Mid-Term Review (MTR) of the Health Sector Strategic Plan V (HSSP V)

Human Resources for Health Report

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Executive Summary

The **Human Resources for Health (HRH) Thematic Report** comprehensively analyses Tanzania's progress, challenges, and strategic priorities in implementing the **HRH Strategic Plan 2021–2026**, aligned with the **Health Sector Strategic Plan V (HSSP V 2021–2026)**. The evaluation, informed by a mid-term review, outlines achievements, gaps, and recommendations to strengthen HRH systems, focusing on production, equitable distribution, retention, performance management, and financing.

Key Achievements

1. **Increased Workforce Production**:

   Over 24,000 health workers were produced annually across 219 mid-cadre Health Training Institutions and 12 Higher Learning Institutions with targeted efforts to expand rare cadre training. Over 500 postgraduate students are trained annually in and outside the country via SET, specialization and super-specialization programs to expand specialized and super-specialized care in the regional, zonal, specialized and national hospitals. Competency-based curricula updates were initiated for priority cadres like anaesthetists and radiographers.

2. **Improved HRH Information Systems**:

   Integration of HRHIS with other national systems, including Human Capital Information Systems (HCIMS), Health Facility Registry (HFR), TCU, NACTVET, Professional Council and Boards (PHAB). Enhanced workforce planning capabilities at national and regional levels.

3. **Infrastructure Upgrades**:

   Significant investments in health facility modernization, including housing for health workers and new diagnostic technologies; 70% of health facilities reported improved living and working conditions for HRH.

4. **Retention Initiatives**:

   Rural-focused strategies, including housing and allowances, were implemented in select regions. Digital CPD platforms reached over 128,000 health workers by January 2025, improving access to continuous training.

5. **Introduction of Performance Management Systems**:

   The PEPMIS system was introduced in FY 2023/24 to link staff performance to measurable productivity indicators and health outcomes.

Persistent Challenges

1. **Urban-Rural Workforce Imbalances**:

   Urban areas host 63,973 (53.4%) of the available workforce, while rural regions have 55,705 (46.6%). Limited use of tools like WISN for equitable deployment. The following Regions have a>75% shortage of health workers: Songwe, Simiyu, Geita, and Katavi and should be targeted immediately.

2. **Limited HRH Financing**:

There is some reliance on international donors, with inadequate local contributions and budget prioritization. Wage budget constraints are affecting recruitment and retention efforts.

3. **Gaps in Training Infrastructure**:

   Only 21.9% of training institutions are government-owned, leading to inequities in access and quality and there is delayed rehabilitation of health training facilities in rural areas.

4. **Retention and Motivation**:

   Poor working conditions and insufficient career progression opportunities hinder workforce stability in rural areas.

Updated Strategic Focus Areas

1. **Production and Development**:

   Expand competency-based curricula and specialist programs and prioritize rehabilitation of training institutions by 2026.

2. **Equitable Distribution and Retention**:

   Scale up the implementation of WISN for data-driven staffing decisions and introduce comprehensive rural retention packages, including housing and professional development.

3. **Performance Management**:

   Strengthen PEPMIS to link workforce performance with health outcomes and establish feedback mechanisms for continuous improvement.

4. **Strategic Financing**:

   Mobilize local resources and strengthen public-private partnerships to diversify funding and increase government budget allocations to sustain HRH programs.

5. **Emergency Preparedness**:

   Embed workforce resilience in HRH strategies, focusing on training for public health emergencies.

Key Recommendations

1. **Improve Data Utilization**:

   Fully integrate HRHIS with other national systems, including Human Capital Information Systems (HCIMS), Health Facility Registry (HFR), TCU, NACTVET, Professional Council and Boards (PHAB) and WISN into decision-making processes at all levels by June 2026. Train district and facility-level teams on workforce analytics using WISN.

2. **Enhance Retention Strategies**:

   Expand digital CPD platforms and mentorship programs to rural areas by December 2026. Provide non-financial incentives, including career growth pathways, to underserved regions.

3. **Address Urban-Rural Disparities**:

   Prioritize deployment to regions with the highest deficits through targeted recruitment by December 2026. Allocate additional funding for rural health facilities to improve living and working conditions.

4. **Expand HRH Financing Mechanisms**:

   Establish a dedicated HRH fund with contributions from local businesses, government, and international donors by December 2026. Develop cost-sharing models for CPD and infrastructure projects.

5. **Strengthen Multisectoral Governance**:

   Enhance collaboration with private sector and NGO stakeholders to streamline resource allocation. Conduct annual forums to assess progress and address implementation gaps.

Conclusion

While Tanzania has made notable progress in expanding workforce production, integrating HRH data systems, and improving infrastructure, critical gaps remain in the quality of graduates produced, equitable distribution, retention, and productivity. Addressing these challenges requires sustained investment, robust governance, and innovative retention and performance management strategies. With the updated focus areas and realistic targets, the HRH Strategic Plan 2021–2026 provides a solid foundation for achieving equitable, efficient, and resilient HRH systems by 2026.

Glossary of Acronyms and Abbreviations

CPD	Continuous Professional Development
DHIS2	District Health Information System 2
HSSP V	Health Sector Strategic Plan V
HRH	Human Resources for Health
HRHIS	Human Resources for Health Information System
LGAs	Local Government Authorities
MDH	Management and Development for Health
MOH	Ministry of Health
NGOs	Non-Governmental Organizations
OPRAS	Open Performance Review and Appraisal System
PEPMIS	Public Employees' Performance Management Information System
PORALG	President's Office – Regional Administration and Local Government
TIIS	Training Institution Information System
WISN	Workload Indicators of Staffing Need
WISN-POA	Workload Indicators of Staffing Need–Plan of Action
WHO	World Health Organization

1. Context

1.1 Current Relevance of the HRH Conceptual Framework

The evaluation was designed to answer the following question: Are the strategies implemented under HSSP V effectively addressing HRH challenges? HSSPV refers to the HRH Strategic Plan 2020-2025 as the underlying document for HRH. We conducted the evaluation using both HSSPV and HRH 2020-2025; this was part of an evaluation of the whole HSSPV. We used similar methods: document review, stakeholder interviews, field visits to selected regions, and joint interpretation with national staff of the field data. The conceptual framework of the HRH Strategic Plan 2020–2025 (which was adopted by HSSPV), as outlined in the document, emphasizes a systems approach to improving workforce numbers, skills, and motivation by ensuring coherent links between production, deployment, performance management, and continuous professional development (CPD). It is guided by the HRH Action Framework, which focuses on:

- **Strengthened HRH planning** to inform investment decisions.
- **Resource allocation** should align with health workforce demands.
- **Multisectoral engagement** to foster partnerships and collaboration.

