the minimum number of health workers required to provide quality health services in these facilities is 145,454. The actual number of health workers available is 63,447 and the shortage is 82,007, which is about 56.38%. The number of workers required in the Health Training Institutions is 4,325 and only 2,820 are available, the shortage of workers in the health training colleges is 1,505 or 34.79%. There is a great challenge of rapidly aging workforce, which will exacerbate the crisis.

On the part of social welfare, a total of 437 social workers are available in the country, which is 13% of the requirement. The available social welfare workers are distributed in various levels of the government departments and institutions. The number of social welfare workers deployed in the public sector differs between regions. This is determined by presence of relevant social service institutions and also the number of districts, which have already enlisted the cadres in their human resources recruitment needs.

Staff availability trend (2010/11-2012/13) for academic staff in training institutions is declining. To reduce the intensity of academic staff shortage, the health training institutions use part time teachers from nearby hospitals or from other institutions. Although this strategy helps to reduce burden to existing teaching staff, the capacity to engage teaching staff has been declining annually from 2010/11 to 2012/13- Figure 3.

***Table 5: HRHSW Available by level of care***

| Level of Care | Required | Available | Deficit | % Shortage |
|---|---|---|---|---|
| Health Service Delivery Facilities | 145,454 | 63,447 | 82,007 | 56.38% |
| Health Training Institutions | 4,325 | 2,820 | 1,505 | 34.79% |
| Total | 149,779 | 66,267 | 83,512 | 56% |

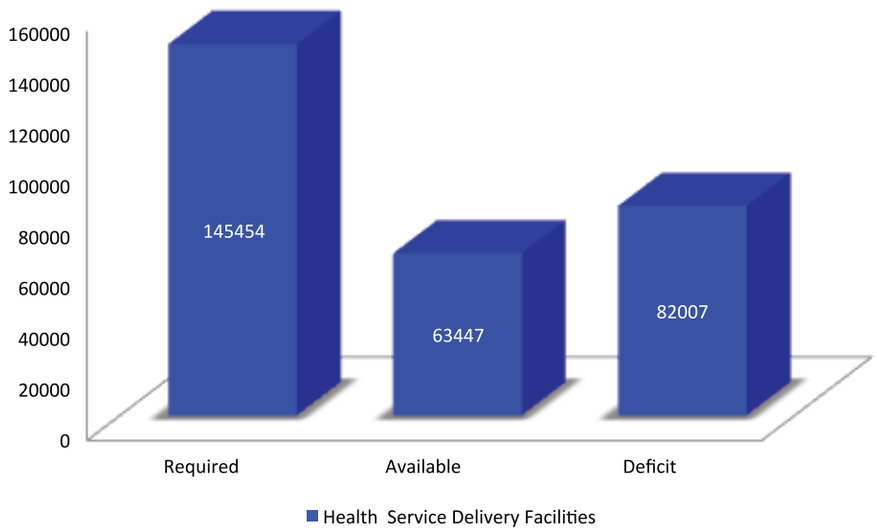



***Figure 3 (a): Availability of staff in health facility***

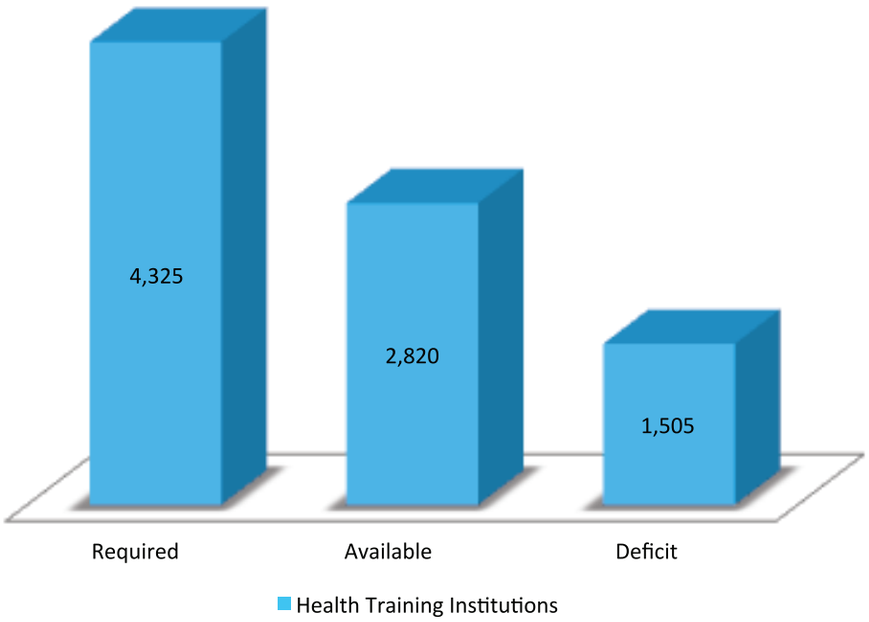



*Figure 3(b): Availability of staff in health training institutions*

The existing workforce is mal-distributed, the situation is worst in dispensaries. Many staff prefer to work in urban rather than rural areas due to poor working and living environment. There is a clear regional disparity with regard to HRH availability. Kilimanjaro, Dar-es salaam, Iringa, Lindi and Pwani are better off compared to regions such as Kagera, Rukwa, Tabora, Kigoma and Shinyanga. Health workers density ranges from 4/10,000 population to 10/10,000 population[1] - figure 4.

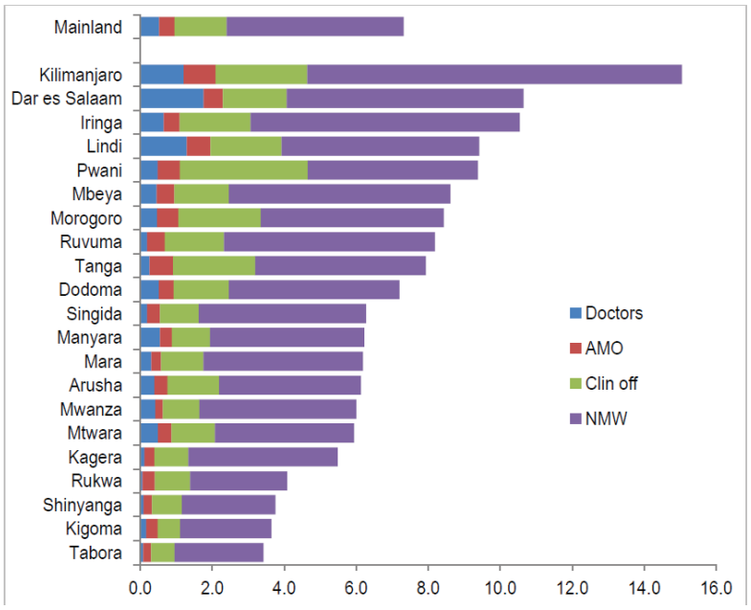



*Figure 4: Health workers Per 10,000 population by regions*

*Source: HRHIS*

1 MOHSW HSSP III Midterm evaluation report September 2013

## 3.3 Training and Development

### 3.3.1 Training Institutions

There are 153 registered training institutions, which offer various training programs for health and social welfare workers. The non-degree level programs for health professionals fall under the Ministry of Health and Social Welfare and accredited by the National Council for Technical Education (NACTE) which is responsible for setting entry qualification and educational standards. The degree programs are under the Ministry of Education and Vocational Training and are regulated by the Tanzania Commission for Universities (TCU). The private sector has a growing number of training institutions in the health sector; and the recent years witnessed an increase in number of private for profit health human resources training facilities. Table 7 shows the number, programs offered and ownership of health training institutions in the country.

*Table 6: Health Training Institutions by ownership*

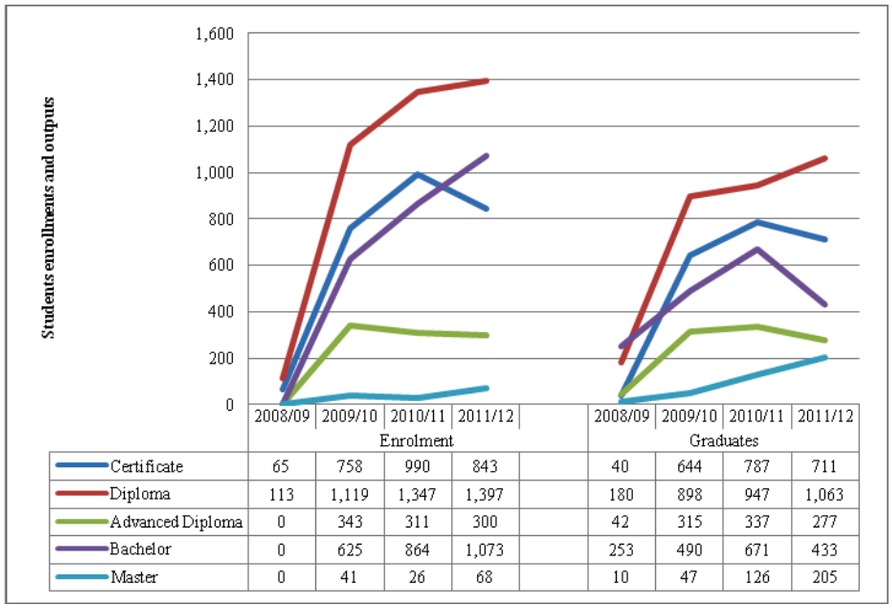
| Training Institutions | Public | Faith Based Organisation | Private | Total |
|---|---|---|---|---|
| Doctor of Medicine | 2 | 6 | 2 | 10 |
| Dentistry | 2 | 1 | 0 | 3 |
| Clinical Officers | 20 | 3 | 3 | 26 |
| Clinical Assistant | 6 | 0 | 3 | 9 |
| Pharmacy | 2 | 1 | 2 | 5 |
| Nursing and Midwifery | 31 | 35 | 7 | 73 |
| Paramedical Laboratory | 4 | 4 | 5 | 13 |
| Paramedical radiology | 0 | 1 | 0 | 1 |
| Paramedical OT/PT | 4 | 0 | 0 | 4 |
| Paramedical Optometry | 1 | 0 | 0 | 1 |
| Environmental and Public Health | 6 | 0 | 0 | 6 |
| Health Record | 1 | 0 | 1 | 2 |
| Total | 79 | 51 | 23 | 153 |

*Table 7: Social Welfare Enrolment*

| Cadres | 2008/2009 | 2009/2010 | 2010/2011 | 2011/2012 |
|---|---|---|---|---|
| Certificate in Social Work | 94 | 117 | 114 | 111 |
| Early Child Hood Development (ECD) | 34 | 30 | 26 | 51 |
| Diploma in Social Work | 151 | 137 | 114 | 204 |
| Bachelor in Social Work | 244 | 225 | 435 | 278 |
| Postgraduate Diploma in Social Work | 28 | 39 | 23 | 15 |
| Total | 551 | 548 | 712 | 659 |

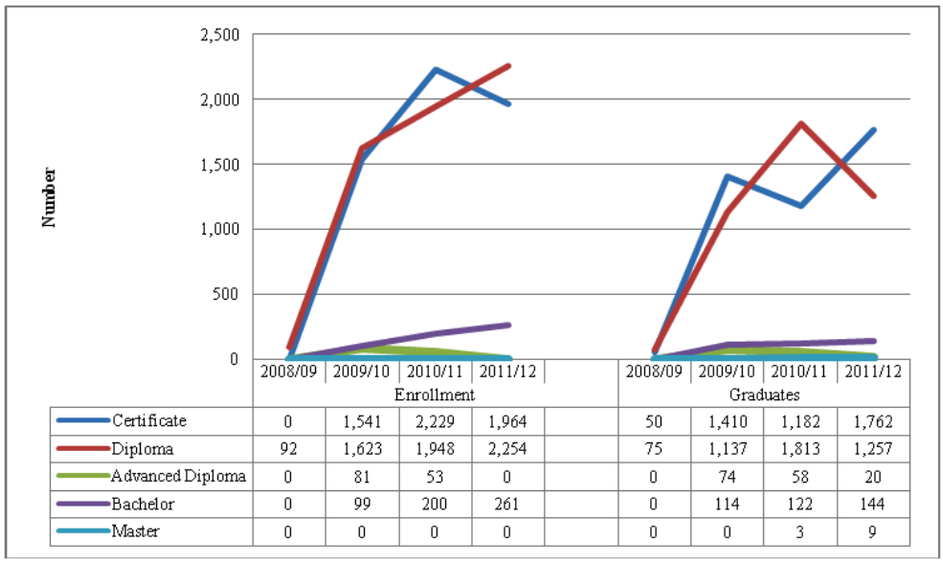
### 3.3.2 Enrolment and Output of Health Training Institutions

The number of enrolled students doubled between 2005 and 2010. 4914 students were enrolled to join various trainings in 2005, while in 2010, the number of enrolled students was 8956. The pool of applicants for medical specialization has increased substantially as a consequence of expansion in basic medical education in the country. This is partly attributed to governmental support through loan from the loan board. The contribution of non-public institution is about 28% of all postgraduate enrolment - Figure 5 and 6.




| | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|---|---|
| | Enrolment | | | | Graduates | | | |
| Certificate | 65 | 758 | 990 | 843 | 40 | 644 | 787 | 711 |
| Diploma | 113 | 1,119 | 1,347 | 1,397 | 180 | 898 | 947 | 1,063 |
| Advanced Diploma | 0 | 343 | 311 | 300 | 42 | 315 | 337 | 277 |
| Bachelor | 0 | 625 | 864 | 1,073 | 253 | 490 | 671 | 433 |
| Master | 0 | 41 | 26 | 68 | 10 | 47 | 126 | 205 |

*Figure 5: Number enrolled and graduated in Allied sciences by course level, 2008-2012*




| | 2008/09 | 2009/10 | 2010/11 | 2011/12 | 2008/09 | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|---|---|
| | Enrollment | | | | Graduates | | | |
| Certificate | 0 | 1,541 | 2,229 | 1,964 | 50 | 1,410 | 1,182 | 1,762 |
| Diploma | 92 | 1,623 | 1,948 | 2,254 | 75 | 1,137 | 1,813 | 1,257 |
| Advanced Diploma | 0 | 81 | 53 | 0 | 0 | 74 | 58 | 20 |
| Bachelor | 0 | 99 | 200 | 261 | 0 | 114 | 122 | 144 |
| Master | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 9 |

*Figure 6: Number enrolled and graduated in Nursing Courses by course level, 2008-2012*

Although there is high production of social welfare workforce in the labour market, the challenge remains in recruitment, deployment and retention of the available graduates from respective Universities and Colleges.

