LESSONS *learnt*

...from the Human Resource for Health Innovative Programmes

Benjamin William Mkapa HIV/AIDS Foundation

H O P E F O R T A N Z A N I A

MKAPA HIV/AIDS FOUNDATION

Mr. Ramadhani Pupwa, a lab technician in Monduli district in the process to take blood sample From a clients during outreach services.

Ms Regina Mathias, a lab technician in Bunda district preparing for blood samples for HIV/AIDS testing.

Dr. Gasper Joseph, a Fellows in Makete district, examining a child patient at CTC clinic

Mr. Chidodo, a Lab technologist a Fellows in Serengeti District Hospital Lab, attending to a client

EHP hire assessing a pregnant mother in Bagamoyo District Hospital

EHP Hire in Kilosa District Hospital examines a young boy to determine HIV status

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October 2009

Benjamin William Mkapa HIV/AIDS Foundation
H O P E F O R T A N Z A N I A

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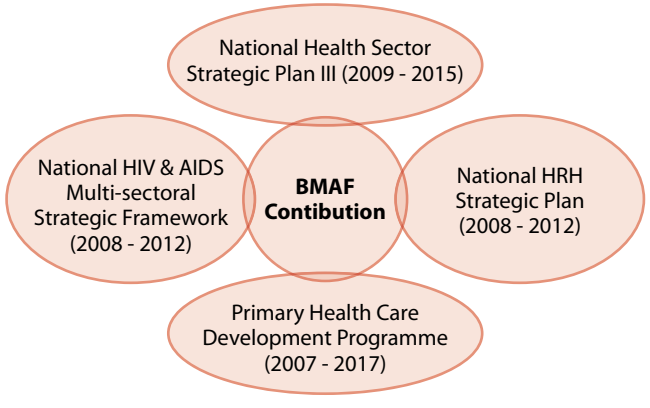
Acronyms

BMAF	Benjamin William Mkapa HIV/AIDS Foundation
HRH	Human Resource for Health
HIV	Human Immunodeficiency Virus
AIDS	Acquired immune Deficiency Syndrome
MMAM	Mpango wa Maendeleo ya Afya ya Msingi
MFP	Mkapa Fellows Programme
EHP	Emergency Hiring Programme
LGA's	Local Government Authority
POPSM	Presidents Office Public Service Management
PMORALG	Prime Minister's Office Regional Administration and Local Government
MOFEA	Ministry of Finance& Economic Affair
MOHSW	Ministry of Health and Social Welfare
CTC	Care and Treatment Clinic
USAID	United States Agency for International Development
OPRAS	Open Performance Appraisal System
P4P	Payment for Performance
CHMT	Councils Health Management Team
HR	Human Resource
NGO	Non Governmental organization
AMO	Assistant Medical Officer
PHC	Primary Health Care
RMO	Regional Medical Officer
DMO	District Medical Officer
ARV's	Antiretrovirals

Introduction

Established in April 2006, the Benjamin William Mkapa HIV/AIDS Foundation(BMAF) aims to complement and contribute to the national efforts in achievement of targets set in the Tanzania National Development Frameworks as well as the Millennium Development Goals. The three pillars of the BMAF five years Strategic Plan (2008 -2012) are as shown below:

BMAF & National Development Frameworks

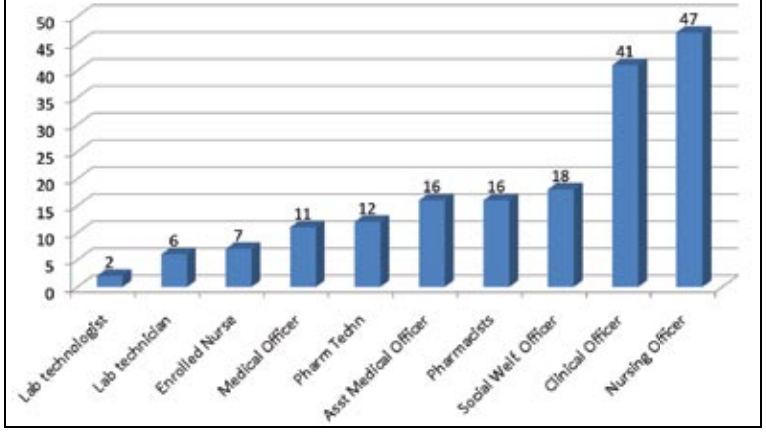


BMAF Stategic Areas (2008-2012)

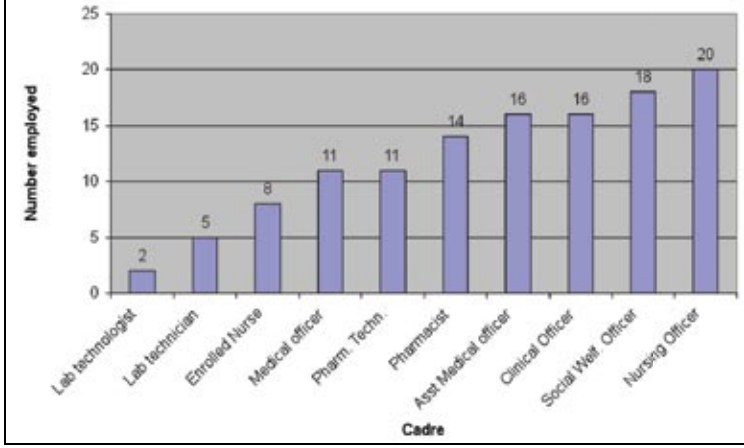
In striving to complement national efforts in minimizing the challenges facing Human Resource for Health, **the Benjamin William Mkapa HIV/AIDS Foundation** is implementing two Human Resources for Health(HRH) initiatives called the Mkapa Fellows Programme (MFP) and the Emergency Hiring Project (EHP), the former being the Foundation's initiative supported by the Royal Government of Norway and Clinton Foundation and the latter is a Ministry of Health and Social Welfare initiative supported by Global Fund to Fight against AIDS, Tuberculosis and Malaria.