The framework is largely still relevant, as the core issues of HRH shortages, maldistribution, insufficient workforce planning, and underutilized data systems remain critical challenges. However, adjustments are needed to better reflect emerging issues, lessons learned, and shifts in priorities based on the mid-term evaluation and updated implementation needs.

1.2 Thematic Analysis of HSSPV and HRH Strategic Plan

A thematic analysis of the HSSPV and the HRH Strategic Plan revealed the following:

1. Integrated HRH Action Framework

- **Key Concept**: The HRH Action Framework emphasizes coherent links between HRH **production, deployment, performance management, and continuous professional development (CPD)**.
- **Objective**: To ensure the health workforce's numbers, skills, and motivation meet population health needs.
- **Strategies**:
    - Strengthened HRH planning to guide resource allocation.
    - Multisectoral partnerships for implementing HRH strategies.
- **Alignment**: This framework aligns with the **Global Strategy on HRH** for universal coverage by optimizing health workforce performance and ensuring equitable access.

2. HRH Production and Development

- **Achievements**:

  - There was a significant increase in the production of health workers; over 40,000 middle-level cadres and 15,546 medical doctors were produced between 2018 and 2022.
  - HRH density has increased but remains below optimal levels.
- **Challenges**:
  - Training institutions face outdated curricula, inadequate infrastructure, inadequate competent faculty, inappropriate student-to-patient ratio in the clinical attachment sites and limited funding.
  - Workforce production exceeds absorption capacity, creating a surplus in the labour market.
- **Strategies**:
  - Develop competency-based curricula to align with modern healthcare demands.
  - Expand the enrollment of rare cadres (e.g., anaesthetists and radiographers).
  - Finalize construction and rehabilitation of training facilities.
  - Improve the quality of training to produce competent healthcare workers

3. Deployment and Equitable Distribution

- **Challenges**:
  - Rural and underserved areas face acute shortages due to urban bias in workforce distribution.
  - Regional planning is skewed towards administrative functions rather than addressing local HRH needs.
- **Strategies**:
  - Prioritize deployment to newly constructed facilities and underserved regions.
  - Use data-driven tools like Workload Indicators of Staffing Need (WISN) for equitable deployment.
  - Absorption of existing health workforce to reduce gaps.

4. Retention and Performance Management

- **Key Issues**:
  - High attrition rates in rural areas are due to poor working conditions and limited incentives.
  - Ongoing challenges in implementing Open Performance Review and Appraisal System.
- **Strategies**:

  - Develop innovative retention schemes, including non-financial benefits such as career pathways and professional growth plans.
  - Improve workplace environments through staff housing and facility upgrades.

5. HRH Financing

- **Current Status**:
  - Financing partly depends on international donors, with local contributions.
  - The HRH strategy has proposed targeted resource mobilization efforts involving private and community stakeholders.
- **Strategies**:
  - Strengthening financial accountability and resource mobilization mechanisms.
  - Integrate HRH financing with broader health sector financial strategies.

6. Continuous Professional Development (CPD)

- **Achievements**:
  - Efforts to standardize CPD linked to re-registration and career progression have shown progress.
- **Challenges**:
  - Limited CPD access for rural health workers.
  - Inconsistent accreditation of CPD programs.
- **Strategies**:
  - Embed CPD in HRH management systems and ensure accreditation of all CPD activities.
  - Leverage digital platforms for wider CPD access.
  - Update the National CPD framework to harmonize the accreditation and certification of CPD programs across cadres.

7. HRH Research and Data Utilization

- **Achievements**:
  - Strengthened HRHIS and integration into decision-making processes.
- **Challenges**:
  - Limited research outputs to guide policy and planning.
  - Inconsistent use of HRH data at subnational levels.
- **Strategies**:
  - Invest in research to identify evolving workforce needs.
  - Build local capacity for data analysis and evidence-based planning.

8. Policy and Governance

- **Focus Areas**:
  - Align HRH strategies with the **National Health Policy (2017)** and the HSSP V objectives for universal health coverage.
  - Enhance multisectoral collaboration to address HRH challenges.
- **Governance Enhancements**
  - Strengthen intersectoral mechanisms and partnerships.
  - Decentralize HRH management to regional and district levels.

1.3 Proposed Changes to the Conceptual Framework

1. Expand Integration of Digital Health Tools

- **Current Gap**: Limited integration of HRHIS, WISN, and TIIS at regional and facility levels, with inadequate use of data for decision-making.
- **Proposed Change**: Strengthen the digital component of the framework to include explicit integration of digital health tools and real-time HRH data systems. This aligns with the increasing reliance on technology for CPD, workforce monitoring, and recruitment.

2. Emphasize Equity and Inclusion

- **Current Gap**: Persistent rural-urban disparities and gender imbalances in HRH distribution and leadership roles.
- **Proposed Change**: Incorporate equity and gender-focused strategies as cross-cutting principles, emphasizing incentives for rural deployment and leadership opportunities for women.

3. Highlight Workforce Resilience and Emergency Preparedness

- **Current Gap**: The COVID-19 pandemic exposed vulnerabilities in workforce resilience and preparedness.
- **Proposed Change**: Embed resilience and emergency response mechanisms in the framework, including capacity-building for pandemics, natural disasters, and other emergencies.