### 3.3.3 Continued Professional Development for Health Workforce

Continued Professional Development (CPD) concept is not adequately emphasized and institutionalised. The available CPD guidelines have not been adequately operationalized and are outdated. The in-service training has been confined to classroom teaching, which mainly complicates the existing HRH crisis by taking the health workers away from their workstation. The potential of applying on-job training, mentoring and coaching, distance learning and e learning are less explored. There is inequity in accessing CPD. It is common to find health workers who have not been refreshed for periods of 5 years or more while others have attended several trainings. After all, there has been little follow up of those who attended such training to establish the effect of the training on their performance.

CPD is not well related and integrated into service provision and practice and thus not reflected in the allocation of health care budgets. Medical schools and health training institutions usually focus on basic and qualification programs -their role in CPD is not clear. There is hardly any emphasis in the curricula that inculcate a culture of lifelong learning that enables the student to appreciate in the future the importance of CPD for their practice and career. There is no system to support or recognize participation of health workers in CPD activities whether inside or outside the country. Certificates and credits gained from these trainings do not usually count towards the promotion of individual health workers and their career development.

Despite the recorded successes, the health training institutions face several challenges which include big shortage of teachers in training institutions and increased workload due to increased enrolments of students. Currently the available number of teachers only few have attended teaching methodology courses and others have not There are no clear mechanisms for updating teachers on new developments in service provision such as changes in case management for certain diseases. Consequently the new graduates go to service without updated knowledge. On the part of practical exposure to students, several challenges have been reported, for example, due to critical shortage of staff in health facilities, trainees get limited exposure time with clinical instructors. Another challenge is the increased number of students and limited numbers of teaching hospitals leading to inadequate exposure of students to patients. Other challenges include: Limited funding and unstable disbursement of funds, poor infrastructure, shortage of learning materials as well as limited enrolment to cope with the existing demand for certain cadres such as laboratory and pharmaceutical staff. Moreover, there is weak quality management framework for ensuring quality of training in schools and adaptation of new technology to increase efficiency in training is limited.

## 3.4 Recruitment and Retention

### 3.4.1 Status of recruitment:

There are several players dealing with HRHSW matters. At least four ministries or government departments are involved in HRHSW decisions, making it challenging to coordinate the recruitment process. There are sentiments that the recruitment process is cumbersome and less efficient. Councils complain that permissions are granted for cadres that were not requested. There are instances where permits granted consist of cadres that are not available in the market. The advertisements for recruiting health staff provide a chance for potential recruits to choose three regions they would like to be posted to. Consequently rural and hard to reach areas are less selected. Not all of the posted employees report. Others report and quit. For example Out of 4812 permits, which were utilised only 63%, reported to their respective stations. Out of the reported staff 13% left for several reasons such as delays in being entered into the payroll and receive salary payment on time

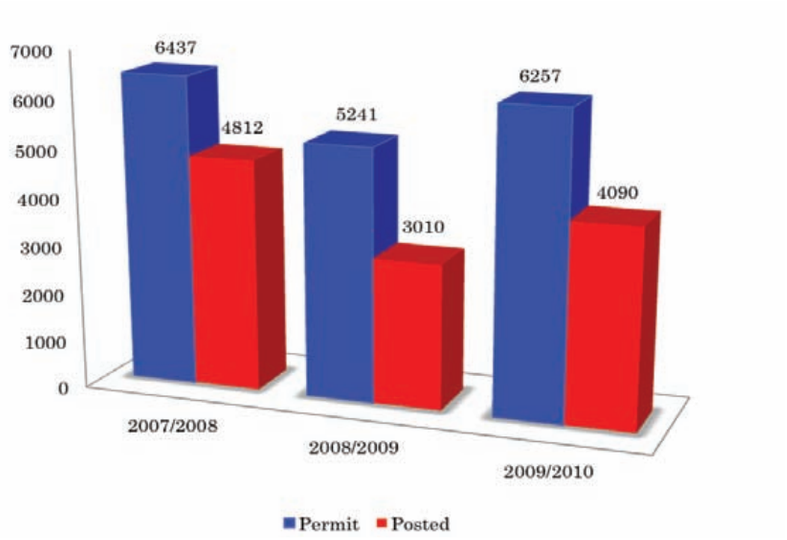



*Figure 7: Utilisation of granted Permits (absolute numbers)*

### 3.4.2 Recruitment Process

Recruitment in the health sector is a multisectoral function; it involves PMORALG through Councils which are charged with the responsibility of identification of new employment posts. Likewise PO-PSM is charged with the responsibility of rationalisation, validation and approves new employment posts. Ministry of Health and Social Welfare is responsible for advertising and posting of health workers to relevant authorities and lastly Ministry of Finance which is responsible for financing new posts in form of salaries.

Challenges in recruitment include low human resource management capacity in the councils, limited allocations for personnel emoluments, poor working conditions (roads, communication network, electricity, recreation, water, and schools for children) especially in rural areas, limited ability of the health and social welfare sector to meet the basic employee personal needs (including pay for extra/ heavy workloads, workplace hazard allowance and opportunities for self development) and brain drain within and outside the country.

For example Out of 4812 permits, which were utilised only 63%, reported to their respective stations. Out of the reported staff, 13% left for several reasons such as delays to clear their claims like subsistence allowance, moving costs and late incorporation into payroll; Poor working environment; un-availability of staff houses, bad roads and lack of essential social services.

### 3.4.3 Retention of Health Workers

The magnitude of retention problem is not well established. For example according to HRH research synthesis commissioned by GIZ in 2011, about 53% of skilled staffs in the districts are intending to leave services. The HRH synthesis recommended that, apart from the various “one-time focused studies on attrition” there is a need to have in place an institutionalised system for continuously and regularly tracking the attrition, identifying reasons and recommending strategies to address the problem.

### 3.4.4 Health Workers Motivation

Retaining HRH has been a problem due to challenges such as compensation and working conditions. The internal and external brain drain is one of the prominent factors. Efforts are underway to attract staff to public sector. The government has been increasing salaries almost annually since 2006. Pilots on ways to attract professionals in underserved areas were conducted to inform the government on issues for consideration both at national and council level. Although there is no national mechanism or guidance on retention of staff, some council specific initiatives to motivate staff have been tried. POPSM developed pay and incentive policy in 2010. The policy needs to be disseminated and operationalized.

## 3.5 Performance Management and Reward Systems

Currently, the government uses OPRAS as a mechanism to enhance performance of public servants including health workers. The use of Open Performance Review Appraisal System (OPRAS) began in 2004, which is one of the outcomes of public services reform of which health sector reform is part. Promotion and career advancement are still rewarded by considering staff working experience and not performance and OPRAS is less utilised. Supervisors are reluctant to use OPRAS due to inadequate knowledge and skills on application of OPRAS. Unfortunately there is limited guidance on how best to use the system to health professionals.

## 3.6 Human Resources for Health Financing

The most critical factor driving health system performance, the health worker, was neglected and overlooked for long. Of late, there is a growing awareness that human resources rank consistently among the most important system barriers to progress. Paradoxically, in countries of greatest need, the workforce is under "attack" from a combination of unsafe and unsupportive working conditions and workers departing for greener pastures. While more money and drugs are being mobilized, human resources for health, remains underfunded. This is contributed by the underfunding of the health sector. The Abuja declaration recommends allocation of 15% of national budget to health sector. Although health sector financing is considerably improving, it is still below the Abuja declaration targets (Table 8) and human resources for health is ill financed.

*Table 8: Total Health Expenditure as a percent of national government budget (three years trend)*

| Year | Budget (Billions) | Total Health Expenditure as % of national government budget |
|---|---|---|
| 2012/2013 | 1,288.8 | 10% |
| 2011/2012 | 1,209.1 | 10% |
| 2010/2011 | 1,206 | 12% |

MoHSW's commitment to adding budget for HRH activities is vivid, but it is impinged by limited budget. For example since 2010/11 MoHSW has increased enrolment to training institutions but the training budget did not increase to cope with the increased enrolment – Figure 8.

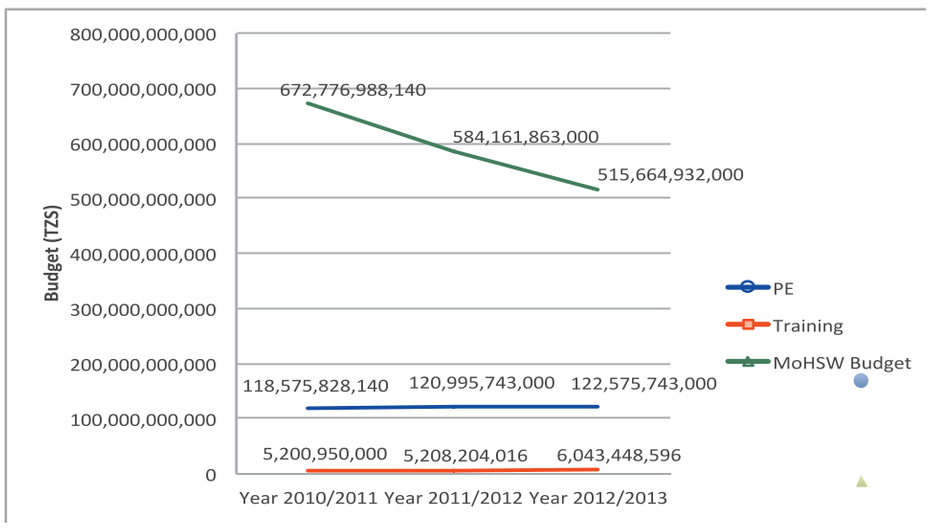



*Figure 8: HRH budget 2010/11 to 2012/13*

## 3.7 Research and Utilisation of Research Findings

The government of the United Republic of Tanzania realises the importance of HRH research in the provision of information for health planning and decision-making. In 2005 and 2011, the Ministry of Health and Social Welfare collected and synthesized various HRH research studies. The 2011 research synthesis noted a research gap with regard to migration, partnership, production and performance of health care workers. The challenging part is the coordination and utilisation of HRH research to inform HRH plans, policies and strategies due to the fact that previous studies focused more on identifying "What and how much questions" and less on "How and why questions"

## 3.8 Stewardship and Partnership

There is need to provide strong leadership to effectively address the human resources crisis. A major challenge has been a chronic low investment on human resources functions. This challenge is attributed partly to limited sector dialogue and weak advocacy. The strengthening of human resources management systems and structure is required at relevant levels.

For the past five years the Ministry of Health and Social Welfare played a key leadership role to address the decentralisation challenges affecting Human Resources for Health Management. MoHSW on behalf of LGAs took a role of recruiting and posting HRH for regional and LGAs. Although there are some limitations that are partly attributable to coordination of various players in recruitment arena as well as peripheral capacity to handle the entrusted responsibilities, MoHSW's involvement in recruitment process has reduced the impact of decentralising human resources for health recruitment process considerably. With regard to financing, MoHSW in recognition of central government's financial limitations- leveraged government's efforts by soliciting funds to address some key strategic interventions. In Global Fund Round Nine, the MoHSW has included a human resources component that contributed a lot in increasing efficiency in recruitment and staff retention. The implementation of this program is done in partnership with a non-government organization – The Benjamin William Mkapa Foundation. Moreover the implementation of outgoing strategic plan attracted several actors and it broadened the partnership base. However, coordination remained a challenge.

The challenges of enhancing leadership and stewardship in HRH still exist. These include

- Challenges of coordination such as limited transparency, duplication of activities and inadequate sharing of information

- Challenges in bringing together different actors in addressing HRH crisis such as leaders and the community from national to village level.

# Chapter Four:

# Key Result Areas, Objectives and Strategies

## 4.1 Introduction

The Key results areas, objectives and strategies of this strategic plan emanate from a thorough situation analysis enriched by data and information from different sources including HRHIS and TIIS reports, empirical information from field interviews, local research evidences and international literature. Important documents like Human Resource Policy Guidelines – 2005, Primary Health Services Development Program (PHSDP), 2007 – 2017, National Health Policy 2007, Tanzania Development Vision 2025, National Strategy for Growth and Reduction of Poverty and Millennium Development Goals (MDGs) were used to guide and inform the development of this plan. Series of Social Welfare Policies and Frameworks were also reviewed to identify key issues for social welfare. In addition the September 2013 Tanzania National HRH conference's recommendations have been considered. The information created basis for setting priority HRH&SW issues. It helped in defining strategic goals and objectives to improve HRH policies, planning, production, distribution and HR management systems for improved individual performance and utilisation. From different sources of information the 2014-2019 HRH Strategic Plan carries forward the 2008-2013 strategic objectives because the issues are still relevant for addressing the crisis.

The government is dedicated to ensure availability of adequate and competent health and social welfare workforce that is motivated and equitably distributed to deliver quality services to all the people wherever they are. This Strategic Plan intends to achieve the following national HRH vision and mission.

## 4.2 Vision Statement and Mission Statements

### 4.2.1 Vision Statement

Making Tanzania a country with adequate health workforce with diversified competencies and motivated to deliver quality health and social welfare services

### 4.2.2 Mission Statement

To ensure availability of adequate number of health and social welfare workforce with the right skills mix that enable them to deliver effective and efficient health and social welfare services and interventions for the achievement of and promotion of a healthy community, through improved HRH &SW functions, strengthened collaboration and improved coordination with partners.

## 4.3 Strategic Planning Framework

To ensure the developed strategies contribute to the health sector's priorities in terms of coverage and accessibility to quality health and social welfare services, the development of key result areas and related strategic objectives was guided by strategic direction as reflected in the HRH&SW strategic planning framework. As shown in Figure 9- the framework advocates for a comprehensive approach to national HRH&SW planning and implementation.