The two programmes successfully managed to recruit, train and deploy 275 skilled health professionals who were placed to work in 52 rural underserved districts of the country. The dual purpose of these innovative programmes were focused on scaling up HIV & AIDS Care and Treatment services in rural areas as well as addressing the Human Resource for Health crisis through a public-private partnership model.

Number of Staff Employed



EHP recruited staff by cadres



For the past three years of implementing the programmes, the Mkapa Foundation has registered key achievements and lessons learnt related to Human Resource for Health policies, practices and systems that emanated from the facility, district, regional and central level. This brief is a consolidation of lessons learnt from the Mkapa Foundation-led programmes in relation to the current Public practices in the areas of recruitment; motivation and retention; leadership and management and health service delivery.

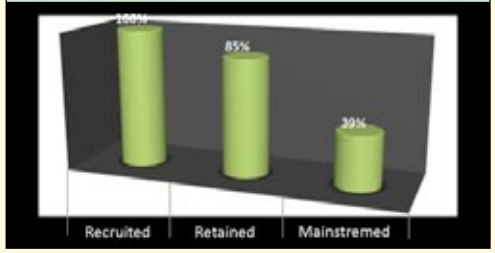
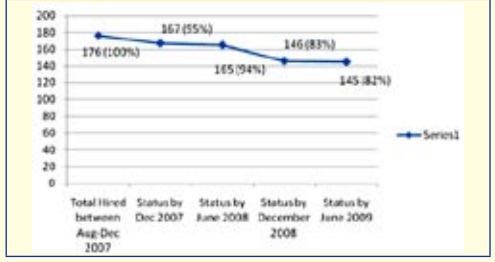
The aim of this brief is to highlight the areas which can be adopted by the key stakeholders within the health sector during the implementation of the various National Development Frameworks that aim to achieve the Millennium Development Goals.

The lessons learnt registered below, are based on the field visits, periodic district reports and desk review of key national and programme documents.

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
1.	**RECRUITMENT**			
1.1.	Steps and processes toward employment of health workers	• The Government system does provide opportunity of a supplementary employment permit upon request from the Local Government Authorities (LGAs) to replace posts falling vacant within the same financial year • Most of the Local Government Authorities (LGAs) delay to secure the supplementary employment permits and thus do not replace the vacant posts accordingly within the same financial year. Thus contributing to the existing shortage of health workers • The Government recruits and deploy as per approved staff establishments from the LGAs and centrally, under permanent and pensionable. In addition to the Health sector, Health Workers aged 45 and above are recruited on contract basis. The recruitment process in health sector had been exempted from competitive recruitment, especially at this time of human resource for health crisis. • LGAs submit their Human Resource requirements for approval at President's Office Public Service Management (POPSM) which is followed by release of recruitment permit for respective LGAs and other Government health institutions. The permit is being managed by the MOHSW by receiving applications for employment followed by being deployed to respective LGAs/institutions. At the LGAs level recruitment is thus made to the respective staff. • In the above recruitment process, there is no district(s) preference made by the interested recruited and deployed Health Workers, rather blanket posting is being made by the MOHSW.	• Vacant posts/Replacements were filled within three to five months, for continuity of services rendered. • This process was possible through the utilization of a staff database that was made following the first recruitments. It gave room for a quick reference for those reserved who had missed the first opportunity. • Group of skilled staff are recruited through a transparent and competitive method and deployed to districts of choice on three years contract basis. • All staffs under the programme are given an opportunity to select districts of preference, which is an aspect noted to contribute to the current retention.	• The LGAs should be more proactive in filling the vacant posts by requesting for supplementary permits timely and use creative means of filling supplementary recruitment permit like use of the available local sources of supply. • Supportive supervision to the district levels should also emphasize the importance of replacement of the vacant posts • Competence assessment should be a critical component in selection process even in exemption of competitive recruitment method, thus the focus should be in both quantity and quality, hence improve quality of health service deliver. • There is need to advocate for benefits and opportunities in public service as the health sector proved to be a potential strategy to attract and retain more workers specifically in underserved districts. • Selection of district of preference for the recruited health workers is essential for attraction and retention. • The Government should consider decentralizing the recruitment process from Ministry level to the Zonal Resource Centres to enable capture health workers in remote districts that are interested in being recruited with public service.