4. Strengthen Stakeholder Coordination

- **Current Gap**: Inefficient collaboration among government, private sector, and NGOs has limited resource mobilization and program alignment.
- **Proposed Change**: Add a dedicated focus on stakeholder coordination to streamline resource allocation, avoid duplication, and maximize impact.

5. Incorporate Outcome-Based Performance Management

- **Current Gap**: The PEPMIS (public employees performance management information system) instead of remains underutilized in tracking productivity and accountability.

- **Proposed Change**: Link performance management directly to outcomes and service delivery improvements, with regular monitoring and feedback loops.

1.3 Updated Conceptual Framework

The updated framework should include the following key components:

1. **HRH Data Systems and Digital Integration**:
    - Real-time data analytics for workforce planning and deployment.
    - Strengthened HRHIS, WISN, and TIIS integration into national health information systems.
2. **Equity and Inclusion**:
    - Targeted incentives for underserved areas.
    - Gender-sensitive policies and leadership training for women.
3. **Workforce Resilience**:
    - Training in emergency preparedness and response.
    - Policies for rapid workforce deployment during crises.
4. **Multisectoral Engagement and Coordination**:
    - Defined roles for government, private sector, and development partners.
    - Regular stakeholder forums to review progress and address gaps.
5. **Outcome-Based Performance Management**:
    - Expansion of PEPMIS with measurable targets linked to service delivery.
    - Feedback mechanisms for continuous improvement.

The updated conceptual framework should be validated in a meeting of relevant stakeholders.

2. Results

2.1 Progress Toward the HRH Strategic Plan 2020–2025 Targets

Thematic Area 1: HRH Information for Decision-Making and Planning

- **Strategic Objective**: Strengthen the HRH planning in line with MOH functional mandates and decentralized settings of health service delivery
- **Progress**:
    - HRHIS and TIIS systems have been improved and integrated with other systems, such as Human Capital Information Systems (HCIMS), Health Facility Registry (HFR), TCU, NACTVET, Professional Council and Boards (PHAB).
    - Analytical capacity at the district and facility levels remains limited, with only partial implementation of training for operational research and HRH data use.
    - Evidence shows improved HRH data utilization at the Ministry and regional levels, but district-level engagement is weak.
- **Outcomes**:

  - Enhanced HRH data systems have led to better workforce planning at the national level but uneven implementation across regions.

Execution of Contributing Interventions:

- Staff audit processes were introduced to improve HRH data quality.
- HRH data systems are updated for better workforce planning and decision-making.

Execution of Non-Planned Interventions:

- Digital integration of health worker registries expanded to improve tracking.
- Some regions implemented unplanned training to address immediate gaps.

Quality of Interventions:

- Reliable HRH data systems were established, though with limited use at the district level.
- Inconsistent utilization of WISN affects planning efficiency.

Challenges:

- Persistent rural retention issues due to lack of incentives.
- Budget constraints impact data utilization and operational planning.

Thematic Area 2: HRH Production and Development

- **Strategic Objective**: Improve the availability of qualified and competent human resources at all levels to adequately correspond with current and future health sector needs.

- **Progress**:

  - Over 24,000 health workers are produced annually from 219 mid-cadre Health Training Institutions and 12 Higher Learning Institutions, but only 21.9% are government-owned, creating a reliance on private training centres.
  - Focused efforts have expanded specialist training opportunities through scholarships and SET programs.
  - Challenges include limited CPD access in rural areas and inadequate integration of CPD into routine performance evaluations.

- **Outcomes**:

  - Increased specialist and mid-level cadre production but with persistent challenges in the equitable distribution of graduates.

Execution of Contributing Interventions:

- Scholarships are offered to specialists to address skill shortages.
- Stakeholder-driven programs like Afya Yangu helped bridge staffing gaps.

Execution of Non-Planned Interventions:

- Volunteer programs were initiated to mitigate shortages in underserved regions.
- Private-sector employment initiatives supplemented public efforts.

Quality of Interventions:

- Urban areas continue to attract more workers than rural areas.
- Recruitment drives were partially effective due to financial constraints.

Challenges:

- Disparities in staff distribution between urban and rural settings.
- Insufficient alignment between infrastructure expansion and workforce availability.

Thematic Area 3: HRH Distribution and Management

- **Strategic Objective**: Improve the recruitment, deployment and retention of health workers using context-specific sound interventions to ensure equitable (needs-based) distribution of health workforce and all levels of the health sector.
- **Progress**:
  - Despite recruiting 30,000 health workers since 2021, a 64% staffing deficit remains, which is more pronounced in the underserved areas.
  - The Accelerated Plan aims to reduce deficits by engaging stakeholders and leveraging private and voluntary sectors.
  - Poor rural working conditions, inadequate incentives, and urban migration hinder retention.
- **Outcomes**:
  - Urban centres remain overstaffed, with severe deficits in rural regions. The WISN tool for equitable staffing is underutilized at lower health system levels.

Execution of Contributing Interventions:

- Strengthened collaboration between training institutions, professional councils, and ministries.
- Investments were made in skills and computer labs to enhance training quality.

Execution of Non-Planned Interventions:

- Curricula revised to address new challenges like emerging diseases.
- Additional workshops were held to improve instructional capacity.

Quality of Interventions:

- Tutor-student ratios improved in training institutions.
- Accredited CPD programs implemented for instructors.

Challenges:

- Limited financial support for training institutions.
- Geographic disparities in training opportunities persist.
- Regulatory challenges in health education leading to production of incompetent skill workforce

Thematic Area 4: HRH Healthy Workplace and Facilities

- **Strategic Objective**: Improve working environments, living conditions, and facilities for HRH.

Progress Towards the HRH Strategic Plan Target

- **Workplace Conditions**:
  - 70% of health facilities reported having good living conditions for HRH, an improvement over previous years.
  - Basic infrastructure enhancements, including housing and equipment, are implemented in select regions.
- **Facility Upgrades**:
  - Increased investments in healthcare infrastructure, with facilities expanded and modernized across levels.
  - New hospitals and clinics are equipped with modern technology like CT scanners and telemedicine tools.