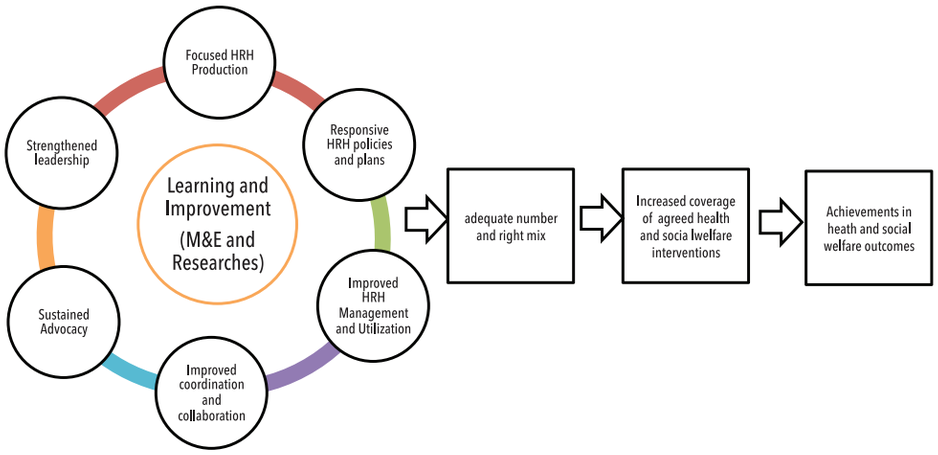



*Figure 9: Strategic Planning Framework*

The framework provided a comprehensive and coherent view for developing the different but interrelated domains of the health and social welfare sectors in a co-ordinated and balanced manner to work towards achieving the goals and objectives of the national health and social welfare strategies.

### 4.3.1 Key Result Areas

The following six areas are identified as key result areas:

| **Key Result Area 1** | **HRH&SW Policy and Planning** |
|---|---|
| **Strategic Objective** | **Strengthen HRH&SW policy development and planning at all levels** |
| Rationale | There has been limited evidence based information for production of comprehensive and realistic HRH&SW plans. The available sources for HRH&SW data are disintegrated, untimely updated, inadequately analyzed and utilized. As a result data users are often confused on what information to rely on when developing HRH&SW plans and policies. Similarly, there has been inadequate dissemination of HRH&SW policies to all levels, and miss-linkages between the national HRH&SW policies and those of the professional associations. The relevant strategies intend to address all critical issues related to HRH&SW policy development and planning including establishment of monitoring and evaluation framework to guide and facilitate effective functioning of Human Resources for Health Technical Working group (HRHTWG). |

| **Key Result Area 2** | **HRH&SW Research** |
|---|---|
| **Strategic Objective** | **Strengthen HRH&SW research and utilization at all levels** |
| Rationale | Most HRH&SW research are not coordinated and the focus has mainly been on answering the 'what and how much' questions and less on the 'how' and 'why' questions. In the same vein, most of the HRH&SW research findings are not shared amongst the key stakeholders. As a result most of HRH&SW interventions have been guided with limited evidence and thus become less responsive. This strategic objective focuses on addressing such urgent need by strengthening the capacity to conduct quality and comprehensive HRH&SW researches as well as ensuring effective coordination and utilization of the findings for HRH&SW policies improvement. |

| Key Result Area 3 | Leadership and Advocacy |
|---|---|
| Strategic Objective | Promote leadership and advocacy for HRH&SW at all levels |
| Rationale | There are still challenges in the area of leadership and stewardship. Some of such challenges include inadequate coordination of HRH&SW initiatives, weak advocacy for HRH & SW funding during the budgeting process, unclear delineated areas of managerial authority, responsibility and accountability at different levels, and inadequate leadership skills. The strategies in this part focus on improving and promoting effective management and advocacy at all levels as key for the attainment of HRH&SW initiatives. |

| Key Result Area 4 | HRH&SW Management |
|---|---|
| Strategic Objective | Strengthen HRH&SW recruitment, retention, career development and utilization at all levels |
| Rationale | There has been low performance and inadequate attraction of health workers to health and social welfare delivery systems. Such situation is highly associated with ineffective practices on recruitment, retention, development and utilization. The relevant strategies intend to enhance effectiveness and efficiency in the implementation of recruitment, retention, development and utilization of health and social welfare workers at all levels. |

| Key Result Area 5 | Production and Quality of HRH&SW |
|---|---|
| Strategic Objective | Increase and standardize production and quality of HRH&SW |
| Rationale | The quality and production of health workers does not match with the need of the health care delivery system. The experiences with various cadres and convexities are mixed. While shortage in some cadres are more severe than others, the shortage in rural is higher than in urban. The related strategies intend enhance production and quality of health and social welfare workers with skill mix that corresponds to the new demand of the time. |

| Key Result Area 6 | Partnership |
|---|---|
| Strategic Objective | Strengthen/promote partnerships and coordination of HRH&SW interventions among stakeholders at all levels |
| Rationale | The efforts of various HRH&SW stakeholders are disintegrated. As a result there have been gaps, duplication of activities, and disharmony in addressing the HRH&SW crisis in the country. The related strategic objective focuses on creating synergy among HRH&SW stakeholders through effective partnership, coordination and implementation of existing regulatory procedures. |

### 4.3.2 Strategic Objectives

The following strategic objectives were identified as priorities to be accomplished during the period of the plan:

## Strategic Objective 1: Strengthen policy development and HRH&SW planning at all levels

*Specific Objectives:*

1. To enhance evidence based HRH&SW planning at all levels by 2015
2. To increase responsiveness of HRH&SW policies to actual needs and demands of providers and clients at all levels by 2018
3. To increase access to HRH and HRH related policies to all levels by 2018
4. To improve monitoring and evaluation of HRH&SW initiatives by 2018
5. To increase effectiveness and efficiency in the implementation of HRH&SW and HRH&SW related policies at all levels by 2019

## Strategic Objective 2: Strengthen HRH&SW research and utilization at all levels

*Specific Objectives:*

1. To improve research activities and utilization for evidence based HRH & SW retention, performance, productivity and partnership by 2018
2. To enhance preciseness of existing HRH&SW research findings to easily inform policy, plan and practice 2016
3. To enhance utilization of existing HRH&SW research evidence for policy, plans and practice improvement by 2016

## Strategic Objective 3: Strengthen leadership and advocacy for HRH&SW at all levels

*Specific Objectives:*

1. To enhance coordination of HRH&SW stakeholders by 2019
2. To increase capacity of health managers on leadership, management and advocacy at all levels by 2019

## Strategic Objective 4: Strengthen HRH&SW recruitment, retention, career development and utilization at all levels

*Specific Objectives:*

1. To increase the number and capacity of health and social welfare workers at all levels and areas of the country based on needs by 2018
2. To enhance retention of health and social welfare workers at all levels by 2018
3. To improve utilization of health and social welfare workers at all levels by 2018

## Strategic Objective 5: Improve production and quality of HRH&SW

### *Specific Objectives:*

1. To improve management capacity of managers working in all Health and Social Welfare Training Institutions (SWTIs) by 2019

2. To improve capacity of HSWTIs by 2019

3. To enhance the quality and effectiveness of Continuing Professional Development (CPD) Programs by 2016

4. To improve the quality of curricula for all health and social welfare programs by 2018

5. To improve collaboration between MoHSW, professional bodies and NACTE in accrediting and regulating health and social welfare training institutions

6. To improve the quality and utilization of medical attendants and day care assistants by the year 2018

## Strategic Objective 6: Support private sector to scale up training of health workers in line with PHSDP/MMAM

### *Specific Objectives:*

1. To improve coordination and alignment of HRH&SW priorities across four key ministries: MOHSW, PMO-RALG, POPSM, MOF and with private HRH&SW stakeholders

2. To improve networking and coordination among HRH&SW stakeholders at all levels by 2018

3. To improve communication between HRH&SW actors both public and private by 2018

# Chapter Five:

# Strategy Implementation

The implementation matrices provide implementers and stakeholders with a logical view of strategies from implementation to monitoring and evaluation. The matrices allow stakeholders who are interested in supporting specific components of this strategic plan to be able to implement and measure the results and their contribution in the overall attainment of the country's HRH&SW vision. The framework calls for strong commitments from both implementers and development partners to play their key roles in making this strategic plan a reality.

## Strategic Objective 1: Strengthen policy development and HRH planning at all levels

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| 1.1.To enhance evidence based HRH&SW planning at all levels by 2019 | 1.1.1.Strengthen the HRH Planning Unit to effectively advocate for HRH development at national, regional and district level and support and supervise the development of HRH plans at all levels | 1.1.1.1.Redefine the roles of of the HRH Planning Unit and develop and support its collaboration in HRH&SW with other departments within the MoHSW and other MDAs | Roles of the HRH Planning Unit re-defined and mechanisms for collaboration in HRH&SW with other departments within MoHSW and other MDAs developed and supported | ▯ List of roles of the HRH Planning Unit and roles of other departments of the MoHSW and other MDAs in HRH&SW<br>▯ Mechanisms for collaboration with other departments of the MoHSW and other MDAs in HRH&SW in place<br>▯ Number and types of collaborative HRH&SW activities between the HRH Planning Unit and other departments of MoHSW and MDAs | ▯ Reports of the designing process of a coordinating mechanism<br>▯ Coordinating mechanism |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | | 1.1.1.2 Staff the HRH Planning Unit with the required number of competent people | The HRH Planning Unit having the right number of staff with the required competencies | Number of staff Qualifications of staff | List of staff with qualifications |
| | | 1.1.1.3.Train the HRH Planning Unit staff in HRH data and information, HRH planning and management | HRH Planning Unit staff trained in HRH data and information, planning and management | Number of staff trained | ☐ Training reports<br>☐ List of staff trained |
| | 1.1.2.Improve HRHIS and TIIS to accurately determine the HRH attrition rate by incorporating leaving rates in addition to retirement and deaths in both public and private sector | 1.1.2.1.Develop and distribute guidelines for collecting and reporting data on HRH leaving by resignation, changing profession or emigration | Guideline on collecting and reporting data on HRH attrition developed and distributed | Number of districts, regions and zones having guidelines on collecting and reporting HRH attrition in place | ☐ Guideline on collecting and reporting attrition rates |
| | | 1.1.2.2 Develop and distribute tools for collecting and reporting leaving HRH | Tools for collecting and reporting data on leaving HRH developed and distributed | Tools for collecting and reporting data on leaving HRH in place | ☐ Reports on tools development process<br>☐ Tools for collecting and reporting data on leaving HRHH |
| | | 1.1.2.3 Train responsible HRH at central, regional and district level for acquisition of data on leaving HRH | Staff responsible for HRH planning and management at central, regional and district level trained on collection and reporting of HRH leaving | Number of staff trained on collection and reporting of HRH leaving | ☐ Training reports<br>☐ List of staff trained |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | 1.1.3.Introduce and develop capacity for applying Workload Indicator Staffing Needs (WISN) for determination of real staff requirements for health facilities at district, regional, zonal and national levels instead of using standard facility type based establishments | 1.1.3.1 Acquire and distribute WISN tools to all district, regional, zonal and national hospitals | Hospitals supplied with WISN materials and tools | Number of hospitals supplied with WISN materials and tools | WISN materials and tools |
| | | 1.1.3.2 Train responsible hospital teams in determining staffing needs using WISN | Hospital teams trained in WISN application | Number of people and hospital teams trained in determination of staff needs using WISN | Training reports<br>Training materials |
| | | 1.1.3.3 Supervise and support the application of WISN in hospitals | Hospitals supervised and supported in determining staff needs using WISN | Number of supervised hospitals on application of WISN | Supervision reports |
| | 1.1.4 Accelerating coverage and utilization of HRHIS/TIIS at all levels. | 1.1.4.1 Sensitize key stakeholders on HRHIS/TIIS database at all levels | Key stakeholders Sensitized on HRHIS/TIIS database | Number of sensitizations done at all levels | Sensitization materials<br>Reports |
| | | 1.1.4.2 Conduct refresher trainings on the proper operationalization of the HRHIS/TIIS | Trained HRH managers on the proper operationalization of the HRHIS/TIIS | Number of Refresher trainings conducted to HRH&SW managers on the proper operationalization of the HRHIS/TIIS | Training Materials<br>Training Reports |
| | | 1.1.4.3.Conduct on site support supervision to ensure proper maintenance and update of the system | Health facilities and Training institutions supported on the maintenance and update of HRHIS/TIIS | Number of supervised health facilities and training institutions. | Supervision reports |
| | | 1.1.4.4.Build capacity of health officials at all levels on HRHIS/TIIS data analysis and utilization | Health Managers with Skills and knowledge to analyze and utilize HRHIS/TIIS data | Number of Capacitated HRH&SW managers on HRHIS/TIIS data analysis and data utilization | Capacity building materials<br>Capacity building reports |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | 1.1.5 Generating HRH&SW planning procedures that is integral to the national planning system | 1.1.5.1 Develop HRH&SW planning guidelines | Developed HRH&SW Planning document | HRH&SW Planning document in place | ☐ HRH&SW planning guidelines<br>☐ HRH&SW plan |
| | | 1.1.5.2.Develop HRH&SW succession and career development plans | Developed HRH&SW succession and career development plan and implementation at all levels | HRH&SW succession and career development plan in place | ☐ Sessions plans for Career development<br>☐ Implementation report |
| | | 1.1.5.3.Advocate and sensitize to planners, managers, trainers, employers and employees on development and implementation of HRH&SW Plans at all levels | Advocated and sensitized planners, managers, trainers, employers and employees on HRH&SW Plans at all levels | Number of planners, managers, trainers, employers and employees implementing HRH activities | ☐ Advocacy and sensitization materials<br>☐ Implementation reports |
| 1.2 To increase responsiveness of HRH&SW policies to actual needs and demands of providers and clients at all levels by 2018 | 1.2.1 Utilization of existing HRH&SW information and consultation of a wider scope of stakeholders to updates existing and formulate new HRH policies to reflect the real situation | 1.2.1.1 Update existing HRH&SW policies, standards and guidelines; formulate new ones and; disseminate | Updated and new HRH&SW Policies, Standards and Guidelines and; disseminated to key stakeholders | ☐ Number of National HRH Policies, standards and Guidelines<br>☐ Number of stakeholders with updated and new policies, standards and guidelines | ☐ Updated and new HRH policies, standards and guidelines<br>☐ Dissemination plan<br>☐ Dissemination report |
| 1.3 To improve monitoring and evaluation of HRH&SW initiatives by 2018 | 1.3.1 Designing and execute frameworks for monitoring implementation of HRH initiatives at all levels | 1.3.1.1 Develop monitoring and evaluation frameworks for HRH initiatives | Developed frameworks for monitoring and evaluation of HRH initiatives | Number of M&E frameworks developed for HRH initiatives | ☐ Report on HRH frameworks development process<br>☐ HRH&SW Frameworks |
| | | 1.3.1.2 Regular review of staffing level according to requirements and monitor its effects | Reviewed and implemented HRH staffing level s according to requirements | Number of reviews of HRH requirement and monitored conducted | Reports on the review of staffing levels |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | | 1.3.1.3 Carry out supportive supervision in the implementation of the NHRH Strategic plan at all levels | Supportive supervision for implementation of HRH Strategic plan Conducted | Number of supportive supervision conducted | ▯ Plan on supportive supervision<br>▯ Supportive supervision reports |
| | | 1.3.1.4 Develop necessary tools and train HR at Central level to implement and facilitate proper M&E for HRH&SW Plans and strategies | ▯ Necessary tools for proper M&E developed<br>▯ HR at central level Trained on how to implement and facilitate HRH&SW plans and strategies | ▯ Number of tools for proper M&E of HRH initiatives<br>▯ Number of HR trained to implement and facilitate HRH plans and strategies | ▯ Tools for M&E of HRH&SW plans<br>▯ Training reports on M&E of HRH&SW plan |
| | | 1.3.1.5 Develop plan for monitoring and evaluation of HRH&SW initiatives at all levels | Plan for monitoring and evaluation of HRH&SW initiatives developed | Monitoring and evaluation plans in place | ▯ Report on development process of M&E plan<br>▯ Plan for M&E of HRH&SW initiatives |
| | | 1.3.1.6 Conduct Mid Term and final Review of the NHRH Strategic Plan and make use of the findings to improve performance | Mid-terms and final reviews of NHRH Strategic Plans conducted and utilized | Number of reviews conducted | ▯ Midterm review Reports of the NHRH strategic plan<br>▯ Final review Reports of the NHRH strategic plan<br>▯ Report on the use of the findings of reviews |
| | | 1.3.1.7 Conduct monthly HRH Technical Working Group Meetings (HRHTWG) | Monthly HRH Technical Working Group Meetings conducted | Number of HRH Technical Working Group Meetings conducted | Minutes of the monthly HRHTWG |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | | 1.3.1.8 Conduct HRH stakeholders' meeting annually | Conducted annual HRH stakeholders' meeting | Number of annual HRH stakeholders' meeting | Minutes of the annual meeting of HRH stakeholders |
| 1.4 To enhance effectiveness and efficiency in the implementation of HRH and HRH related policies and guidelines at all levels by 2019 | 1.4.1 Promote development of HRH capacity to translate and utilize the existing HRH policies and guidelines | 1.4.1.1 Train relevant HRH on policy and guidelines translation and utilization | Relevant HRH trained on policy and guidelines translation and utilization | Number of relevant HRH trained on policy and guidelines translation and utilization | □ Training reports<br>□ Certificate of participation |
| | | 1.4.1.2.Follow up translation of various HRH&SW policies and guidelines | Translation of various HRH&SW policies and guidelines Followed up<br>Mentoring sessions on | Number of policies and guidelines translation and utilization followed ups | Follow up reports on policies and guidelines translation |
| | | 1.4.1.3 Provide mentoring sessions to facilitate policy translation and utilization | Policies and guidelines translation and utilization are provided. | Number of relevant HRH mentored on policies and guidelines translation and utilization | Mentorship Reports |
| 1.5 To increase access to HRH&SW and related policies to all levels by 2016 | 1.5.1 Promote dissemination of HRH&SW and related policies | 1.5.1.1 Design frequently updated HRH&SW and related policies inventories | Inventory of HRH&SW and related policies developed | Inventory of existing HRH&SW and related policies in place | Report on the development of the inventory |
| | | 1.5.1.2 Design a mechanism to frequently contacts relevant directorates, departments, sections and stakeholders to disseminate HRH and related policies | A mechanism for frequent contacts of directorate, departments, sections and stakeholders developed | A mechanisms for frequent contacts of directorate, departments, sections and stakeholders | □ Inventory of HRH and related policies<br>□ Report on the development of a mechanism<br>□ Report on the frequent contact of directorate, departments, sections and stakeholders |