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
1.2.	Retired health workers	• The policy guide to recruit retired health workers has been enacted but not enforced • The implementation of the policy guide still faces challenges in its implementation at the Central and Local Government authority which results to inability of tapping the pool of retired staffs who can still be useful to relieve the shortage	• 23% of recruitees under the BMAF programme are between 50 – 60 years and 5% are above 60 years • Most of retirees were posted to districts near their places of domicile • Have shown to be fully committed and experienced, with high morale and adherence to professional ethics and code of conduct. They are likely to be potential resource persons for mentoring & coaching of young professionals.	• The Government should facilitate effective enforcement of policy to recruit retirees thus to enhance the implementation of recruiting retired health workers • In enacting the policy guide, there should be clear definition of roles and steps to be to be taken on recruitment process of retired health workers by defining each levels responsibility such as the Ministry of Health and Social Welfare, POPSM, Zonal Resource Centres, Regional and Local Government Authorities level • The Zonal Resource Centres and LGAs should be encouraged to advocate and take lead in advertising vacancies for retired skilled health workers and post them to areas of their preference • Due to the retirees' additional qualities and experience, mechanism should be in place to have them utilized more, such as in mentorship and training programmes.
1.3.	Orientation prior to deployment of health workers	• Health workers deployed in public service receive minimal structured and less comprehensive orientation at their working station on reporting • The Government had set centralized orientation system for the recruited public servants	An orientation package composed of technical, systemic structures and ethics was developed and conducted for one day to all BMAF recruited staff before deployment. In attendance were team from district and regional health authorities. This lead to ownership and a common understanding of the programme and team work before the staff reported to the districts.	The Government should develop a comprehensive and structured orientation/induction package and should support and oversee the Local Government Authorities in implementing the package and it should be applied to orient new health and used also as a refresher for existing health staff at their work places
1.4.	Team Placement	• Manning level per health facility focuses on team of expertise (cadres) required to effectively undertake prescribed functions in health service delivery as per capacity/eligibility of the health facility, however due to the shortage of health workers the team concept is marginalized.	• Posting of BMAF employed health workers based on team concept i.e. team of three and teams of nine staff per district to ensure complementarity of services to be delivered such as the HIV/AIDS services. This was found to enhance staff performance and services improvement The complementarity have further been extended to skills, knowledge, attitudes and behavior and has brought a sense of togetherness by empowering and supporting each other, which has significantly contributed to increased retention rate.	For effective performance, complementarity of expertise and skills is potential,thus in the development of staff establishments and filling the vacant post in public service, the Government should consider filling through the team of experts as required by the staff establishment.

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
1.5.	Attraction and retention of skilled personnel in underserved areas	• The proportion of skilled staff of higher level cadres deployed into the rural areas is lesser than the middle level cadre.	• Similar findings have also been noted in the Emergency Hiring Project as highly skilled personnel showed more resistance to accept job offers as compared to middle level carders and those higher carders who accepted them, showed higher turnover rate such as Pharmacists, Medical Officers etc. • However, those staff under Mkapa Fellows Programmes who had a relatively more incentives, had 100% acceptance to job offers and reported to remote districts.	• Attraction and incentive package should consider the market value, market competitiveness, job weight and job risks. • Government should hasten the process of defining underserved areas and corresponding package. • Emphasis should be made to enhance skills in different specialties and encourage task shifting program. • Middle level cadres are found to be more potential in improving health services at primary health facilities and have high likelihood of being retained in these areas. • To effectively implement Primary Health Development Programme (Mpango wa Maendeleo ya Afya ya Msingi-MMAM), the Government and Partners should consider increasing the production of middle level cadres.
1.6.	Job Description	• The government have in place the generic job descriptions for each health cadre • There has been ongoing structural and technical advancements in health sector, such that the current job descriptions fail to meet the need and sometimes not in line with the current set up of activities. Hence staff performance may not be easily tracked, supported and monitored. • Every supervisor is obligated to develop specific duties and responsibilities for staff under his/her section, the practice of which most often is not implemented.	The BMAF led programme customized the generic public job descriptions for the program health staff to suit the programmatic activities in line with the actual implementation at the district level.	• The Ministry of Health & Social Welfare (MOHSW) needs to review the generic job descriptions of all health cadres according to the changes of the sector/services and will be a valuable input into assessing staff performance through performance agreement. • The supervisors in the health facilities should develop specific duties and responsibilities for their subordinates that will promote focus in their performance.
2.	MOTIVATION AND RETENTION			
2.1.	Incentive package	• There is current effort of the central government to define incentive package to attract and retain skilled staffs in underserved which is yet to be finalized. • In addition there are some local initiatives by LGA's	• The BMAF programme has defined an incentive package both monetary and non monetary which attracted skilled health professionals and within 24 months the program managed to overall retain staffs in the 52 districts at a rate of 89% package that	• The Government should hasten the process of defining underserved areas and develop a package to enable retention of skilled staff in rural remote areas. This can be initiated from the health sector followed by other sectors.