Outcomes

- **Increased HRH Retention**:
  - Improvements in living and working conditions contributed to better retention in targeted regions.
  - Enhanced morale was reported among staff in upgraded facilities, leading to higher performance.
- **Resource Utilization**:
  - Newly installed medical equipment improved diagnostic and treatment capabilities, reducing patient wait times.

Execution of Contributing Interventions

- **Housing Initiatives**:
  - Construction and renovation of staff housing in rural and underserved areas.
- **Infrastructure Development**:
  - Upgraded facilities to meet modern healthcare standards, including maternity wards and emergency services.
- **Capacity Building**:
  - Supportive supervision and CPD initiatives were conducted to address workplace gaps.

Execution of Non-Planned Interventions

- **Emergency Upgrades**:
  - Temporary staff housing was set up in high-need areas due to urgent shortages.
- **Stakeholder Partnerships**:
  - NGOs contributed to improving work environments, such as funding facility renovations.
- **Voluntary Programs**:
  - Community-driven efforts improved local facility conditions and housing for health workers.

Quality of Interventions

- **Improved Work Environment**:
  - Facilities with upgraded infrastructure showed significant improvements in staff satisfaction.
  - However, disparities in implementation quality exist across urban and rural areas.
- **Staff Motivation**:
  - Staff in better-equipped and well-maintained facilities demonstrated higher motivation and productivity.

Challenges

- **Resource Allocation**:
  - Insufficient funds to upgrade all facilities consistently across regions.
- **Rural Disparities**:
  - Rural facilities lag urban centres in infrastructure and improving living conditions.
- **Inconsistent Stakeholder Engagement**:
  - Contributions from private and community stakeholders varied, leading to uneven progress.
- **High Workload**:
  - Despite better conditions in some areas, staff workload remains excessive, limiting the full impact of interventions.

Thematic Area 5: HRH Strategic Financing

- **Strategic Objective**: Strengthen mobilization of HRH financing from government, locally based community stakeholders such as WDC, business companies, and development partners locally and internationally

Progress Towards the HRH Strategic Plan Target

- Expansion of partnerships with development partners, such as USAID and WHO, to support HRH financing.
- Introduction of initiatives to engage private sector contributions, such as collaborations with Non-State Organizations for staffing support in HIV care services.
- HRH budget allocation increased moderately but remains below the required level to meet workforce needs.
- Local-level financing mobilized through councils to address immediate staffing gaps.

Outcomes

- Non-state actors (e.g., Benjamin Mkapa Foundation, MDH, IMF, Global Fund, and other NGOs) have contributed more than 34,000 healthcare providers acting as contractual employees or volunteers per district in some regions to cover gaps in HIV care.
- Local government councils used internally generated funds to recruit health workers for new and existing facilities.
- Voluntary and temporary employment models addressed short-term shortages, contributing to service continuity in underserved areas.

Execution of Contributing Interventions

- Advocacy efforts focused on mobilizing resources from government and international development partners.
- Stakeholders were engaged at regional and national levels to co-finance HRH interventions.
- Digital platforms and financial systems facilitated streamlined allocation and tracking of resources.

Execution of Non-Planned Interventions

- Emergency staffing is financed through local budgets and partnerships during critical shortages.
- Engagement with NGOs and private healthcare providers to fund specialist positions and other cadres.
- Voluntary workforce programs initiated with ad hoc financial support.

Quality of Interventions

- Strategic partnerships improved the resource base for HRH but lacked sustainability in some cases.
- Though inconsistently applied, financial planning tools are used to address regional disparities in funding.
- Local community contributions, such as from businesses, were minimal compared to international financing.

Challenges

- HRH financing remains insufficient, with gaps between budget allocations and actual needs.
- Local stakeholder engagement has been inconsistent, with varying contribution levels from councils and private companies.
- Dependence on development partners for significant funding creates vulnerabilities in long-term planning.
- Expansion of healthcare infrastructure without matching increases in funding exacerbates the financial burden.

- Weak integration of private sector contributions into systematic HRH financing strategies.

2.3 Quality of HRH Interventions in Tanzania

2.3.1. Lessons Learned (Supported by Evidence)

- **Data-Driven Decision-Making**:
  - Integrating HRHIS into planning systems enhanced workforce distribution and training initiatives, but district-level utilization remains weak.
  - Lesson: Investments in HRH information systems are critical but require capacity-building at all health system levels for equitable benefits.
- **Capacity Building**:
  - CPD, through e-learning, reached more than 96,000 health workers by 2023, demonstrating the scalability of digital platforms.
  - Leverage the use of technology to conduct training through ECHO and consultations via Telemedicine.
  - Lesson: Leveraging technology for training can significantly expand access, particularly in resource-constrained settings.
- **Retention Challenges**:
  - Urban preference and limited rural incentives hinder workforce distribution.
  - Lesson: Retention requires a multifaceted approach, including improved working conditions and robust incentive programs.

2.3.2. People-Centeredness

- **Tailored Interventions**:
  - The HRH strategy addressed community-specific needs, such as increasing the number of maternal health specialists in underserved regions.
  - Challenges: Limited engagement of rural communities in workforce planning undermines efforts to align services with local health priorities.
- **CPD and Career Development**:
  - Specialist training and scholarships showed responsiveness to the aspirations of health workers, enhancing job satisfaction and career growth.

2.3.3. Equity

- **Urban-Rural Imbalances**:
  - Despite progress, more than 53% of the health workforce is in urban areas, while rural health facilities face staffing deficits of up to 54%.
  - Initiatives like the Accelerated Plan aimed to address disparities, but implementation challenges persist.
- **Gender Equity**:
  - Women constitute 51% of the health workforce, predominantly in nursing roles. However, leadership positions remain male-dominated.

  - Efforts to promote equitable representation in leadership and high-demand cadres remain inadequate.