## Strategic Objective 2: Strengthen HRH&SW research and utilization at all levels

| Specific objectives | Strategies | Activities | Output | Indicators | Means of verification |
|---|---|---|---|---|---|
| 2.1 To improve research activities and utilization by 2019 | 2.1.1 Coordinate HRH&SW research activities and promote its utilization | 2.1.1.1 Develop HRH&SW research agenda and disseminate to key stakeholders | HRH&SW research agenda developed and disseminated | ▫ Number of Identified HRH&SW related research areas & topics<br>▫ Number of relevant stakeholders with HRH&SW research agenda | ▫ Report on the development process of the research agenda<br>▫ Research agenda |
| | | 2.1.1.2 Advocate implementation of research agenda to key stakeholders. | Implementation of research agenda advocated to key stakeholders | Number of key stakeholders implementing the research agenda | ▫ Plan of the advocate of the research agenda<br>▫ Report of the advocate of the research agenda |
| | | 2.1.1.3 Train HRH&SW managers and relevant health care professionals on research and utilization of findings. | HRH&SW managers Trained in research and development. | Number of trained HRH&SW managers in research and development. | ▫ Training materials on research and utilization of findings<br>▫ Training reports |
| | | 2.1.1.4 Mapping of potential local and international HRH research organizations and institutions and; establish the research linkages | ▫ Potential local and international HRH research organizations and institutions identified<br>▫ Potential local and international HRH research organizations and institutions liked for HRH research | ▫ Number of local and international organizations and institutions active in HR research identified<br>▫ Number of linkages established with HRH research Organization and institutions | ▫ Report of the mapping of research organizations and institutions<br>▫ Report of the agreed linkages for research |
| | | 2.1.1.5 Commission and supervise HRH related research studies. | Commissioned and supervised HRH related research studies. | Number of Commissioned and supervised HRH related research studies in place | ▫ Report of the process to identify researcher<br>▫ Proposals<br>▫ Reports on supervision of the commissioned research<br>▫ Research reports |
| | | 2.1.1.6 Disseminate findings from HRH related research studies and | ▫ Findings from HRH related research studies disseminated | ▫ Number of findings from HRH related | ▫ Plan for dissemination of findings and program implications |

| Specific objectives | Strategies | Activities | Output | Indicators | Means of verification |
|---|---|---|---|---|---|
| | | identify policy and programme implications | and<br>□ Implications of research findings in policies and programme identified | research studies disseminate<br>□ Number of HRH research implications for policies and programme identified | □ Dissemination reports |
| | | 2.1.1.7 Coordinate and monitor HRH research and utilise findings in decision making. | □ HRH research Coordinated and monitored<br>□ HRH research findings utilised for HRH decision making | □ Number of HRH research coordinated and monitored<br>□ Number of findings utilised for HRH decision making | □ Report of the process for undertaking coordination and monitoring<br>□ Report on coordination and monitoring of HRH&SW research and utilization |
| 2.2 To enhance availability of up to date research data on Community Health Workers (CHWs) | 2.2.1 Promote researches on Community Health Workers (CHWs) | 2.2.1.1 Conduct research on community health system | Research on community health system conducted | Number of researches on community health system conducted | Research reports on community health system conducted |
| | | 2.2.1.2 Conduct research on harmonization of community health indicators | Research on harmonization of community health indicators conducted | Number of researches on harmonization of community health indicators conducted | Research reports on harmonization of community health indicators conducted |
| | | 2.2.1.3 Conduct research on mobilization and management of community generated resources for health | Research on mobilization and management of community generated resources for health conducted | Number of researches on mobilization and management of community generated resources for health conducted | Research reports on mobilization and management of community generated resources for health conducted |
| | | 2.2.1.4 Conduct research on community mobilization, participation and empowerment | Research on community mobilization, participation and empowerment conducted | Number of researches on community mobilization, participation and empowerment conducted | Research reports on community mobilization, participation and empowerment conducted |
| | | 2.2.1.5 Conduct research on bottom-up versus top-down planning approaches | Research on bottom-up versus top-down planning approaches conducted | Number of researches on bottom-up versus top-down planning approaches conducted | Research reports on bottom-up versus top-down planning approaches |
| | | 2.2.1.6 Conduct research on financing mechanism | Research on financing mechanism for community | Number of researches on financing | Research reports on financing mechanism for |

| Specific objectives | Strategies | Activities | Output | Indicators | Means of verification |
|---|---|---|---|---|---|
| | | for community health interventions | health interventions conducted | mechanism for CHWs interventions conducted | CHWs interventions |
| | | 2.2.1.7 Conduct research on cost effectiveness of community health interventions | Research on cost effectiveness of community health interventions conducted | Number of researches on cost effectiveness of CHWs interventions conducted | Research reports on cost effectiveness of CHWs interventions |
| | | 2.2.1.8 Conduct research on coordination of community health stakeholders and their programs | Research on coordination of community health stakeholders and their programs conducted | Number of researches on coordination of CHWs and their programs conducted | Research reports on coordination of CHWs and their programs |
| 2.3 To enhance utilization of existing HRH&SW research evidence for Policy, Plans and Practice improvement by 2019 | 2.3.1 Monitor utilization of the HRH&SW research findings | 2.3.1.1 Disseminate existing HRH&SW research findings to stakeholders at all levels | Existing HRH&SW research findings disseminated to stakeholders at all levels | Number of HRH&SW research findings disseminated | Report on dissemination of HRH&SW research findings |
| | | 2.3.1.2 Follow up utilization of HRH&SWfindings in policies, plans and practices | Utilization of HRH&SW research findings Followed up | Number of stakeholders followed up for utilization of HRH&SW research findings | Reports on follow up of stakeholders |
| 2.4 To improve repackaging of existing HRH&SW research findings to easily inform policy, plan and practice 2016 | 2.4.1 Translate HRH&SW research evidence into simple and precise terms | 2.4.1.1.Design a data base for various HRH&SW research findings | Data base for various HRH research findings designed | Data base for various HRH research findings in place | Reports for development data base for HRH research findings |
| | | 2.4.1.2 Design a mechanism to translate various HRH research findings into simplified and easy to use terms for policy, plans and practice improvements | Mechanism to translate various HRH research findings designed | Mechanism to translate various HRH research findings in place | Data base for HRH findings<br>Reports for design a mechanism to translate various HRH research findings |

| Specific objectives | Strategies | Activities | Output | Indicators | Means of verification |
|---|---|---|---|---|---|
| | | 2.4.1.3 Develop a mechanisms for sharing translated HRH research findings | ▯ Mechanisms for sharing translated HRH research findings developed | ▯ Mechanisms for sharing translated HRH research findings developed | ▯ Mechanism for translation of various HRH research findings<br>▯ Report for development of mechanism for sharing translated HRH research findings<br>▯ Mechanisms for sharing translated HRH research findings |

## Strategic Objective 3: Strengthen leadership and advocacy of HRH&SW at all level

| Specific objectives | Strategies | Activities | Output | Indicators | Means of verification |
|---|---|---|---|---|---|
| 3.1 To enhance coordination of HRH&SW issues among stakeholders by 2019 | 3.1.1 Design and implement a coordinating mechanism of HRH issues among stakeholders | 3.1.1.1Develop and support mechanisms for intra and intersectoral collaboration in support of HRH&SW issues | Mechanisms for intra and inter-sect oral collaboration in support of HRH&SW issues Developed and supported | ▯ Mechanisms for intra and inter-sect oral collaboration in support of HRH&SW issues in place<br>▯ Number of support provided to the mechanism for intra and inter-sect oral collaboration in support of HRH&SW issues | ▯ Reports of the designing process of a coordinating mechanism<br>▯ Coordinating mechanism |
| | | 3.1.1.2 Conduct quarterly reflection meeting with all stakeholders in HRH&SW implementation initiatives | Quarterly reflection meeting with all stakeholders in HRH&SW implementation initiatives conducted | Number of quarterly reflection meeting with all stakeholders in HRH&SW implementation initiatives conducted | Minutes of the reflection meeting |
| 3.2 To increase capacity of health managers on leadership, management and advocacy of the health system all levels by 2019 | 3.2.1 Define dimensions of health managers authority; train health managers on leadership and management skills Leadership and; conduct follow ups on leadership and management practices | 3.2.1.1 Delineate dimensions of health managers' authority, responsibility and accountability at different levels. | Dimensions of health manager, authority, responsibility and accountability delineated | Delineated dimensions of health managers to exercise authorities, responsibilities and accountability in place | ▯ Report of the dimensions of health managers<br>▯ Training materials on leadership and management<br>▯ Training report on leadership and management |
| | | 3.2.1.2 Conduct a comprehensive management capacity audit of functions, structures and skills at all levels. | Comprehensive management capacity audit of functions, structures and skills of health care managers Conducted | Management capacity audit of functions, structures and skills of health care managers in place. | ▯ Inception reports on the process of undertaking audit<br>▯ Audit reports |
| | | 3.2.1.3 Identify problematic areas and systemic gaps and management/leadership needs. | Problematic areas and systemic gaps and management/leadership needs Identified | Problematic areas and systemic gaps and management/leadership needs in place | ▯ Inception reports on the process for identifying problematic areas, gaps and needs<br>▯ Reports on the |

| Specific objectives | Strategies | Activities | Output | Indicators | Means of verification |
|---|---|---|---|---|---|
| | | | | | identified problematic areas, systemic gaps and management/leadership needs |
| | | 3.2.1.4 Develop relevant health leadership and management development programmes for strategic intervention | Relevant health leadership and management development programmes for strategic intervention Developed | Relevant leadership and management development programmes for strategic intervention in place | Leadership and management development programs |
| | | 3.2.1.5 Evaluate the impact of health leadership and management interventions and initiated improvements | The impact of health leadership and management interventions and initiated improvements evaluated | Evaluation of the impact of interventions and initiated improvements in place | Inception report to undertake evaluation of impact of health leadership and management<br>Evaluation reports |
| | | 3.2.1.6 Conduct a comprehensive management capacity audit of functions, structures and skills at all levels | Comprehensive management capacity audit of functions, structures and skills of health care managers Conducted | Management capacity audit of functions, structures and skills of health care managers in place | Inception report to undertake audit<br>Report of the audit |