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
		and partners to attract and retain staff. However, these only reach few and might cover few cadres.	comprises components of monetary and non monetary, as reflected in appendix A. • Mkapa Fellows Programme: **Mkapa Fellows Retained and Mainstreamed %**  NB.Of the 88 retained, it includes the 39 mainstreamed in public service. • Emergency Hiring Project **EHP Progress - Retention of 80% (145 out of 176 recruited)** 	• The Government and partners should recognize, document, scale up and support efforts made by different LGAs in creating and using the local incentive packages to the newly deployed staff • LGAs should be encouraged to be more innovative to develop their own incentive packages (localized package) that uses the available district funding envelope and this package shall be able to attract and retain highly skilled personnel.
2.2.	Housing for staff	• Housing allowance is paid to few eligible staffs as per Government standing orders. E.g. Entitled staff such as Medical Officers are paid at a rate of 80,000.00 per month or rented a house by the respective authority. • Decent housing in most underserved districts is a challenge for most staff and particularly for	• As part of the incentive package and to facilitate employed programme staff to have decent accommodations, the BMAF programme allocated housing allowance to all health staff cadres at a flat rate of 200,000/= per month (for Mkapa Fellows)and 10% of basic salary (for EHP staff).	• The Government should regard staff accommodation as essential commodity to all staffs, thus consider integration of housing allowance to all health cadres in underserved as an enhancive incentive to enable them live in decent accommodations • District Councils should partner with Private

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		newly posted staff	• The programme extended its support in areas which had staff houses which were dilapidated such as renovating one government staff quarter in Manyoni District and two houses in Micheweni districts(to support the Mkapa fellows)	sector or Parastatal institutions in building low cost staff houses. In addition the presence of Local Government Capital Development Grant - Health Window should consider and prioritize construction of low cost staff houses in remote health facilities within the districts.
2.3.	Career Development	• All staff in public service have an equal opportunity to develop career wise, thus attracting and retaining more staff	• Under the BMAF programme, career professional advancement has been one item of the incentive package mainly applied in the Mkapa Fellows Programme. However, HIV & AIDS training was provided for both programmes. • In the course of implementation, the need for long-term training has been a great concern to significant number of employees under the BMAF programme, with few dropping from the programme for reasons being lack of long term career development plan.	• The Government should have clear and transparent career development guideline focusing on complementing the skill gaps. • As the HRH supportive supervision is being revived by the district and regional teams, it is expected that the respective levels will ensure regular tracking of staff development plans and its implementation.
2.4.	Working environment	• The Government has progressively increased resource envelope to improve working environment of health workers through Health Basket grant, Central Government Grant and Local Capital Development Grant – Health Window. However some of the grants have limitations on improving infrastructure. In addition, due to competing priorities, the funds have not been able to fully meet the need of individual worker or workers.	• Efforts have been done by the programme to improve working environment such as installation of internet in 19 districts, installation of solar power system to 1 district and renovation of three districts staff houses. • Through linkage with other Partners such as Capacity Project (USAID funded), the programme supported: o Review of the HRH component of the National Supportive Supervision guide, o Capacity building on HRH planning and Monitoring • Provision of grants for HRH strengthening in 6 of the 19 EHP districts for implementing their developed action plans on improving working environment. • Linking with respective District Councils and HIV/AIDS RegionalizedPartners, some sections/units such as laboratory, CTC clinics and theatres have been renovated in respective districts.	• Good working environment is one of major staff retention factors particularly those serving the underserved areas. • The Government and Partners to encourage applications of innovative ways of utilizing existing district grants to improve the staff working environment. This will enhance staff motivation as well as staff retention

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The settler of the Foundation addressing the audience during the 1st Annual Review Meeting held on 17th October 2007.

The Prime Minister Hon. Mizengo Kayanza Pinda hands over vehicle registration documents to the Mpanda District Executive Director, Mr. Denis Bandisa.

The CEO, Dr. Ellen Mkondya-Senkoro presenting the Foundations progress to the BMAF Board.

Fellows batch one and two related to Computer skills was conducted and further training is scheduled in July 2008 by University of DSM, Computing Centre

BMAF management team briefing partners from Bill and Melinda Gates Foundation at the BMAF offices, April 2008

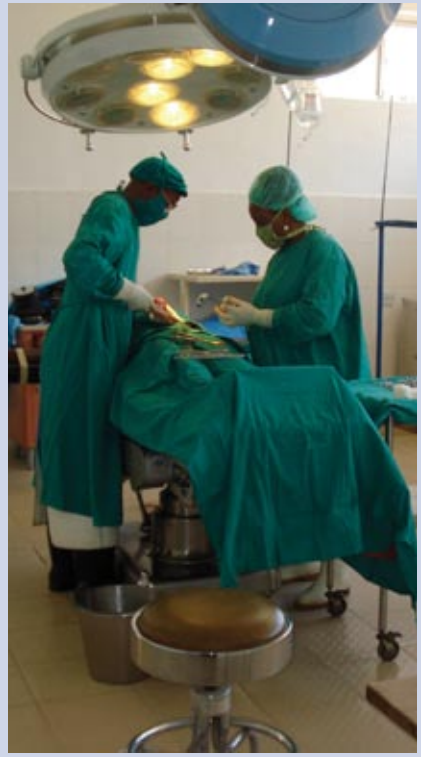
Participants during the 1st Annual Review Meeting held in October 2007

The BMAF Management team with the Vice President Dr. Mohamed Shein and the Settler, Former President BenjaminWilliam Mkapa during the 2nd Annual Stakeholders Meeting held in November 2009

A Laboratory Technician Mkapa Fellow in Makete district processing blood samples collected from their clients

A social worker under EHP counseling a client at the HIV clinic

Mkapa Fellow in Bunda district attending to a client at the Out Patient clinic



BMAF employees at the district involved in other surgical procedures

Mkapa Fellows in Hanang working together to ensure good record keeping of clients data

A mother with a healthy baby after a safe delivery from Ikungi Health center, Singida rural district