2.3.4. Efficiency (Stakeholders' Coordination and Cost Control)

- **Stakeholder Engagement**:
  - Coordination among government, NGOs, and private sectors facilitated significant progress in recruitment and training.
  - Gaps: Inconsistent collaboration led to uneven outcomes, especially in rural deployments.
- **Cost Control**:
  - The rapid scale-up of HRH through the Accelerated Plan strained wage budgets, highlighting the need for a sustainable funding model.

2.3.5. Effectiveness

- **Implementation of Strategies**:
  - Online recruitment systems streamlined hiring processes, enabling the recruitment of more than 30,000 health workers in 2021.
  - CPD programs effectively enhanced skills but lacked widespread implementation in rural areas.
- **Impact on Health Outcomes**:
  - Increased staffing and CPD initiatives contributed to better service delivery in urban centres but had minimal impact on underserved areas.

2.3.6. Gender

- **Workforce Composition**:
  - Gender disparities persist, with men dominating specialized and managerial roles despite women forming most of the workforce.
  - Recommendations for gender-sensitive policies include targeted leadership training for women and addressing gender-based barriers to professional growth.

2.3.7. Ethics

- **Transparent Recruitment**:
  - The online recruitment system ensured fairness and reduced nepotism, fostering trust in the hiring process.
- **Ethical Challenges in Distribution**:
  - The failure to prioritize rural areas perpetuated inequities, raising ethical concerns about the fairness of resource allocation.

2.4 Challenges in Implementing HRH Interventions in Tanzania

Introduction

Implementing the Human Resources for Health (HRH) Strategic Plan (2021–2026) in Tanzania has encountered several challenges that have limited progress toward achieving its targets. Despite notable successes, gaps remain due to unfinished agendas, interventions carried forward, emerging threats, and resource constraints. This report explores these challenges, supported by evidence from the mid-term evaluation.

2.4.1 Unfinished Agenda

1. **Urban-Rural Disparities**:
   - **Evidence**:
     - Urban areas, such as Dar es Salaam, continue to host 53.45% of the health workforce, while rural regions face staffing deficits of up to 54%.
   - **Impact**:
     - These disparities limit access to quality healthcare in underserved areas, undermining the equity goals of the HRH strategy.
2. **Underutilization of Workforce Planning Tools**:
   - **Evidence**:
     - While introduced, the WISN tool has not been fully implemented or utilized at the district and facility levels.
   - **Impact**:
     - The lack of evidence-based staffing decisions perpetuates inefficiencies in workforce deployment.
3. **Limited CPD Access in Rural Areas**:
   - **Evidence**:
     - Continuous Professional Development (CPD) programs reached more than 128,000 participants by January 2024, but rural health workers report limited access due to logistical challenges.
   - **Impact**:
     - This limits skill enhancement and affects service quality in underserved regions.

2.4.2 Interventions Carried Forward

1. **Delayed Infrastructure Development**:
   - **Evidence**:
     - Plans to improve teaching hospitals and skills laboratories have been partially implemented, with gaps in rural infrastructure development.
   - **Impact**:
     - Delayed projects hinder the production of adequately trained health workers.

2. **Retention Strategies**:
    - **Evidence**:
        - Rural retention incentives, such as housing and allowances, were inconsistently applied or underfunded.
    - **Impact**:
        - High attrition rates in rural areas necessitate a renewed focus on retention strategies in the subsequent implementation phase.
3. **Integration of HRH Data Systems**:
    - **Evidence**:
        - While HRHIS has been integrated into national systems, its utilization at local levels remains incomplete.
    - **Impact**:
        - Limited data integration at lower levels impedes comprehensive workforce planning.

2.4.3 Anticipated or Emerging Threats

1. **Economic Constraints**:
    - **Evidence**:
        - The rapid scale-up of HRH through the Accelerated Plan strained wage budgets, with limited funding for additional hires.
    - **Impact**:
        - The availability of funds threatens the sustainability of HRH interventions.
2. **Workforce Attrition**:
    - **Evidence**:
        - The ageing workforce (20% over 45 years) and migration to urban areas or abroad exacerbate staffing shortages.
    - **Impact**:
        - Continue plans to hire younger people to replace an ageing workforce.
3. **Pandemic-Related Disruptions**:
    - **Evidence**:
        - The COVID-19 pandemic disrupted training programs and routine health services, highlighting vulnerabilities in HRH systems.
    - **Impact**:

- Any future health emergencies could further strain the already limited workforce.

2.4.4 Availability of Resources

1. **Need for Funding Diversification**:
   - **Evidence**:
     - Major rehabilitations and constructions of health training institutions are ongoing with government support. Staff recruitment is conducted via central government; career development is done via government support. Donors have only supported the development of guidelines for the conduct of CQI.
   - **Impact**:
     - Emphasis should be made on funding diversification.
2. **Limited Infrastructure**:
   - **Evidence**:
     - Only 21.9% of health training institutions are government-owned, creating a reliance on private facilities that are often inaccessible to rural candidates.
   - **Impact**:
     - Unequal access to training opportunities perpetuates workforce shortages in underserved areas.
3. **Inconsistent Stakeholder Engagement**:
   - **Evidence**:
     - Collaboration between government, NGOs, and the private sector has been uneven, leading to missed opportunities for resource mobilization.
   - **Impact**:
     - Inefficiencies in resource allocation slow progress toward HRH targets.

2.4.5 Proposed Solutions for Overcoming Challenges

1. **Addressing Unfinished Agendas**:
   - Strengthen the implementation of WISN and HRH data systems at all levels.
   - Scale up CPD access in rural areas through digital platforms and targeted funding.
2. **Carrying Forward Key Interventions**:
   - Prioritize infrastructure development in rural areas.
   - Implement comprehensive rural retention packages, including competitive salaries, housing, and professional development opportunities.
3. **Mitigating Emerging Threats**:

- Develop a contingency plan for economic challenges, including diversifying funding sources through public-private partnerships.
- Increase investments in workforce production to counterbalance attrition and migration trends.

4. **Enhancing Resource Availability**:
   - Secure sustainable funding for HRH programs through government budget prioritization and international donor partnerships.
   - Promote equitable access to training by expanding government-owned institutions and offering scholarships to rural candidates.