## Strategic Objective 4: Strengthen HRH&SW recruitment, retention, career development and utilization at all levels

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| 4.1 To increase the number of Health and Social Welfare workers from the current 66,348 to 98,226 and improve the skills mix from the current composition of high level 11.9%, mid level 53.6% and support level 34.4% to 12.6%, 56.5% and 30.9% respectively by 2019 and deploy them at all levels and areas of the country based on needs by 2019 | 4.1.1 Accelerating recruitment procedures, capacity building and ensure equity distribution of health workers at all levels | 4.1.1.1 Prepare and submit to the Treasury prior to commencement of the recruitment process a detailed 5-Year Recruitment Plan to obtain 'authority to recruit' 34,098 health and social welfare workers and achieve a skills mix of high level 12.6%, mid level 56.5% and support level of 30.9% by 2019 | Detailed 5-Year recruitment plan to obtain 'authority to recruit' prior to commencement of the recruitment process prepared and submitted to the Treasury | Detailed 5-Year recruitment plan of health workers in place | 5-Years recruitment plan<br>Submission letter to treasury |
| | | 4.1.1.2 Conduct bi-annual Recruitment Campaigns through the local print media as well as radio and TV to attract health workers who have retired, resigned or changed their professions to re-join the health service. | Recruitment campaigns to attract health workers to re-join the health service for work conducted | Number of recruitment campaigns conducted.<br>Number of health workers re-joined the health service for working | Designed Recruitment campaigns for print media, radio and TV<br>Letter of submission to the relevant media, radio and TV |
| | | 4.1.1.3 Collaborate with health workers employment authorities in all recruitment matters i.e. from planning to implementation | Employment authorities in all recruitment matters i.e. from planning to implementation Collaborated | Number of health workers employment authorities identified<br>Number of recruitment matters of health workers collaborated | Report on collaborative activities in all employment matters |
| | | 4.1.1.4 Conduct key stakeholders meeting to identify bottleneck of recruitments and posting process of HRH | Stakeholders meetings on identifying bottlenecks of health workers recruitment and posting conducted | Number of Stakeholders meetings conducted<br>Number of stakeholders participated in the meeting | Minutes of the key stakeholders meeting |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | | | | Number of bottlenecks of health workers recruitment and posting identified | |
| | | 4.1.1.5 Conduct key HRH stakeholders meetings to share the HRH posting and recruitments evaluation findings | Stakeholders meetings to share HRH posting and recruitment findings conducted | Number of HRH stakeholders meetings to share the HRH recruitment and posting findings conducted<br>Number of HRH recruitment and posting findings shared<br>Number of Stakeholders with who the HRH recruitment and posting findings have been shared with | Minutes of the key stakeholders meeting |
| | | 4.1.1.6 Conduct advocacy meeting regarding recruitment and deployment of HRH among key stakeholders | Meetings regarding recruitment and deployment of HRH among key stakeholders conducted | Number of advocacy meetings conducted<br>Number of recruitment and deployment issues discussed | Minutes of the key stakeholders meeting |
| | 4.1.2 Promote smooth recruitment process | 4.1.2.1 To review the current recruitment process in order to reduce delays in HRH recruitment and other challenges related to postings and mismatch | The recruitment process reviewed | Number of issues addressed to smoothen recruitment process | Review report<br>Recruitment reports |
| | 4.1.3 Promote budget increase for HRH retention activities | 4.1.3.1 To advocate for the review of the current CCHP guidelines so as to accommodates more HRH components with substantial amount set for HRH retention | Percentage increase of budget for HRH retention activities | Number of HRH retention activities planned<br>Number of HRH retention activities implemented | CCHP plans<br>Councils reports on implementation of CCHP |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| 4.2 To enhance retention of HRH at all levels by 2018 | 4.2.1 Establish and implement retention mechanisms of health workers | 4.2.1.1 Build capacity for Human Resource Development (HRD) and Human Resource Management (HRM) at all levels to improve deployment and utilization of HRH | Enhanced capacity for Human Resource Development (HRD) and Human Resource Management (HRM) at all levels of health | Types of training programmes for HRD and HRM developed<br>Number of trainings conducted<br>Number of managers trained<br>Number of managers deployed at all levels | Training reports<br>List of managers trained<br>Vacancies for HRD and HRM created and filled |
| | | 4.2.1.2 Improve the pay and compensation packages and terms and conditions of employment to improve motivation, productivity and commitment of the health workforce | The pay and compensation packages and terms and conditions of employment improved | Improved pay and compensation packages and terms and condition of employment in place | Reports on the development process f the pay and compensation packages |
| | | 4.2.1.3 Develop and Implement the comprehensive Motivation and Retention mechanism | comprehensive motivation and retention mechanisms developed and implemented | Comprehensive motivation and retention mechanims in place<br>Number of comprehensive motivation and retention mechanims implemeted | Report of the development process of the motivation and retention mechanism<br>Motivation and retention mechanism |
| | | 4.2.1.4 Develop guidelines and procedures for managing the movement of health and social welfare workers within the public sector and across the public/private sector interface | Guidelines and procedures for managing the movement of health and social welfare workers within the public sector and across the public/private sector interface developed | Guidelines and procedures for managing the movement of health and social welfare workers within the public sector and across the public/private sector interface in | Report on the development process |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | | | | place | |
| | | 4.2.1.5 Disseminate health worksrs motivation and retention mechanisms | Health workers motivation and retention mechanism disseminated | Number of mechanisms disseminated<br>Number of stakeholders aware of health workers motivation and retention mechanisms<br>Number of stakeholders with a copy of health workers motivation and retention mechanisms | Plan of dissemination of the motivation and retention mechanism<br>Report of the dissemination of the motivation and retention mechanism |
| | | 4.2.1.6 Design and implement comprehensive induction programmes for all cadres who are newly appointed health workers. | Induction programmes for all health cadres who are newly appointed health workers designed and implemented | Induction programmes for all health cadres who are newly appointed in place.<br>Number of induction conducted to newly appointed health cadres<br>Number of newly appointed health cadres who have received induction | Report on the designing process of induction program<br>Induction program |
| | | 4.2.1.7 Develop, establish and enforce new types of contractual agreements such as bonding system for students receiving fellowships or loans from public funds | New types of contractual agreements for students receiving fellowdhip or loans from public funds developed and enforced | Number and types of contracts in place<br>Number of students signed contracts | Reports of development process<br>Copies of signed contracts |
| 4.3 To increase utilization of HRH at all levels by 2019 | 4.3.1 Establish the necessary tool (s) to facilitate performance management and career development | 4.3.1.1 Update and develop job descriptions for all positions of health cadres. | Job descriptions for all positions of health cadres updated and developed. | Job description for all health cadres in place | Report on the development process of job descriptions<br>Job description |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | and; implement and follow ups. | | | | |
| | | 4.3.1.2 Disseminate job description for HRH to all levels | Job description disseminated | Number of dissemination conducted<br>Number of health workers aware of their job description<br>Number of health workers with job description | Dissemination plan<br>Report of dissemination of job descriptions |
| | | 4.3.1.3 Develop and distribute HR career information packs and conduct career talks at all levels | HR career information packs and career talks at all levels developed and distributed | HR career information packs in place<br>Number of HR career information packs distributed<br>Number career talks conducted | Reports of the development process of career information package<br>Career information package<br>Report of the career talks |
| 4.4 To improve the management of health institutions by creating a university level professional management cadre with a career ladder | 4.4.1 Create a university level professional management cadre with a career ladder | 4.4.1.1 Review the current health management programmes with the concerned universities and improve them accordingly | University level health management training curricula reviewed | Reviewed university level health management training curricula in place | Report on the review process |
| | | 4.4.1.2 Work with universities to ensure validation of the curricula by TCU | Training curricula validated by TCU | TCU validated university level health management training curricula in place | TCU validation certificate |
| | | 4.4.1.3 Work with POPSM to establish health institutions manager's cadre with a career structure | Health institutions managers' cadre with career structure established | Health managers' cadre with career structure in place | Report of the development process |
| | | 4.4.1.4 Appoint graduates of health management programmes with the necessary experience to | Graduates of university level health management training programmes appointed as managers of | Number of positions of managers of health institutions filled | List of health institutions being managed by professional managers |

| Specific Objective | Strategies | Activities | Output | Indicators | Means of Verification |
|---|---|---|---|---|---|
| | | manage health institutions | health institutions | by degree level graduates of health management | |
| 4.5 To enhance utilization of Medical Attendants (Community Health Workers, Social Welfare assistants and Medical Attendants) by 2019 | 4.5.1 Formalization of CHW cadres into the national health system | 4.5.1.1 Conduct advocacy sessions for establishment of scheme of service | Advocacy sessions for establishment of scheme of service for CHWs conducted | Number of advocacy sessions conducted<br>Number of stakeholders involved in the advocacy | Report on the advocacy sessions |
| | | 4.5.1.2 Follow up of establishment of scheme of services for community health workers (CHWs) | Establishment of scheme of services for CHWs followed up | Scheme of service for CHWs in place | Report on the establishment process of CHWs scheme of services<br>Scheme of service for CHWs |
| | 4.5.2 Promote the recruitment of CHWs | 4.5.2.1 Develop CHWs requirement plan | CHWs requirement plan developed | CHWs requirement plan in place | Report on the development process of CHWs requirement plan<br>CHWs requirement plan |
| | | 4.5.2.2 Advocate the recruitment of CHWs | Recruitment of CHWs advocated | Number of CHWs recruited | Report on the recruitment of CHWs<br>Employment letters |
| | 4.5.3 Promote standardization of motivation package for community health workers | 4.5.3.1 Update inventory list of CHWs and replace the drop out | Inventory list of CHWs and replacement of the drop out update | Updated inventory list of CHWs in place<br><br>Number of CHWs drop out replaced | Reports of the update process of inventory list of CHWs<br>Report of the CHWs drop outs replaced |