Left and Right:
Women and Children receiving Maternal and Child health services through EHP staff and Mkapa Fellows

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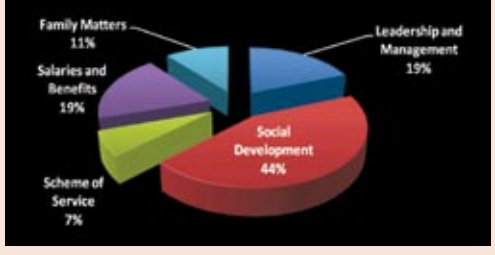
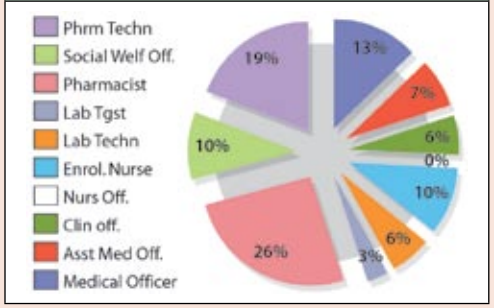
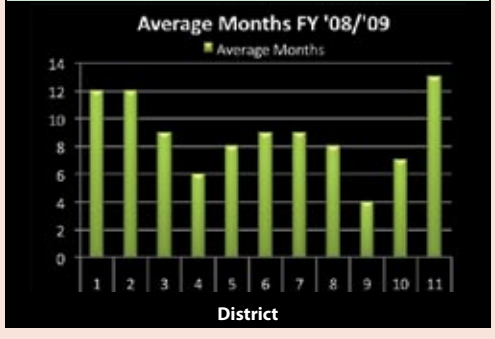
	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
2.5.	Social Development	Striking efforts on development of the social sectors have been undertaken by the Government and Partners. Nevertheless, the social development in underserved areas has some limitation in holistically covering the needs of skilled personnel and their families. E.g. Electricity, good roads, comfortable houses, subsidies for social services such as schools for children within regions; entertainment, advanced health care etc	• Social development has been one of major complaints of BMAF staff posted to rural districts which necessitated the Foundation to renovate three staff houses allocated to Fellows and provision of housing allowance. • It was also observed that some spouse (and children) could not join their partners at duty station, necessitating frequent absenteeism to attend family matters. • The programme supported installation of solar power system to district hospital which assured staff and services to be provided within 24 hours.	• Collective efforts in the district is proposed in a multi-sectoral fashion in order to address social development matters. • This is possible by linking with the ongoing Primary and Secondary Education Development Programmes, Road and Infrastructure Development programmes within the catchment areas.
3.	**LEADERSHIP AND MANAGEMENT**			
3.1.	Confirmation of staff:	All employed staffs are to be confirmed six months after deployment, following a satisfactory recommendation from the supervisor.	Only 52% of BMAF programme staff have been confirmed within 2 years whereas in ideal sense it's supposed to be within 6 months	The Council Employment Board to take the matter on staff confirmation as a priority in the district councils.
3.2.	Performance Management	• The Government has developed a policy of using performance monitoring system known as Open Performance Review and Appraisal System (OPRAS) throughout the country • The implementation of the policy is still challenging in most levels.	• The programmes had instructed the districts to set performance targets with all staff posted • Out of 26 districts visited only 30% of them filled the forms of OPRAS with targets but lacked doing reviews (mid year and annually), despite most of the health team members have been trained by MOHSW and PMORALG on the process.	• The Government should practically institute performance management systems in all districts for accountability of resources. Failure to implement OPRAS should be taken as a challenge to be addressed,, thus a study should be conducted to ascertain why it failed. The study will assist to plan for appropriate interventions. • In-order to be more effective, it is recommended that OPRAS be linked with the Payment for Performance (P4P) system which is expected to be initiated by the Public Health sector.
3.3.	LGA's Leadership and Management	• The existing health system has a well organized and clearly stipulated Leadership and Management hierarchy. • Through Government initiatives and other stakeholders, most of the Council Health Management Team (CHMT) have been trained on leadership and management skills training • However there are still some limitations in skill levels to some of the districts health managers.	• From the programme experience, 19% of deployed staff reported unfavourable district leadership and management were reasons for reluctance to be mainstreamed into public service.	• Human Resource Management is a cornerstone to retention thus should be integrated in the Government plans (Centrally and at Council level) and should be part and parcel of the current on-going reforms and decentralization. • The Government to consider developing standard module tailored for Local Government settings and a programme of grooming leaders of health sector at pre service training level (new graduates)

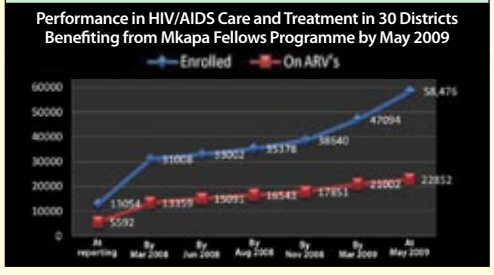
	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
		• Until December 2008, out of 133 district councils, 19 (14.3%) did not have qualified DMOs and good efforts are underway by the MOHSW in collaboration with Prime Ministers Office Regional Administration and Local Government (PMORALG) to fill in the gap.	**Reasons for Rejecting Mainstreaming %**  • There has been management trainings offered to CHMTs and Regional Health Management Teams as follows: o BMAF in collaboration with Capacity Project of Intra Health International trained 21 districts and 12respective regional health teams on HRM to effectively plan and manage its HRH. o As part of induction towards the Mkapa Fellows programme, 33 District Medical Officers were trained in general management skills through collaboration with Mzumbe University • BMAF participated in the module development by Capacity Project on Comprehensive Leadership and Management Training for Leader of Health Centres and dispensaries that has been reviewed by MOHSW and partners. The module is expected to be scaled up at district level under the leadership of BMAF in collaboration with Intrahealth International, MOHSW and PMORALG as from January 2010. • To fill the district health department leadership gaps, 8 Medical Officers (Fellows) have been appointed with PMORALG to be the Acting District Medical Officers (DMOs) in 8 rural districts, hence reducing the gap by 7.5%	