2.5 Recommendations and Key Action Points

1. Strengthen HRH Planning and Data-Driven Decision-Making

- **Recommendation**: Expand the integration and utilization of HRH Information Systems (HRHIS and WISN).
- **Key Actions**:
  - **Build district and facility-level analytical capacity** through training on HRH data tools.
    - **Responsible**: MOH HRH Directorate, Regional Health Management Teams
    - **Deadline**: June 2026
  - **Scale up the use of WISN** to ensure evidence-based staffing decisions.
    - **Responsible**: MOH HRH Directorate, PORALG
    - **Deadline**: December 2026
  - **Regularly audit HRH data quality** to improve workforce tracking and planning.
    - **Responsible**: MOH, HRHIS Unit
    - **Deadline**: Annually, starting March 2026

2. Improve HRH Production and Development

- **Recommendation**: Align training programs with current and future health sector needs while addressing quality gaps.
- **Key Actions**:
  - **Finalize construction and rehabilitation of training institutions**, prioritizing rural areas.
    - **Responsible**: Ministry of Education, MOH, PORALG
    - **Deadline**: December 2026
  - **Update and implement competency-based curricula**, focusing on rare cadres like anaesthetists and radiographers.

        - **Responsible**: MOH Training Directorate, Health Training Institutions
        - **Deadline**: June 2026
    - **Establish standardized CPD requirements** linked to career progression and re-registration.
        - **Responsible**: Professional Councils, MOH
        - **Deadline**: June 2026

3. Address Urban-Rural Disparities in HRH Deployment

- **Recommendation**: Prioritize equitable workforce distribution through targeted recruitment and deployment.
- **Key Actions**:
    - **Allocate resources for recruitment in underserved regions and newly constructed facilities, starting with Regions with >75% staffing shortage (Songwe, Simiyu, Geita, and Katavi).**
        - **Responsible**: MOH, PORALG
        - **Deadline**: December 2026
    - **Develop rural-focused incentives** such as housing, allowances, and career advancement.
        - **Responsible**: MOH, LGAs
        - **Deadline**: June 2026
    - **Strengthen local HRH planning processes** to address regional needs.
        - **Responsible**: Regional and District Health Management Teams
        - **Deadline**: December 2026

4. Enhance Retention Strategies

- **Recommendation**: Develop innovative retention schemes to improve workforce stability, particularly in rural areas.
- **Key Actions**:
    - **Introduce non-financial incentives** like professional growth plans and mentorship programs.
        - **Responsible**: MOH, Professional Councils
        - **Deadline**: June 2026
    - **Improve working conditions** through consistent infrastructure upgrades, including staff housing.
        - **Responsible**: MOH, PORALG, LGAs
        - **Deadline**: December 2026

- **Expand CPD access in rural areas** through digital platforms and mobile training units.
  - **Responsible**: MOH, Training Institutions
  - **Deadline**: December 2026

5. Expand HRH Financing Mechanisms

- **Recommendation**: Diversify and increase funding sources to meet workforce needs.
- **Key Actions**:
  - **Mobilize community-based resources** through local government authorities and private sector partnerships.
    - **Responsible**: MOH, PORALG, Finance Ministry
    - **Deadline**: December 2026
  - **Advocate for increased government budget allocations** for HRH programs.
    - **Responsible**: MOH, Finance Ministry
    - **Deadline**: June 2026
  - **Establish a fund for HRH development** supported by international donors and local businesses.
    - **Responsible**: MOH, Development Partners
    - **Deadline**: December 2026

6. Integrate Equity and Inclusion in HRH Policies

- **Recommendation**: Address gender and geographic disparities in HRH planning and implementation.
- **Key Actions**:
  - **Design leadership training programs targeting women** to increase their representation in senior roles.
    - **Responsible**: MOH, Training Institutions
    - **Deadline**: December 2026
  - **Establish incentives for women** to pursue high-demand cadres like specialists and managers.
    - **Responsible**: MOH, Professional Councils
    - **Deadline**: June 2026
  - **Embed equity principles** in HRH recruitment and deployment policies.
    - **Responsible**: MOH, PORALG

- **Deadline**: December 2026

7. Build Workforce Resilience and Emergency Preparedness

- **Recommendation**: Develop a resilient HRH framework to address public health emergencies.
- **Key Actions**:
  - Regular training on emergency response and pandemic preparedness must be conducted.
    - **Responsible**: MOH, Training Institutions
    - **Deadline**: December 2026
  - Develop policies for rapid workforce deployment during crises.
    - **Responsible**: MOH, Disaster Management Unit
    - **Deadline**: June 2026
  - Establish a reserve health workforce to address sudden surges in demand.
    - **Responsible**: MOH, PORALG
    - **Deadline**: December 2026

8. Strengthen Multisectoral Engagement and Governance

- **Recommendation**: Improve collaboration among government, private sector, and development partners.
- **Key Actions**:
  - Establish regular forums for stakeholder engagement to align priorities and resources.
    - **Responsible**: MOH, Development Partners
    - **Deadline**: Annually, starting March 2026
  - Create a centralized coordination mechanism to streamline HRH investments.
    - **Responsible**: MOH
    - **Deadline**: December 2026
  - **Foster partnerships for shared training programs and infrastructure development.**
    - **Responsible**: MOH, Private Sector Partners
    - **Deadline**: June 2026

9. Enhance Performance Management

- **Recommendation**: Link workforce performance to measurable outcomes to drive accountability and productivity.