## Strategic Objective 5: Improve production and quality of HRH&SW at all levels

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| 5.1 To enhance management capacity of managers working in all Health and Social Welfare Training Institutions by 2019 | 5.1.1 Imparting managerial skills to all managers in all HSWTIs and follow ups- (here the managers refers: Principal/Head of Schools, Academic Officers, Vice Principals, Wardens, Administrators, Accountants, Supplies Officer) | 5.1.1.1 Conduct training on managerial skills to all managers in HSWTIs | Training on managerial skills to all managers in HSWTIs Conducted | Number of managers in HSWTIS trained on Managerial skills | ☐ Training Materials<br>☐ Training reports |
| | | 5.1.1.2 Conduct follow up to evaluate the effect of the training on managerial practices | Follow up to evaluate the effect of the training on managerial practices conducted | ☐ Number of follow ups to evaluate the effect of the training on managerial practices conducted<br>☐ Number of managers followed ups to evaluate the effect of the training on managerial practices | ☐ Follow up reports |
| 5.2 Solicit and motivate the participation of all public and private universities and health and social welfare training institutions to contribute towards the realization of the HRH Production Plan 2014-2024 goals and objectives | 5.2.1 Disseminate the HRH Production Plan 2014-2024 to all public and private training institutions and solicit for their contribution to its realization | 5.2.1.1 Produce and distribute copies of the Production Plan 2014-2024 to all public and private universities and health and social welfare training institutions, relevant ministries and development partners | Copies of the Production Plan distributed to public and private universities and health training institutions, relevant ministries and development partners | ☐ Number of copies distributed<br>☐ Number of institutions with copies of the Production Plan. | ☐ Copies of the Production Plan document<br>☐ Acknowledgement reports from stakeholders |
| | | 5.2.1.1 Conduct meetings with stakeholders | Meetings with stakeholders conducted | ☐ Number of meetings with stakeholders held | ☐ Meeting reports |
| 5.3 To increase capacity of Health and Social Welfare Training Institutions (HSWTIs) so as to enhance | 5.3.1 Develop a more detailed training business plan with the involvement of | 5.3.1.1 Conduct workshops with universities and health and social welfare training institutions to | Workshops with stakeholders held and commitments of stakeholders identified | ☐ Number of workshops held<br>☐ Number of stakeholders | ☐ Workshop reports |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| production of HRH by increasing student enrolment in universities and health and social welfare training institutions from the current 6,059 to 17,778 and improve the skills mix from the current composition of high level 11.9%, mid level 53.6% and support level 34.4% to 12.6%, 56.5% and 30.9% respectively by 2019. | public and private universities and health and social welfare training institutions. | guide the development of the Training Business Plan and its requirements | | involved | |
| | | 5.3.1.2 Assign universities and health and social welfare training institutions for the production of specific health and social welfare cadres in required numbers | Assigned roles and commitments of universities and health and social welfare training institutions identifiied | ☐ Number of universities and health and social welfare training institutions involved<br>☐ List of commitments for the involved training institutions | ☐ Meeting reports<br>☐ List of commitments |
| | | 5.3.1.3 Receive training business plans from universities and health and social welfare training institutions | Training business plans from universities and health and social welfare training institutions received | ☐ Numbers of training business plans received | ☐ Copies of training business plans |
| | | 5.3.1.4 Compile and harmonize the business plans from universities and health and social welfare institutions into a One Plan (The Business Plan) | A compiled and harmonized Training Business Plan | ☐ A single National Training Business Plan in place | ☐ Copies of the National Training Business Plan |
| | 5.3.2 Expand and improve HSWTIs infrastructure in to support the required intake of the students | 5.3.2.1 Renovate, extend existing buildings and Construct new structures (buildings/sites) for HSWTIs | Existing and new structures (buildings/sites) for HSWTIs renovated and constructed | ☐ Number of building/sites renovated<br>☐ Number buildings constructed | ☐ Renovation reports<br>☐ Construction reports<br>☐ Enrolment report |
| | 5.3.3 Expand enrolment by increasing more cadres in institutions | 5.3.3.1 Enrols more cadres in institutions that train rare cadres (Optometry, | More cadres in institutions that training rare cadres enrolled | Percentage of enrolment increase in institutions that train rare cadres | Enrolment reports on rare cadres |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| | that train mono cadres | Physiotherapy, anaesthesia, pharmaceutical technicians, Health laboratory technologists, radiology, health assistants and emerging) | | | |
| | | 5.3.3.2 Supply health training institutions with current health learning and teaching materials including tablets to support teaching and learning | Health training institutions supplied with health learning and teaching materials | ▫ Number of Health learning and teaching materials supplied<br>▫ Number of health training institutions received learning and teaching materials | ▫ Reports of the received learning and teaching materials |
| | 5.3.4 Make effective- support skills laboratory for appropriate students practical learning experiences | 5.3.4.1 Renovate support skills laboratory rooms | Support skills laboratory rooms in all health training institutions renovated | ▫ Number of support skills laboratory renovated | ▫ Tender documents<br>▫ Renovation reports |
| | | 5.3.4.2 Supply support skills laboratory with necessary equipment and materials | Support skills laboratory rooms in all health training institutions supplied with necessary equipment's and materials | ▫ Number of equipment and materials supplied to health training institutions | ▫ Inventory register<br>▫ Supply reports |
| | | 5.3.4.3 Procure vehicles for students supervision and field visits | Vehicles for students supervision and field visits procured | Number of vehicles procured for students supervision and field visits | ▫ Vehicle Purchase documents<br>▫ Vehicle purchase report |
| | 5.3.5 Increase enrolment of off campus students | 5.3.5.1 Enrol off-campus students in at least 2 HTIs per zone | Off-campus students in at least two HTIs per zone per annum enrolled | ▫ Number of off-campus students | ▫ Application letters<br>▫ Admission letters<br>▫ Students registration |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| | | per annum | | enrolled | reports |
| | 5.3.6 Enhance capacity of training in health training institutions | 5.3.6.1 Recruit and post the required number of teaching staffs to health and social welfare training institutions | The required number of teaching staffs to health and social welfare training institutions recruited and posted | □ Number of teaching staff recruited and posted<br>□ Number of training institutions with new teaching staff Number of health training institutions with the required number teachers | □ Employment letters of newly recruited staff<br>□ Payroll<br>□ Distribution report of newly recruited staff |
| | | 5.3.6.2 Establish a scheme of service for Health and Social welfare tutors | Scheme of service for health and social welfare tutors established | Scheme of service for health and social welfare tutors in place | □ Scheme of service for health and social welfare tutors |
| | 5.3.7 Build capacity of teaching staff in health training institutions on teaching methodology | 5.3.7.1 Conduct training on teaching methodology and new developments to teaching staffs in training institutions | Training on teaching methodology and new developments of teaching staffs in training institutions | □ Number of training on teaching methodology for teaching staff in health training institutions conducted<br>□ Number of teaching staff trained on teaching methodology<br>□ Number of teaching staff practicing | □ Training materials on teaching methodology<br>□ Training reports on teaching methodology |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| | | | | proper teaching methodology | |
| | 5.3.8 Support technically HSWTIs | 5.3.8.1 Conduct supportive supervision in all HSWTIs | Supportive supervision in all HSWTIs conducted | ▯ Number of supportive supervision conducted<br>▯ Number of training institutions that received supportive supervision | ▯ Supportive supervision plan<br>▯ Supportive supervision reports |
| 5.4 To enhance the quality and effectiveness of Continuing Professional Development (CPD) Programs by 2019 | 5.4.1 Strengthen CPD programs | 5.4.1.1 Develop mechanisms for recognition and accreditation of in-service training by involving health professional regulatory bodies and associations | Mechanisms for recognition and accreditation of in-service training by involving health professional regulatory bodies and association developed | Mechanisms for recognition and accreditation of in-service training in place | ▯ Report on the development of mechanisms for recognition and accreditation of in-service training<br>▯ Accreditation certificates for approved in-service training |
| | | 5.4.1.2 Update CPD guideline to incorporate current development | CPD guideline to incorporate current development updated | Updated CPD guideline in place | Report of the updates of CPD guidelines |
| | | 5.4.1.3 Introduce licensing and re-licensing of higher level cadres to maintain standards of practice | Licensing and re-licensing procedures incorporated into the legislations of the different professional councils and the CPD guidelines | Updated legislations of different professional councils and CPD guidelines in place | Reports of the updates of the legislations of the different professional councils and CPD guidelines |
| | | 5.4.1.3 Promote operationalization of CPD guideline | Operationalization of CPD guideline promoted | Number of promotion activities conducted | Report on activities conducted for promotion CPD guidelines |
| | | 5.4.1.4 Develop database for in-service training | Database for in-service training developed | Database for in-service training in place | Report on development of the data base |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| | | 5.4.1.5 Promote utilisation of other methods for in-service training such as distance, e-learning, on job training | Utilisation of other methods for in-service training such as distance, e-learning, on job training promoted | Number of methods utilised for in-service training<br><br>Number of students trained using the distance, e-learning and on job training | ☐ Report on promoted methods for in-service training<br><br>☐ Inventory of students using the distance, e-learning and on job training methods |
| 5.5 To improve the quality of curricula for all health and social welfare programs by 2019 | 5.5.1 Update and enrich curricula for all health and social welfare programs | 5.5.1.1 Review and finalize the curricula for all health and social welfare programs | Curricula for all health and social welfare programs reviewed and finalised | Number of curricula reviewed and finalized | ☐ Reports of the reviewed circulars for all health and social welfare programs<br><br>☐ Reviewed circulars for all health and social welfare programs |
| | | 5.5.1.2 Adopt WHO guideline for task sharing and Incorporate Task sharing in Health and Social Welfare curricula with the involvement of professional bodies | | | |
| | 5.5.2 Validate curricula for all health and social welfare programs | 5.5.2.1 Submit reviewed and finalized curricula to NACTE for validation | Reviewed and finalized curricula to NACTE for validation submitted | ☐ Number of reviewed and finalized curricula submitted<br>☐ Number of reviewed and finalized curricula validated | ☐ Submission letter of circular to NECTA<br>☐ Validated circular by NECTA |
| 5.6 To improve collaboration between MoHSW, professional bodies and NACTE in accrediting and regulating health and social welfare training | 5.6.1 Set standards for accreditation and regulation of health training institutions and; establish compliance among the key stakeholders | 5.6.1.1 Mapping of health training stakeholders | Stakeholders for health training mapped | Number of stakeholders identified | Report of the mapping of health training stakeholders |
| | | 5.6.1.2 Conduct needs and expectations assessment of | Needs and expectations assessment of stakeholders conducted | Needs and expectations of health training | ☐ Inception reports of the assessment process<br>☐ Report of the needs |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| institutions | | stakeholders | | stakeholders in place | and expectation of stakeholders |
| | | 5.6.1.3 Develop TORs and MOU for collaboration in health training | TORs and MOU for collaboration in health training | Number of TORs and MOU developed<br>Number of collaboration in health training entered<br>Number of collaboration in health training in the process to be entered | Terms of References (TORs) for collaboration in health training<br>Memorandum of Understanding (MOU) for collaboration in health training |
| | 5.6.2 Promote regulation of clinical officers and clinical assistants | 5.6.2.1 Collaborate with Medical Council of Tanganyika for inclusion of clinical officer and clinical assistant in their regulatory system | Regulation of clinical officer and clinical assistant included in the Medical Council of Tanganyika | Regulation of clinical officer and clinical assistance procedure in the Medical Council of Tanganyika | Reports of collaborative activities for inclusion of clinical officer and clinical assistance procedure in the Medical Council of Tanganyika |
| | 5.6.3 Ensure effective execution of defined roles among collaborative partners | 5.6.3.1 Identify focal persons | Focal persons identified | Number of focal person identified | Appointment letter of the identified focal persons |
| | | 5.6.3.2 Define roles and responsibilities of each focal person | Roles and responsibilities of focal persons defined | Number of defined roles and responsibilities for focal person<br>Number of focal person with defined roles and responsibilities | Roles and responsibilities for the focal person |
| | | 5.6.3.3 Develop a mechanisms for | Mechanisms for communication and | Mechanisms for communication and | Report of the development process |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| | | communication and information sharing among collaborative partners | information sharing among collaborative partners developed | sharing information among collaborative partners in place | of the mechanism<br>□ Mechanisms for communication and information sharing |
| 5.7 To improve the quality and utilization of Medical attendants, social welfare attendants and Community Health Workers by the year 2019 | 5.7.1 Establish Curricular for Medical attendants, social welfare attendants and Community Health Workers' trainings | 5.7.1.1 Conduct Training Need Assessment for Medical attendants, social welfare attendants and Community Health Workers' trainings | Training Need Assessment for Medical attendants, social welfare attendants and Community Health Workers' trainings conducted | Number of knowledge and skills gaps for Medical attendants, social welfare attendants and Community Health Workers' trainings identified | □ Inception report of training need assessment<br>□ Training need assessment report |
| | | 5.7.1.2 Develop curricula for Medical attendants, social welfare attendants and Community Health Workers' trainings | Curricular for Medical attendants, social welfare attendants and Community Health Workers' trainings Developed | Number of curricular for Medical attendants, social welfare attendants and Community Health Workers' trainings developed | □ Report on development process of the circular<br>□ Curricular for medical and social welfare attendants |
| | | 5.7.1.3 Facilitate accreditation of the curricular for Medical attendants, social welfare attendants and Community Health Workers' trainings | Curricular for Medical attendants, social welfare attendants and Community Health Workers' trainings facilitated for accreditation | □ Number of Curricular for Medical attendants, social welfare attendants and Community Health Workers' trainings facilitated for accreditation<br>□ Curricular accredited | □ Accredited curricular |
| | | 5.7.1.4 Disseminate curricular for Medical attendants, social welfare attendants and Community Health Workers' trainings to the relevant institutions | Curricular for Medical attendants, social welfare attendants and Community Health Workers' trainings to the relevant institutions disseminated | □ Number of curricular for Medical attendants, social welfare attendants and Community Health | □ Dissemination plan<br>□ Reports on dissemination of circulars |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| | | | | Workers' trainings disseminated<br>□ Number of relevant health training institutions aware of curriculum for Medical attendants, social welfare attendants and Community Health Workers' trainings<br>□ Number of relevant health training institutions with curriculum for Medical attendants, social welfare attendants and Community Health Workers' trainings<br>□ Number of relevant health training institutions training Medical attendants, social welfare attendants and Community Health Workers | |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of verification |
|---|---|---|---|---|---|
| | | 5.7.1.5 Build capacity of Medical attendants, social welfare attendants and Community Health Workers | Trained Medical attendants, social welfare attendants and Community Health Workers' trainings using the developed curricular | Number of Medical attendants, social welfare attendants and Community Health Workers trained | □ Training materials on capacity buildings of Medical attendants, social welfare attendants and Community Health Workers<br>□ Training reports |

## Strategic Objective 6: Strengthen partnerships and coordination of HRH&SW interventions among stakeholders at all levels

| Specific Objective | Strategies | Activities | Output | Indicator | Means of Verification |
|---|---|---|---|---|---|
| 6.1 To improve coordination and alignment of HRH&SW priorities across four key ministries- MOHSW, PMO-RALG, POPSM, MOF and with other HRH stakeholders by 2019 | 6.1.1 Establish regular forum and workshops for sharing HRH&SW priorities | 6.1.1.1 Develop a ministerial coordinating team | Ministerial Coordinating team developed | Ministerial coordinating team in place | ☐ List of team members<br>☐ Team development report |
| | | 6.1.1.2 Develop guidelines for forums and workshops | Guidelines for ministerial forums and workshops developed | Number of guidelines developed | ☐ Report on development of guidelines<br>☐ Guidelines |
| | | 6.1.1.3 Conduct forums and workshops as per guidelines | Forums and workshops for conducted as per guidelines | Number of forums and workshops conducted | Forums and workshops reports |
| | 6.1.2 Promote sharing new HRH&SW developments and priorities | 6.1.2.1 Develop leaflets and policy brief on new HRH developments and priorities | Leaflets and policy brief on new HRH developments and priorities developed | Number of leaflets and policy brief on new HRH developments and priorities | Leaflets and policy brief |
| | | 6.1.2.2 Design a mechanism including frequency for sharing new HRH developments and priorities | A mechanism including frequency for sharing new HRH developments and priorities designed | A mechanism including frequency for sharing new HRH developments and priorities in place | Report on development of a mechanisms including the frequency |
| | | 6.1.2.3 Sharing new HRH developments and priorities | New HRH developments and priorities shared | Number of New HRH developments and priorities shared | Report on the inventory of New HRH developments and priorities shared |
| 6.2 To improve networking and coordination among HRH stakeholders by 2019 | 6.2.1 Establishing a mechanisms for coordination and collaboration among HRH&SW stakeholders | 6.2.1.1 Design and implement inter-ministerial HRH development and management committee meetings | Inter-ministerial HRH development and management committee meetings designed and implemented | ☐ Inter - ministerial development and management committee meetings established<br>☐ Number of Inter - ministerial development and management committee meetings conducted | ☐ Report of the establishment of inter-ministerial HRH&SW committee<br>☐ Minutes of the inter-ministerial HRH&SW development and management committee |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of Verification |
|---|---|---|---|---|---|
| | | 6.2.1.2 Conduct at least two per annum HRH&SW stakeholders meetings to share HRH&SW key issues and implementation of strategic plan | At least two per annum HRH&SW stakeholders meetings to share HRH&SW key issues and implementation of strategic plan conducted | Number of HRH&SW stakeholders Meetings conducted | Minutes of the HRH&SW stakeholders meetings |
| | | 6.2.1.3 Commission and supervise HRH&SW related research studies. | Commissioned and supervised HRH related research studies. | Number of Commissioned and supervised HRH related research studies in place | ☐ Report on supervision HRH&SW related research<br>☐ Research report related to HRH&SW |
| | | 6.2.1.4 Disseminate findings from HRH&SW related research studies and identify policy and programme implications | ☐ Findings from HRH&SW related research studies disseminated<br>☐ Implications of research findings in policies and programme identified | ☐ Number of findings from HRH&SW related research studies disseminate<br>☐ Number of HRH research implications for policies and programme identified | ☐ Plan on dissemination of HRH&SW research findings<br>☐ Dissemination reports of HRH&SW finings |
| | | 6.2.1.5 Coordinate and monitor HRH research and utilise findings in decision making. | ☐ HRH research Coordinated and monitored<br>☐ HRH research findings utilised for HRH decision making | ☐ Number of HRH research coordinated and monitored<br>☐ Number of findings utilised for HRH decision making | ☐ Report on coordination and monitoring of HRH&SW research<br>☐ Report on the utilization of HRH&SW research findings on decision making |
| | 6.2.2 Foster smooth implementation of | 6.2.2.1 Develop proper implementation | ☐ Implementation guideline for HRH | ☐ Availability of guidelines for | ☐ Guidelines for HRH activities |

| Specific Objective | Strategies | Activities | Output | Indicator | Means of Verification |
|---|---|---|---|---|---|
| | HRH&SW activities | guideline, which shall state clear roles and responsibilities of each HRH actors. | activities in place | HRH activities | ☐ Report on implementation of HRH activities |
| 6.3 To improve communication between HRH&SW actors both public and private by 2018 | 6.3.1 Design appropriate feedback mechanism | 6.3.1.1 Develop forms which will acknowledge receipt & reading of any relevant document | ☐ To have a well functioning feedback mechanism by 2015 | ☐ Number of feedback from HRH actors.eg on strategic plans documents, policies etc.<br>☐ Number of meetings and participants attended to discuss HRH issues.<br>☐ Level of interactions and updates on HRH matters. | ☐ Feedback forms available and acknowledged<br>☐ Number of meetings conducted |
| | | 6.3.1.2 Select a secretariat which shall supervise feedback mechanisms | | | |
| | | 6.3.1.3 Promote information exchange among HRH actors<br>6.3.1.4 Emphasize regular meetings to discuss HRH matters. | | | |
| 6.4 Support private sector to scale up training of health workers in line with PHSDP/MMAM | 6.4.1 Private sector engagement in HRH | 6.4.1.1 Assess capacity of Private institutions in Training and service delivery | ☐ Capacity of private sector institutions assessed | Number of private institutions assessed | ☐ Assessment report<br>☐ List of private sector institutions and their capability statements |
| | | 6.4.1.2 Support the private sector to scale up training of health and social welfare workers in line with PHSDP | ☐ Private sector institutions supported to scale up training of health and social welfare workers | Number of private sector institutions supported | ☐ List of private sector institutions supported |
| | | 6.4.1.2 Sub-contract private training institutions to contribute in the training of mid level cadres | ☐ Some private health training institutions sub-contracted to train mid level cadres | Number of institutions contracted to private sector to train mid level cadres | ☐ List of institutions contracted to private sector<br>☐ Number of graduates from institutions contracted to the private sector |