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
3.4.	Exit Interview to staff drop outs	• Currently there is no clear tracking system to track and interview staff leaving the Government employment that can be an avenue of understanding reasons for turn over from the service whereas this will provide insight on areas for improvement.	• BMAF introduced a system of tracking staff that leave the programme by developing an exit interview form. The system was applied to most staff that left the programme. Until recent, at least 45% of staff who dropped out of the programme filled in the form and analysis conducted. • A graph showing cadres that drop out mostly **Drop out by Carders%**  • Reasons for most programme staff leaving the programme included: o Inadequate remuneration package compared to the market demand of the specific category of staff; o Weak leadership and management practices at the district health department and/or district hospitals including the Designated District Hospitals (DDH) o Weak coordination of various HIV/AIDS programme at district health department. o Weak collaboration and coordination between the DDH and Local Government Authorities or District Medical Officers office. o Difficult working environment including lack of staff accommodation, lack of basic equipments and supplies	• The Government should develop tracking system of posted and leaving staff. This will assist registering of any challenges affecting staff retention in that particular council, but also serve as information for the MOHSW to take steps on. The developed tool by Mkapa Foundation can be adopted by the MOHSW, PMORALG and respective LGAs. • The Government has initiated the process of reviewing the scheme of service of health cadres. The new scheme of service once approved should be used as an attraction package for secondary student to join the health sector, hence its promotion is important.

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
			o Lack of long term career progression plans within the programme and at the district level; o Under utilization of some cadres especially Medical Doctors and Pharmacists of which some are placed at health centre levels which have limitation in providing specific health services or medical procedures. o Personal differences due to fear of existing health managers on their posts, of being challenged by the new enthusiastic and qualified health professionals under the programme.	
3.5.	Staff Salaries and Mainstreaming into Public service	• All new health sector employees have been paid their salaries according to the Government scales. However, it takes 3 to 12 months for the new employees to be integrated into the payroll. • The Government has been placing health staff to Faith Based Organizations through secondment to ensure wider coverage of service within the country. There are limited programmes under Non-Governmental Organisation (NGO) apart from Faith Based Organisation that recruit health workers and ultimately streamline them in the Government system	• The BMAF programme has been able to effect payments timely to the hired health staff as soon as they are employed in the programme. This facilitated early arrival of staff to duty station and to be motivated. These payments include monthly salaries; installation grant; annual leave allowance and transportation of staff items and families on ending the contract. • BMAF recruit health staff on contract basis and to ensure sustainability of the services, the Foundation mainstream the respective staff into the public services. By October 2009, through collaboration with MOHSW, POPSM and PMORALG a total of 119 health workers under the two programmes have been mainstreamed into the public service through the recruitment permit of the FY 2008/2009 and 2009/2010. • There has been delay in mainstreamed staff to enter into Government payroll, whereas there is variation from one district to another; i.e. taking 2 -12 months.	• The MOHSW should play a deliberate facilitative role in obtaining sustainable intervention to address the systemic bottlenecks which is multisectoral that hinder early payments of salaries to the newly employed staff(LGAs/ PMORALG; POPSM,MOFEA and MOHSW) • The best practices in LGA's such as those that manage to integrate new health staff into the payroll early(within 1-2 months), should be learnt by other LGAs for improving the practices • Accountability and close supervision of the responsible officer for payroll management (from central to district levels) is mandatory, to ensure that timely and correct information gets into the appropriate channel,so as to reduce delays in getting into the payroll • The District Councils should allow the District Health Secretary to play their role actively in ensuring new staff enter into payroll timely as opposed to centralization to the District Human Resource Officer who oversees multiple departments/sectors thus have competitive demands.

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
			Payroll Integration Length of Time for mainstreamed fellows on FY 2008/2009  • To combat the challenge of delay in entering into the government payroll system for the mainstreamed programme staff, the Foundation provided salary advances to mainstreamed health workers for a period of 3-12 months. • The districts that were pro-active in following up the data sheets with POPSM and MOFEA, took a short duration for staff to enter into the pay roll. • Delays to enter into pay roll system has been noted to be attributed by the following: *1. District level* o There are cost implications on making close follow up and submission of data sheets at the Central/Ministry level o Limited accountability and commitment of the administrators in following up the matter *2. Central Level* o Bureaucratic procedures and processes which consume more time at POPSM & MOFEA	• The Government should consider creation of a 'Revolving fund' or HR capitalization fund which will be a short- term intervention to support new staff to obtain salaries as soon as they are posted to the duty station and this will enhance retention • The Government should consider the decentralization of payroll management systems to the regional or zonal level which is anticipated to reduce the delays in payroll management for the health sector staff.
3.6.	Under-utilization of specific cadres:	• All cadres are posted to the respective working stations to render services, as per the establishment of the level of service delivery	• There has been underutilization of some cadres such as Pharmacists, Pharmaceutical technicians and Assistant Medical officers, whereby some have	• The Government and partners should consider increase of production from training institutions and fast recruitment of mid level cadres