- **Key Actions**:
  - Implement and expand PEPMIS to monitor performance against service delivery targets.
    - **Responsible**: MOH, LGAs
    - **Deadline**: December 2026
  - Integrate performance feedback loops into routine HRH management processes.
    - **Responsible**: MOH, Facility Managers
    - **Deadline**: December 2026
  - Reward high-performing staff with career growth opportunities and incentives.
    - **Responsible**: MOH, LGAs
    - **Deadline**: December 2026

10. Promote HRH Research and Evidence-Based Policy

- **Recommendation**: Invest in HRH research to inform planning and policy decisions.
- **Key Actions**:
  - Establish annual research dissemination forums for HRH stakeholders.
    - **Responsible**: MOH, Academic Institutions
    - **Deadline**: Annually, starting March 2026
  - Prioritize studies on workforce distribution, retention, and emerging health sector needs.
    - **Responsible**: MOH, Research Institutions
    - **Deadline**: December 2026
  - Incorporate research findings into strategic HRH decisions at national and regional levels.
    - **Responsible**: MOH
    - **Deadline**: Ongoing

Implementation Phases

- **Immediate (0–6 months)**: Initiate WISN training, update curricula, and expand CPD access.
- **Mid-Term (6–18 months)**: Operationalize retention incentives, strengthen equity policies, and enhance HRH financing mechanisms.
- **Long-Term (18–24 months)**: Achieve full integration of HRH systems, workforce resilience frameworks, and sustainable financing solutions.

3. Updated Results Framework

Thematic Area	Strategic Objective	Result Area	Outcome	Baseline	Target	Mid-Point	Who Is Responsible	Deadline
HRH Planning and Information for Decision-Making	Strengthen HRH planning in line with decentralized health service delivery mandates.	Integrated HRH data systems for informed decision-making.	HRHIS and TIIS are fully operational and integrated with other systems.	36% of facilities meet staffing norms; HRH data integration is limited.	50% of facilities meet staffing norms; HRH data integration at all levels.	45% of facilities meet staffing norms; district-level integration is achieved.	MOH HRH Directorate, Regional Health Management Teams	June 2026
HRH Recruitment and Deployment	Increase the recruitment and equitable deployment of health workers across regions.	Enhanced staff distribution to underserved areas.	Equitable distribution of staff in line with regional and facility needs.	Urban-rural disparity: 53.4% of the health workforce in urban areas; regional planning focuses on administration rather than needs-based deployment.	40% increase in rural staff deployment; equitable staff ratios.	20% increase in rural staff; 10% improvement in equitable ratios.	MOH HRH Directorate, Local Government Authorities (LGAs)	June 2027
HRH Production and Development	Improve availability and competence of health workers through enhanced training.	Competency-based training programs implemented.	Increased production of trained health workers in priority cadres.	Training institutions often lack modern infrastructure, and limited rare cadre programs; curricula need alignment with modern needs	100% compliance with competency-based standards; rare cadres doubled.	95% compliance with standards; rare cadre programs expanded by 50%.	Training institutions, MOH, Professional Councils	June 2027

Thematic Area	Strategic Objective	Result Area	Outcome	Baseline	Target	Mid-Point	Who Is Responsible	Deadline
				(competency-based).				
Pre-Service Training	Improve the quality and accessibility of training in Health Training Institutions.	Enhanced learning environments in Health Training Institutions.	Increased enrollment and improved training quality in rare cadres.	Incomplete infrastructure in several institutions, outdated curricula, and inadequate enrollment in rare cadres.	Full rehabilitation of non-functional institutions; expanded rare cadre enrollment; modernized curricula.	Rehabilitation of 50% of non-functional institutions; rare cadre enrollment increased by 30%.	MOH, Health Training Institutions, Ministry of Education	June 2027
HRH Healthy Workplace and Facilities	Improve working environments, living conditions, and facilities for HRH.	Upgraded workplace and living conditions for HRH.	Improved retention rates and staff satisfaction.	70% of facilities report adequate living conditions, limited non-financial benefits for remote workers, and inconsistent implementation of task sharing.	90% of facilities report improved conditions and staff housing.	80% of facilities report improved conditions and housing; non-financial retention schemes operationalized.	MOH, LGAs, Private Sector Partners	June 2027
HRH Performance Management	Improve retention through career pathways and innovative incentive schemes for remote areas.	Coordinated CPD and retention initiatives implemented.	Improved retention and skill development among health workers.	Limited CPD opportunities in remote areas; lack of career progression pathways; insufficient non-financial benefits	A comprehensive CPD framework has been operationalized, and innovative retention schemes are in	CPD participation increased by 50%; retention schemes were piloted in high-need regions.	MOH, Training Institutions, LGAs	June 2027

Thematic Area	Strategic Objective	Result Area	Outcome	Baseline	Target	Mid-Point	Who Is Responsible	Deadline
				for rural workers.	place nationwide.			
HRH Strategic Financing	Strengthen mobilization of HRH financing from government and stakeholders.	Diversified and increased HRH financing sources.	Increased funding from local, national, and international sources.	HRH financing heavily reliant on international partners; weak engagement with local private sector and stakeholders.	50% funding sourced locally and nationally; diversified partners.	35% of funding is sourced locally and nationally; there is ongoing diversification.	MOH, Finance Ministry, Development Partners.	June 2027
HRH Research	Conduct HRH research to inform evidence-based policy and practice.	Research-based insights on HRH challenges and opportunities.	Improved decision-making and planning in HRH initiatives.	Limited HRH research outputs and utilization in planning processes.	Annual HRH research dissemination forums; research incorporated in all strategic decisions.	Two HRH research studies are conducted annually; results are disseminated to stakeholders.	MOH, Academic Institutions, Research Councils	June 2027

4. Annex

Government-Provided Jobs by Year (Translated), Source MOH

Number	Cadre	May-17	Jun-18	Jul-19	May-20	Jun-21	Jun-22	Jun-23	Jun-24	Total Government-Provided Jobs
1	Additional Specialist Doctor	0	0	0	0	0	0	2		2
2	Medical Doctor	206	204	232	610	93	657	271		2370
3	Dental Surgeon	0	2	34	0	1	3	0		9
4	Assistant Medical Officer	0	0	0	0	0	0	1		8
5	Assistant Dental Officer	0			0	0	0	0		0
6	Assistant Clinical Officer	0	2	24	0	196	1314	1894		5006
7	Dental Therapist	0	56	74	0	9	142	127		344
8	Clinical Officers	0	129	226	0	176	300	407		1948
9	Nursing Officer	0	63	70	0	20	72	1185		1389
10	Assistant Nursing Officer	0	817	817	0	124	2345	998		2247
11	Nurse	301	730	800	4	87	3389	634		7023
12	Radiology Technologist	0	45	56	0	30	120	61		286
13	Technologist - Optometry	0			0	3	0	10		13
14	Laboratory Technology Officer	0	50	55	0	0	30	13		95
15	Technologist - Laboratory	0	125	126	0	10	13	18		595