# Chapter Six:

## Summary of Activity Cost

Human Resources for Health Strategic Plan Budget Estimates

| Sn | Strategic Objectives | Activities | Cost |
|---|---|---|---|
| 1 | Strategic Objective 1: Strengthen policy development and HRH planning at all levels | 18 | 7,118,159,300 |
| 2 | Strategic Objective 2: Strengthen HRH&SW research and utilization at all levels | 12 | 5,557,936,000 |
| 3 | Strategic Objective 3: Strengthen leadership and advocacy of HRH at all level | 8 | 2,441,075,000 |
| 4 | Strategic Objective 4: Strengthen HRH&SW recruitment, retention, career development and utilization at all levels | 14 | 2,225,160,000 |
| 5 | Strategic Objective 5: Improve Production and quality of HRH&SW | 31 | 55,347,586,000 |
| 6 | Strategic Objective 6: Strengthen partnership and coordination of HRH&SW stakeholders at all levels | 11 | 1,230,550,000 |
| | **Grand Total** | **94** | **73,920,466,300** |

# Chapter Seven

# Monitoring and Evaluation

## 7.1 HRH Monitoring and Evaluation Framework

Monitoring of this section is designed to provide information regarding progress and achievement at different stages during the implementation period. An M&E framework for the national HRH strategic plan will be developed. This will lay down a foundation for a sound empirical evidence for informed policy decision-making and monitor the progress of HRH development interventions both at strategic and operational levels. It will serve as powerful and effective monitoring tool that will be used by HRH managers at different levels of the health system to gather, analyze, generate timely information, submitting reports and getting feedback to solve problems related to human resources on timely manner and explore new solutions to overcome chronic HRH issues.

The framework will in addition:

- Provide systematic mechanism for monitoring HRH in health sector
- Provide evidence to inform HRH policy and planning & decision making
- Reinforce HRH accountability within the health sector
- Enhance better understanding of the trends in HRH
- Create a basis to measure and monitor impact of HRH interventions
- Enhance sub-national comparability
- Harmonization and alignment with other M&E frameworks and information systems
- It will also assist in capturing lessons learned, identify and document the best practices to be shared in-country and globally

## 7.2 Things to be monitored

In order to be able to measure change key targets for some specific areas have been set below.

| Areas of Focus | Develop Targets | Source Of Information |
|---|---|---|
| 1. Recruitment | Shortage of staff reduced from 52% in 2014 to 30% in 2019<br><br>Utilisation of granted permits increased from 60% in 2014 to 100% in 2019 | HRHIS/TIIS<br><br>POPSM permits on annual basis<br><br>Posting report on annual basis |
| 2. Production | Production of health workers increased based on demand from 7,000 graduates in 2014 to 10,000 graduates 2019 | TIIS |
| 3. Retention | 70% of staff posted to districts are retained within the health sector | HRHIS/TIIS |

***Key Indicators for HRH Production Plan***

The following are key monitoring indicators for the HRH Production Plan

1. Total health personnel
2. Population per worker
3. Health worker per 100,000 population
4. Physicians (including AMOs) per 100,000 population
5. Nursing and midwifery personnel per 100,000 population

## 7.3 Progress monitoring

While most of the indicators are strategic objective specific and denotes to certain activities, a sensitive set of CORE HRH indicators will be identified. This will emanate from the MOHSW milestones and other key strategic documents. Specifically the following will be tracked. The reporting process will take into consideration vertical and horizontal strategies to ensure total coverage of partners and relevant stakeholders for HRH&SW. In order to capture data adequately; an Input – Output – Outcome – Impact data collection, analysis and reporting approach will be applied. Specifically the following will be tracked.

### Accomplishment status of planned activities

In order to establish whether activities are implemented as planned. Progress reporting mechanism will be used to establish the status of implementation of planned activities at all levels. Progress indicators will be extracted from operational plans to establish whether the planned activities have been accomplished. To ensure that this happens, all levels develop an operational plan on annual basis with clear progress indicators. In addition there will be an inclusion and review of councils quarterly technical report tool to ensure key information on HRH is collected on quarterly basis.

### Inputs availability

For activities to be implemented the identified inputs need to be available. The experience of the implementation of HRHSP 2008 -2013 indicates difficulties in capturing how much funding is set and utilised for HRH issues. A possibility of embedding an extra form in the existing information to capture HRH financing at all levels will sought so that financial data is collected.

### HRH demand and supply

The developed HRHIS and TIIS will continue to be strengthened and its utilisation be promoted. Since this was 100% supported by a project a clear sustainability plan will be set to ensure a smooth exit of the supporting project and mainstreaming of the two systems into the overall government structure in terms of technical and financial support. The information about HRH available, recruitments, training and attrition will be captured. Enrolment, outputs from training institution will be tracked.

## 7.4 Information sources

Monitoring will be informed by activity reports from councils, ministries departments and partners, HRHIS, TIIS, DHIS and HMIS. The information will be harmonized to enhance consistency and reliability.

## 7.5 Strategy evaluation

In general, there will be two main categories of evaluations to be conducted within the lifespan of the strategic plan. These are midterm and final evaluation. Midterm Evaluation will focus on how the HRHSP 2014-2013 is being implemented to determine if the programme is on the right track towards the achievement of planned results and if not, what are the influencing factors. This will be done in year three. This will be an external evaluation. Final evaluation will be done at the end of year five. This will also be an external evaluation.

## 7.6 Utilization of Monitoring and Evaluation Results

In the monitoring and evaluation process, good and bad practices will be identified and documented to inform future design and implementation of HRH&SW strategic plan. In addition, the documented good practices will used to improve the ongoing implementation. To ensure effective use of M&E results, documented good practices will be shared with HRH&SW stakeholders.

## 7.7 Important Assumptions

The success in putting this strategic plan into action will highly depend on:

- Reliable financing of planned activities: It very clear that the government financing alone will not cater for all financial requirement of implementing this strategy. Support from other stakeholders is crucial for the realisation of the planned activities. To ensure that stakeholders access and are aspired of the strategic direction taken by the government in addressing HRH crisis and increase access to health services to its population, a resources mobilisation and a communication plan for this strategic plan will be developed to ensure that key stakeholders are informed of the strategic directions and envisaged changes.

- Committed implementers: With limited resources available implementers at all levels will translate the strategic plan into operational plans. CHMTs are expected to incorporate HRH issues into CCHPs.

- Accountability: The strategic plan implementation will be realised if the implementers inculcate a sense of accountability. This will be enhanced by ensuring activities are planned, implemented and reported. An extra mile will be achieved in this strategic plan if implementers at council level with leadership of RHMTs do both routine and innovative actions to increase numbers of human resources, enhance their retention and elevate their morale.

- Partnership and Coordination. Since resources are scarce putting efforts together in a coordinated manner will make the planned strategies and envisaged changes reality. Transparency and scaling up of support to cover areas that less resourced will enhance equitable distribution of HRH and avoid duplication of efforts.

# References

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# Appendix: Activity Costs

## Strategic Objective 1: Strengthen policy development and HRH planning at all levels

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To enhance evidence based HRH&SW planning at all levels by 2019 | Strengthen the HRH Planning Unit to effectively advocate for HRH development at national, regional and district level and support and supervise the development of HRH plans at all levels | Redefine the roles of the HRH Planning Unit and develop and support its collaboration in HRH&SW with other departments within the MoHSW and other MDAs | DHR | 150,000,000 | | | | | |
| | | Staff the HRH Planning Unit with the required number of competent people | DHR<br>DAP | 50,000,000 | | | | | |
| | | Train the HRH Planning Unit staff in HRH data and information, HRH planning and management | DHR | 100,000,000 | | | | | |
| | Improve HRHIS and TIIS to accurately determine the HRH attrition rate by incorporating leaving rates in addition to retirement and deaths in both public and private sector | Develop and distribute guidelines for collecting and reporting data on HRH leaving by resignation, changing profession or emigration | DHR | 300,000,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| | | Develop and distribute tools for collecting and reporting leaving HRH | | | | | | | |
| | | Train responsible HRH at central, regional and district level for acquisition of data on leaving HRH | DHR | 500,000,000 | | | | | |
| | Introduce and develop capacity for applying Workload Indicator Staffing Needs (WISN) for determination of real staff requirements for health facilities at district, regional, zonal and national levels instead of using standard facility type based establishments | Acquire and distribute WISN tools to all district, regional, zonal and national hospitals | DHR | 150,000,000 | | | | | |
| | | Train responsible hospital teams in determining staffing needs using WISN | DHR | 500,000,000 | | | | | |
| | | Supervise and support the application of WISN in hospitals | DHR | 300,000,000 | | | | | |
| | Accelerating coverage and utilization of HRHIS/TIIS at all | Sensitize key stakeholders on HRHIS/TIIS database at all levels | DHR<br>RMO<br>DMO<br>Principals | 201,630,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| levels by 2019 | levels. | Conduct refresher trainings on the proper operationalization of the HRHIS/TIIS | DHR<br>RMO<br>DMO<br>Principals | 150,399,300 | | | | | |
| | | Conduct on site support supervision to ensure proper maintenance and update of the system | | 300,000,000 | | | | | |
| | | Build capacity of health officials at all levels on HRHIS/TIIS data analysis and utilization | | 232,875,000 | | | | | |
| | Generating HRH planning procedures that is integral to the national planning system | Develop HRH planning guidelines | | 129,720,000 | | | | | |
| | | Develop HRH succession and career development plans | | 101,040,000 | | | | | |
| | | Advocate and sensitize to planners, managers, trainers, employers and employees on development and implementation of HRH Plans at all levels | | 383,120,000 | | | | | |
| To increase responsiveness of HRH policies to actual needs and demands of providers and clients at all levels by 2018 | Utilization of existing HRH information and consultation of a wider scope of stakeholders to updates existing and formulate new HRH policies to reflect the real situation | Update existing HRH policies, standards and guidelines; formulate new ones and; disseminate | | 383,120,000 | | | | | |
| To improve monitoring and evaluation of HRH initiatives by 2018 | Designing and execute frameworks for monitoring implementation of | Develop monitoring and evaluation frameworks for HRH initiatives | | 101,040,000 | | | | | |
| | | Regular review of staffing | | | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| | HRH initiatives at all levels | level according to requirements and monitor its effects | | 779,400,000 | | | | | |
| | | Carry out supportive supervision in the implementation of the NHRH Strategic plan at all levels | | 1,135,280,000 | | | | | |
| | | Develop necessary tools and train HR at Central level to implement and facilitate proper M&E for HRH&SW Plans and strategies | | 93,950,000 | | | | | |
| | | Develop plan for monitoring and evaluation of HRH&SW initiatives at all levels | | 93,950,000 | | | | | |
| | | Conduct Mid Term and final Review of the NHRH Strategic Plan and make use of the findings to improve performance | | 300,800,000 | | | | | |
| | | Conduct monthly HRH Technical Working Group Meetings (HRHTWG) | | 371,240,000 | | | | | |
| | | Conduct HRH stakeholders' meeting annually | | 250,000,000 | | | | | |
| To enhance effectiveness and efficiency in the implementation of HRH and HRH related policies and guidelines at | Promote development of HRH capacity to translate and utilize the existing HRH policies and guidelines | Train relevant HRH on policy and guidelines translation and utilization | | 1,128,300,000 | | | | | |
| | | Follow up translation of various HRH policies and guidelines | | 50,000,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| all levels by 2019 | | Provide mentoring sessions to facilitate policy translation and utilization | | 766,400,000 | | | | | |
| To increase access to HRH and related policies to all levels by 2016 | Promote dissemination of HRH and related policies | Design frequently updated HRH and related policies inventories | | 0 | | | | | |
| | | Design a mechanism to frequently contacts relevant directorates, departments, sections and stakeholders to disseminate HRH and related policies | | 50,000,000 | | | | | |

## Strategic Objective 2: Strengthen HRH&SW research and utilization at all levels

| Specific objectives | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To improve research activities and utilization by 2018 | Coordinate HRH research activities and promote its utilization | Develop HRH research agenda and disseminate to key stakeholders | | 16,690,000 | | | | | |
| | | Advocate implementation of research agenda to key stakeholders. | | 325,810,000 | | | | | |
| | | Train HRH managers and relevant health care professionals on research and utilization of findings. | | 351,256,000 | | | | | |
| | | Mapping of potential local and international HRH research organizations and institutions and; establish the research linkages | | 37,700,000 | | | | | |
| | | Commission and supervise HRH related research studies. | | 31,890,000 | | | | | |
| | | Disseminate findings from HRH related research studies and identify policy and programme implications | | 62,600,000 | | | | | |
| | | Coordinate and monitor HRH research and utilise findings in decision making. | | 52,100,000 | | | | | |

| Specific objectives | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To enhance utilization of existing HRH research evidence for Policy, Plans and Practice improvement by 2016 | Monitor utilization of the HRH research findings | Disseminate existing HRH research findings to stakeholders at all levels | | 3,310,700,000 | | | | | |
| | | Follow up utilization of HRH findings in policies, plans and practices | | 31,890,000 | | | | | |
| To enhance preciseness of existing HRH research findings to easily inform policy, plan and practice 2016 | Translate HRH research evidence into simple and precise terms | Design a data base for various HRH research findings | | 242,100,000 | | | | | |
| | | Design a mechanism to translate various HRH research findings into simplified and easy to use terms for policy, plans and practice improvements | | 1,042,600,000 | | | | | |
| | | Develop a mechanisms for sharing translated HRH research findings | | 52,600,000 | | | | | |