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
		• The deployed staffs are posted with their job description where more clarity on the task and responsibilities are being given by the districts where they are expected to serve.	been deployed to lower Health Facilities and have lacked basic equipment to provide service. • On being mainstreamed some skilled health professionals such as Assistant Medical Officer (AMOs), Pharmaceutical technician and Nursing officers have been rejected by the Councils with concern of not having a district hospital, or not being appropriate to serve at the health centres or dispensaries.	to serve the lower Primary Health Centre (PHC) which is expected to increase with the start of MMAM implementation. • Development Partners including Global initiatives to increase resource allocation to support Health Workforce Initiatives particularly in underserved areas of Tanzania; Increasing outputs of health work force (productions) and theirmanage ment. • The District Councils under the guidance of the DMO and Regional Medical Officer (RMO) should consider effective utilization of available/deployed staffs versus the health system structure in place. They should consider reinforcing the health centre levels to provide additional and quality health services to the clients, by using the deployed skilled health professionals such as Pharmaceutical technicians, AMOs, Nursing officers etc, as opposed to underutilization, rejection or pooling them at the district hospitals and administrative levels.
4.	**HEALTH SERVICES**			
4.1.	District health Service Delivery	Commendable Government efforts are noted in recruiting and deploying health workforce of all cadres including skilled and rare cadres. A great challenge which still stands is staff accepting to work in hard to reach areas especially the rare, skilled and marketable cadres. This has resulted into mal-distribution and poor skill mix Government and Partners resources on HIV and AIDS programme has increased progressively over years with more integration of HIV and AIDS services in the district health delivery systems.	The two programme deployed high skilled and rare cadres in hard to reach districts. In some areas these cadres were not in place by the time the staffs were deployed. e.g. Simanjiro, Namtumbo and Meatu Presence of the programme staffs have significantly contributed to increase in establishment of Care & Treatment Clinic/sites and increase of Clients enrolled on care and treatment and those started on Anti-Retroviral (ARV) drugs.	Disease specific approaches with reasonable incentive that could attract staff should be considered as a good entry point to fill positions of skilled and rare cadres.

	ISSUE	CURRENT PUBLIC PRACTICE	BMAF HRH PROGRAMME LESSONS LEARNT	KEY MESSAGE
			• Mkapa Fellows Programme: **HIV service delivery impact contribution: 3-4 fold increase in enrollment & started on Art**  • Emergency Hiring Project: **Facilities' CTC Performance in 19 EHP Districts** Service Performance in EHP districts (20 months) ** 2.5 fold increase on enrollment ** 3 fold increase on clients started on ART  • Efforts on improvement of care and treatment in the respective districts were contributed by the joint efforts of the districts teams. Staff and HIV/AIDS Regionalized Partners • Other health service delivery were improved such as Medical and Surgical Services, Maternal and Child Health, Tuberculosis (TB), Dental and Social Welfare services.	