## Strategic Objective 3: Strengthen leadership and advocacy of HRH at all level

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To enhance coordination of HRH issues among stakeholders by 2019 | Design and implement a coordinating mechanism of HRH issues among stakeholders | Develop and support mechanisms for intra and inter-sect oral collaboration in support of HRH issues | | 20,000,000 | | | | | |
| | | Conduct quarterly reflection meeting with all stakeholders in HRH&SW implementation initiatives | | 135,400,000 | | | | | |
| To increase capacity of health managers on leadership, management and advocacy of the health system all levels by 2019 | Define dimensions of health managers authority; train health managers on leadership and management skills Leadership and; conduct follow ups on leadership and management practices | Delineate dimensions of health managers' authority, responsibility and accountability at different levels. | | 1,143,300,000 | | | | | |
| | | Conduct a comprehensive management capacity audit of functions, structures and skills at all levels. | | 342,625,000 | | | | | |
| | | Identify problematic areas and systemic gaps and management/leadership needs. | | 342,625,000 | | | | | |
| | | Develop relevant health leadership and management development programmes for strategic intervention | | 133,700,000 | | | | | |
| | | Evaluate the impact of health leadership and management interventions and initiated improvements | | 268,425,000 | | | | | |
| | | Conduct a comprehensive management capacity audit of functions, structures and skills at all levels | | 55,000,000 | | | | | |

## Strategic Objective 4: Strengthen HRH&SW recruitment, retention, career development and utilization at all levels

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To increase the number of Health and Social Welfare workers from the current 66,348 to 98,226 and improve the skills mix from the current composition of high level 11.9%, mid level 53.6% and support level 34.4% to 12.6%, 56.5% and 30.9% respectively by 2019 and deploy them at all levels and areas of the country based on needs by 2019 | Accelerating recruitment procedures, capacity building and ensure equity distribution of health workers at all levels | Prepare and submit to the Treasury prior to commencement of the recruitment process a detailed 5-Year Recruitment Plan to obtain 'authority to recruit' 34,098 health and social welfare workers and achieve a skills mix of high level 12.6%, mid level 56.5% and support level of 30.9% by 2019 | DHR<br>DAP<br>DPP | 85,270,000 | | | | | |
| | | Conduct bi-annual Recruitment Campaigns through the local print media as well as radio and TV to attract health workers who have retired, resigned or changed their professions to re-join the health service. | | 150,950,000 | | | | | |
| | | Collaborate with health workers employment authorities in all recruitment matters i.e. from planning to implementation | | 100,410,000 | | | | | |
| | | Conduct key stakeholders meeting to identify bottleneck of recruitments and posting process of HRH | | 29,470,000 | | | | | |
| | | Conduct key HRH stakeholders meetings to share the HRH posting and | | 28,090,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| | | recruitments evaluation findings | | | | | | | |
| | | Conduct advocacy meeting regarding recruitment and deployment of HRH among key stakeholders | | 20,130,000 | | | | | |
| | Promote smooth recruitment process | To review the current recruitment process in order to reduce delays in HRH recruitment and other challenges related to postings and mismatch | | 28,090,000 | | | | | |
| | Promote budget increase for HRH retention activities | To advocate for the review of the current CCHP guidelines so as to accommodate more HRH components with substantial amount set for HRH retention | | 329,520,000 | | | | | |
| To enhance retention of HRH at all levels by 2018 | Establish and implement retention mechanisms of health workers | Build capacity for Human Resource Development (HRD) and Human Resource Management (HRM) at all levels to improve deployment and utilization of HRH | | 300,000,000 | | | | | |
| | | Improve the pay and compensation packages and terms and conditions of employment to improve motivation, productivity and commitment of the health workforce | | 200,000,000 | | | | | |
| | | Develop and Implement | DHR | | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| | | the comprehensive Motivation and Retention mechanism | DAP<br>DPP | 329,520,000 | | | | | |
| | | Develop guidelines and procedures for managing the movement of health and social welfare workers within the public sector and across the public/private sector interface | | 200,000,000 | | | | | |
| | | Disseminate health worksrs motivation and retention mechanisms | DHR | 329,520,000 | | | | | |
| | | Design and implement comprehensive induction programmes for all cadres who are newly appointed health workers. | DHR | 410,680,000 | | | | | |
| | | Develop, establish and enforce new types of contractual agreements such as bonding system for students receiving fellowships or loans from public funds | DHR | 200,000,000 | | | | | |
| To increase utilization of HRH at all levels by 2019 | Establish the necessary tool (s) to facilitate performance management and career development and; implement and follow ups. | Update and develop job descriptions for all positions of health cadres. | DHR<br>DAHRM<br>RMOs<br>DMOs | 33,200,000 | | | | | |
| | | Disseminate job description for HRH to all levels | DHR | 330,020,000 | | | | | |
| | | Develop and distribute HR career information packs and conduct career talks at all levels | DHR | 102,290,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To improve the management of health institutions by creating a university level professional management cadre with a career ladder | Create a university level professional management cadre with a career ladder | Review the current health management programmes with the concerned universities and improve them accordingly | DHR | 150,000,000 | | | | | |
| | | Work with universities to ensure validation of the curricula by TCU | | 50,000,000 | | | | | |
| | | Work with POPSM to establish health institutions manager's cadre with a career structure | DHR | 50,000,000 | | | | | |
| | | Appoint graduates of health management programmes with the necessary experience to manage health institutions | PS<br>DAP | | | | | | |

## Strategic Objective 5: Improve Production and quality of HRH&SW

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To enhance management capacity of managers working in all Health and Social Welfare Training Institutions (SWTIs) by 2019 | Imparting managerial skills to all managers in all HSWTIs and follow ups- (here the managers refers: Principal/Head of Schools, Academic Officers, Vice Principals, Wardens, Administrators, Accountants, Supplies Officer) | Conduct training on managerial skills to all managers in HSWTIs | DHR<br>DAP<br>RMO<br>DMO | 297,297,000 | | | | | |
| | | Conduct follow up to evaluate the effect of the training on managerial practices | DHR<br>DAP | 49,605,000 | | | | | |
| Solicit and motivate the participation of all public and private universities and health and social welfare training institutions to contribute towards the realization of the HRH Production Plan 2014-2024 goals and objectives | Disseminate the HRH Production Plan 2014-2024 to all public and private training institutions and solicit for their contribution to its realization | Produce and distribute copies of the Production Plan 2014-2024 to all public and private universities and health and social welfare training institutions, relevant ministries and development partners | DHR | 100,000,000 | | | | | |
| | | Conduct meetings with stakeholders | DHR | 150,000,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To increase capacity of Health and Social Welfare Training Institutions (HSWTIs) so as to enhance production of HRH by increasing student enrolment in universities and health and social welfare training institutions from the current 6,059 to 17,778 and improve the skills mix from the current composition of high level 11.9%, mid level 53.6% and support level 34.4% to 12.6%, 56.5% and 30.9% respectively by 2019. | Develop a more detailed training business plan with the involvement of public and private universities and health and social welfare training institutions. | Conduct workshops with universities and health and social welfare training institutions to guide the development of the Training Business Plan and its requirements | DHR | 300,000,000 | | | | | |
| | | Assign universities and health and social welfare training institutions for the production of specific health and social welfare cadres in required numbers | DHR | - | | | | | |
| | | Receive training business plans from universities and health and social welfare training institutions | DHR | - | | | | | |
| | Expand and improve HSWTIs infrastructure in to support the required intake of the students | Renovate, extend existing buildings and Construct new structures (buildings/sites) for HSWTIs | DHR<br>DPP<br>PMU | 9,000,000,000 | | | | | |
| | | Purchase furniture (tables, desks etc) | DHR<br>DPP<br>PMU | 3,000,000,000 | | | | | |
| | Expand enrolment by increasing more cadres in institutions that train mono cadres | Enrols more cadres in institutions that train rare cadres (Optometry, Physiotherapy, anaesthesia, pharmaceutical technicians, Health laboratory technologists, | DHR<br>HTI<br>Principals | 100,000,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| | | radiology, health assistants and emerging) | | | | | | | |
| | | Supply health training institutions with current health learning and teaching materials including tablets to support teaching and learning | DHR<br>HTI<br>Principals | 5,000,000,000 | | | | | |
| | Make effective-support skills laboratory for appropriate students practical learning experiences | Renovate support skills laboratory rooms | DHR<br>HTI<br>Principals | 5,000,000,000 | | | | | |
| | | Supply support skills laboratory with necessary equipment and materials | DHR<br>HTI<br>Principals | 5,000,000,000 | | | | | |
| | | Procure vehicles for students supervision and field visits | DHR | 1,300,000,000 | | | | | |
| | Increase enrolment of off campus students | Enrol off-campus students in at least 2 HTIs per zone per annum | DHR | 23,160,000,000 | | | | | |
| | Enhance capacity of training in health training institutions | Recruit and post the required number of teaching staffs to health and social welfare training institutions<br><br>Establish a scheme of service for Health and Social welfare tutors | DHR<br><br>DHR<br>DAP | 45,000,000<br><br>160,000,000 | | | | | |
| | Build capacity of teaching staff in health training institutions on teaching methodology | Conduct training on teaching methodology and new developments to teaching staffs in training institutions | DHR | 249,612,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| | Support technically HSWTIs | Conduct supportive supervision in all HSWTIs | DHR | 43,240,000 | | | | | |
| To enhance the quality and effectiveness of Continuing Professional Development (CPD) Programs by 2016 | Strengthen CPD programs | Develop mechanisms for recognition and accreditation of in-service training by involving health professional regulatory bodies and association | DHR<br>NACTE | 400,000,000 | | | | | |
| | | Update CPD guideline to incorporate current development | DHR | 121,000,000 | | | | | |
| | | Introduce licensing and re-licensing of higher level cadres to maintain standards of practice | DHR<br>MCs | 50,000,000 | | | | | |
| | | Promote operationalization of CPD guideline | DHR | 80,000,000 | | | | | |
| | | Develop database for in-service training | DHR | 63,820,000 | | | | | |
| | | Promote utilisation of other methods for in-service training such as distance, e-learning, on job training | DHR | 42,000,000 | | | | | |
| To improve the quality of curricula for all health and social welfare programs by 2018 | Update and enrich curricula for all health and social welfare programs | Review and finalize the curricula for all health and social welfare programs<br><br>Adopt WHO guideline for task sharing<br><br>Incorporate Task sharing | DHR | 84,090,000<br><br>77,740,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| | | in Health and Social Welfare curricula with the involvement of professional bodies | | 44,720,000 | | | | | |
| | Validate curricula for all health and social welfare programs | Submit reviewed and finalized curricula to NACTE for validation | DHR | 0 | | | | | |
| To improve collaboration between MoHSW, professional bodies and NACTE in accrediting and regulating health and social welfare training institutions | Set standards for accreditation and regulation of health training institutions and; establish compliance among the key stakeholders | Mapping of health training stakeholders | DHR | 1,050,000 | | | | | |
| | | Conduct needs and expectations assessment stakeholders | DHR | 38,920,000 | | | | | |
| | | Develop TORs and MOU for collaboration in health training | DHR | 38,920,000 | | | | | |
| | Promote regulation of clinical officers and clinical assistants | Collaborate with Medical Council of Tanganyika for inclusion of clinical officer and clinical assistant in their regulatory system | DHR | 0 | | | | | |
| | Ensure effective execution of defined roles among collaborative partners | Identify focal persons | DHR | 0 | | | | | |
| | | Define roles and responsibilities of each focal person | DHR | 0 | | | | | |
| | | Develop a mechanisms for communication and information sharing among collaborative partners | DHR<br>DAP<br>DPP | 7,000,000 | | | | | |
| To improve the quality and utilization of medical and social welfare | Establish Curricular for m attendants, Community health workers | Conduct Training Need Assessment for Medical, community health workers and social welfare Attendants | DHR | 39,334,000 | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| attendants by the year 2018 | and social welfare trainings | Develop curricula for medical community health workers, and social welfare attendants | DHR | 54,534,000 | | | | | |
| | | Facilitate accreditation of the curricular for Media community health workers and social welfare attendants | DHR | 2,000,000 | | | | | |
| | | Disseminate curricular for health community health workers, and social welfare attendants to the relevant institutions | DHR | 47,704,000 | | | | | |
| | | Build capacity of medical, community health workers and social welfare attendants | DHR | 1,800,000,000 | | | | | |

## Strategic Objective 6: Strengthen partnership and coordination of HRH&SW stakeholders at all levels

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| To improve coordination and alignment of HRH priorities across four key ministries: MOHSW, PMO-RALG, POPSM and MOF | Establish regular forum and workshops for sharing HRH priorities | Develop a ministerial coordinating team | DHR | 0 | | | | | |
| | | Develop guidelines for forums and workshops | DHR | 85,900,000 | | | | | |
| | | Conduct forums and workshops as per guidelines | DHR | 224,700,000 | | | | | |
| | Promote sharing new HRH developments and priorities | Develop leaflets and policy brief on new HRH developments and priorities | DHR | 228,750,000 | | | | | |
| | | Design a mechanism including frequency for sharing new HRH developments and priorities | DHR | 0 | | | | | |
| | | Sharing new HRH developments and priorities | DHR | 85,900,000 | | | | | |
| To improve networking and coordination among HRH stakeholders by 2018 | Establishing a mechanisms for coordination and collaboration among HRH stakeholders | Design and implement inter-ministerial HRH development and management committee meetings | DHR | 85,900,000 | | | | | |
| | | Conduct at least two per annum HRH&SW stakeholders meetings to share HRH&SW key issues and implementation of strategic plan | DHR | 85,900,000 | | | | | |
| | | Commission and supervise HRH&SW related research studies. | DHR | 22,400,000 | | | | | |
| | | Disseminate findings from HRH&SW related research studies and identify policy and programme implications | DHR | 133,700,000 | | | | | |
| | | Coordinate and monitor HRH research and utilise findings in decision making. | DHR | 133,700,000 | | | | | |
| | Foster smooth | Develop proper | DHR | | | | | | |

| Specific Objective | Strategies | Activities | Responsible | Budget | TIMEFRAME | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
| | implementation of HRH activities | implementation guideline, which shall state clear roles and responsibilities of each HRH actors. | | 133,700,000 | | | | | |
| □o improve communication between HRH actors □□inistries, agencies, departments | □esign appropriate feedbac□ mechanism | □evelop forms which will ac□nowledge receipt □ reading of an□ relevant document | □HR | 0 | | | | | |
| | | □electa secretariat which shall supervise feedbac□ mechanisms | | 0 | | | | | |
| | | □romote information e□change among HRH actors | | 0 | | | | | |
| | | □onduct regular meetings to discuss HRH matters. | | 100,000,000 | | | | | |

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