Appendix 1

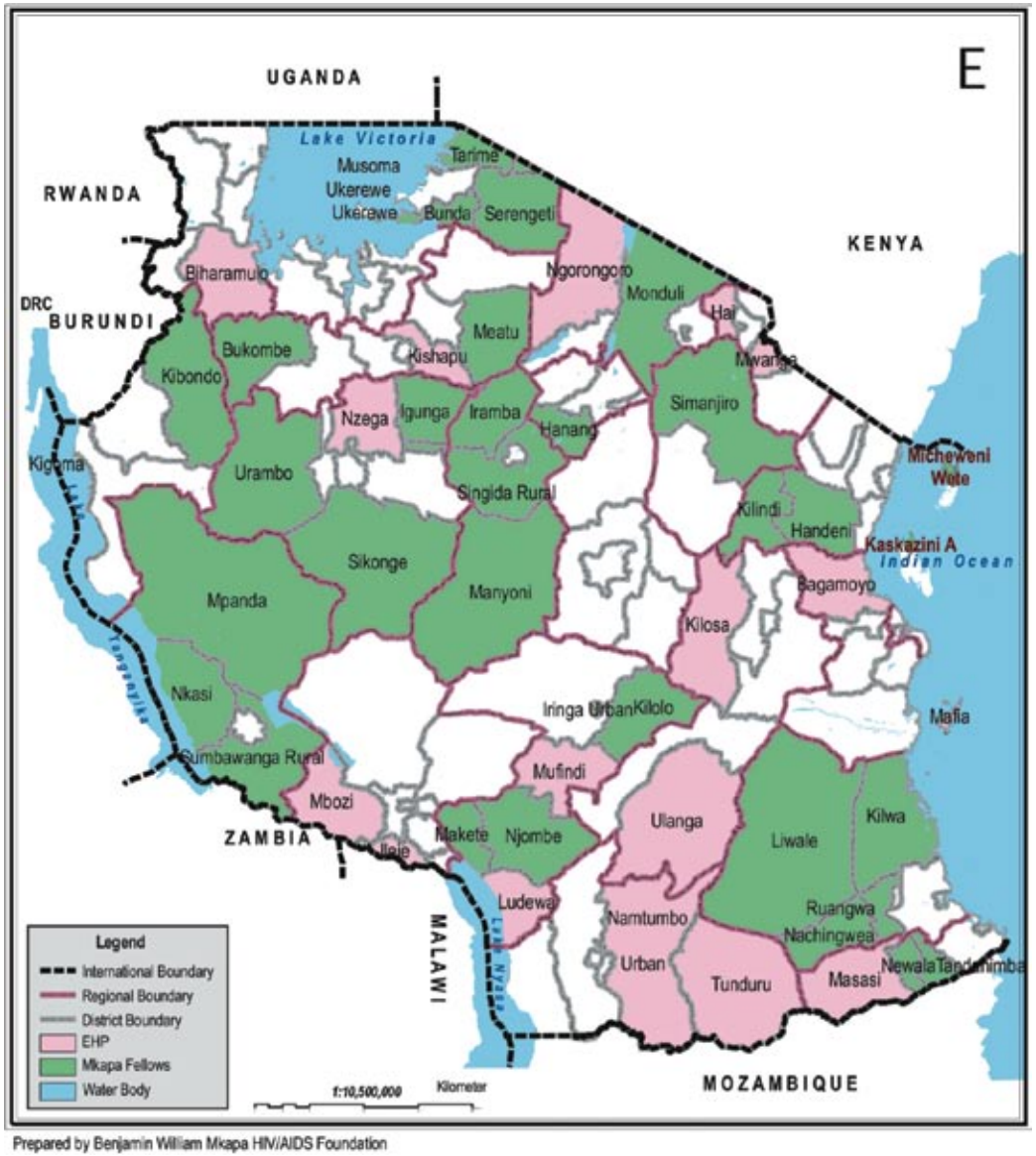
The comparison of the incentive package instituted by the Government and the two HRM innovative programmes (Makapa Fellows Programme & Emergency Hiring Project) in Tanzania

	Mkapa Fellows Programme	Emergency Hiring Programme	Government
1.	**Salary**		
	Enhanced salary (at least double of Government level for FY 2006/7)	Enhance salary (as per Government FY 2006/7 salary scale) Graduate: Principle level None Graduate: Senior level	The Government salaries have increased during FY 2007/8 and 2008/9
2.	**Housing Allowance**		
	To all Mkapa Fellows - Flat rate US$ 166 per month	To all hires - 10% of the basic salary	To Entitled officers and Medical Doctors - 30% basic salary
3.	**Reallocation/Installation grant**		
	Payment of US$ 1,042 each Transportation of family (spouse + 4 children)	Subsistence allowance - US$ 250 Luggage allowance - US$ 417 and Transport allowance - 5% of basic salary Transportation of family (spouse + 4 children)	Transportation of personal effects based on mileage and weight, Subsistence allowance Disturbance allowance (for employee, his/her spouse + 4 children)
4.	**Pension Schemes**		
	National Social Security Fund (NSSF) - 20% contributed by the employer Temporary for 3 years through an agreement between NSSF and employer		Permanent and Pensionable Contribution made by either • NSSF- 10% employee, 10% employer • Local Authority Pension Fund (LAPF) - 5% employee, 15% employer • Parastatal Social Pension Fund (PSPF) -5% employee, 15% employer

	Mkapa Fellows Programme	Emergency Hiring Programme	Government
5.	**Health Insurance**		
	Benefits from Social Health Insurance Benefit (SHIB) under the NSSF		Benefits from National Health Insurance Fund (NHIF) - 6% of basic salary (3% employee & 3% employer contribution
6.	**Gratuity**		
	5% of 3 years basic salary plus 20% of NSSF contribution paid at the end of the contract		Permanent Pension for pensionable employees.
7.	**Other Staff Incentives**		
	Orientation session; Induction HIV/AIDS Management training; Provision of Laptops; Mobile phones; Monthly mobile phone airtime (US$ 25); Periodic continuing education trainings	Orientation session; Induction HIV/AIDS training	Short and long term training (salaries are paid through the training period), housing and health cover. Extra hours allowance
8.	**District and Regions Incentives**		
	Monthly mobile phone airtime (US$ 25); Internet installation at district level; One Computer set	HRH management training District Grants to 5 districts (through Capacity project/USAID)	Use of Local Capital Development Grant, Health Basket Fund; Central Government subvention for improving HRH Management

Appendix 2

EHP and Mkapa Fellows Districts



Prepared by Benjamin William Mkapa HIV/AIDS Foundation

DeSIgN by: *hexadmedia@gmail.com* | 0713 / 754 255 775

LESSONS *learnt*

...from the Human Resource for Health Innovative Programmes

For Further information please conctact:

Benjamin William Mkapa HIV/AIDS Foundation
Benjamin William Mkapa Pension Towers (Formerly Mafuta House)
3rd Floor, Wing B, Azikiwe Street, P.O. Box 76274 Dar es Salaam, Tanzania,

Tel: +255 (22) 220 0010/1/3 / 220 0074
Fax: +255 (22) 220 0012

Email: *info@mkapahivfoundation.org*

Website: ***www.mkapahivfoundation.org***

MKAPA HIV/AIDS FOUNDATION