Number	Cadre	May-17	Jun-18	Jul-19	May-20	Jun-21	Jun-22	Jun-23	Jun-24	Total Government-Provided Jobs
16	Assistant Technologist - Laboratory	0	250	250	0	142	150	88		734
17	Assistant pharmaceutical Technologist	0	0	0	0	0	0	0		151
18	Pharmacist	0	79	79	15	4	226	57		242
19	Technologist - Pharmaceutical	0	123	205	0	2	250	89		689
20	Assistant Technologist - radiography	0	60	60	0	6	0	70		286
21	Environmental Officer	0	60	60	4	2	0	20		121
22	Assistant Environmental Officer	0	82	82	0	7	100	66		441
23	Health Assistant	0	18	19	45	33	434	27		746
24	Biomedical Engineer	0	22	43	0	0	0	0		22
25	biomedical technician	0			4	0		69		69
26	Medical Equipment Designer	0	2	12	10	0	102	2		107
27	Technologist Physiotherapy							2		2
28	Physiotherapist/Practitioner	0	30	33	0	5	0	48		91
29	HEALTH SECRETARY	0	25	27	22	20	75	40		166
30	Health Assistant	0	126	201	0		400	872		1612
31	(Mortuary Attendant)	0	25	25	0	0	0	0		26

Number	Cadre	May-17	Jun-18	Jul-19	May-20	Jun-21	Jun-22	Jun-23	Jun-24	Total Government-Provided Jobs
32	Laundry Assistant	0	0	0	1	0	0	3		4
33	Nutrition Officer	0	0	0	0	12	63	116		197
34	Social Welfare Officer	0	0	0	0	18	65	57		140
35	Health Records Assistant	0	0	0	0	0	0	0		0
GRAND TOTAL		507	3125	3610	715	1000	10250	7247	13187	39641

HRH Needs Vs Staff Availability (estimated in 2019)

Facility Levels	HRH Required in 2019	HRH Available in 2023	HRH Available in 2024	Shortage in 2023	Shortage in 2024	Percent Shortage in 2023	Percent Shortage in 2024
Dispensary	100,646	30,525	32,524	70,121	70,121	69.67%	70%
Health Centre	68,204	24,314	28,548	43,890	43,890	64.35%	64%
District Hospital	125,624	36,633	38,756	88,991	88,991	70.84%	71%
Other Hospital	18,133	9,268	11,423	8,865	8,865	48.89%	49%
Regional Hospital	16,324	9,373	5,589	6,953	6,951	42.58%	43%
National, Zonal, Specialized and Referral Hospitals	18,471	8,968	9,327	4,160	4,160	28.67%	23%
Health Training Institutions	1,521	597	758	624	624	47.24%	41%
Grand Total	**348,923**	**119,678**	**126,925**	**229,245**	**221,998**	**66%**	**64%**

Source HRHIS 2024/AHSPR 2023

Selected HRH Indicators

Indicator	Number in 2024
a) HRH Planning and Information for Decision Making	
i. Density of HRH per 10,000 populations (Clinicians, Nurses and Midwives, Pharmacist, Health Lab)	8.4
ii. Regions and Councils with a critical shortage of HRH	GEITA, SIMIYU and MANYARA
iii. Advocacy strategy developed and disseminated at all levels	No strategy but advocacy is occurring
b) HRH Distribution and Management	
i. % of health facilities with at least two qualified healthcare workers	81%
ii.% of LGA implementing Makole Model	30%
iii.% of health facilities with health workforce in accordance with HRH staffing norms	36%
c) HRH Production and Development	
i.% of training programs that match or surpass position requirements	Indicator unclear
ii. % of courses devoted to country-priority diseases.	Indicator unclear
iii. % of health training institutions and universities with a standard number of qualified instructors per cadre	90
d)HRH Healthy Workplace and facilities	
i.% of Health facilities with good living conditions and working environment for HRH	70%
ii.% of health training institutions with good living conditions and working environment for HRH	60%

HRH Distribution by Region, 2023, Source MOH

Regions	Required	Available	Shortage	Percentage Shortage
Dar es Salaam	15,193	8,175	7,018	46.19%
Kilimanjaro	21,699	10,139	11,560	53.27%
Arusha	21,306	9,681	11,625	54.56%
Morogoro	16,133	7,086	9,047	56.08%
Dodoma	17,757	7,726	10,031	56.49%
Kagera	10,986	4,485	6,501	59.18%
Mtwara	21,597	8,671	12,926	59.85%
Pwani	15,335	6,012	9,323	60.80%
Tabora	20,604	7,933	12,671	61.50%
Singida	10,551	4,003	6,548	62.06%
Mwanza	20,907	7,322	13,585	64.98%
Mara	15,438	5,349	10,089	65.35%
Iringa	14,675	5,069	9,606	65.46%
Mbeya	11,902	3,956	7,946	66.76%
Ruvuma	11,008	3,572	7,436	67.55%
Tanga	12,203	3,826	8,377	68.65%
Rukwa	8,959	2,606	6,353	70.91%
Njombe	9,917	2,883	7,034	70.93%
Lindi	10,300	2,993	7,307	70.94%
Kigoma	10,191	2,858	7,333	72%
Shinyanga	8,642	2,409	6,233	72.12%
Manyara	12,667	3,226	9,441	74.53%
Songwe	8,244	1,984	6,260	75.93%
Simiyu	2,832	645	2,187	77.22%
Geita	8,571	1,951	6,620	77.24%
Katavi	11,306	2365	8,941	79.08%
	348,923	**126,925**	**221,998**	63.62%

Source: HRHIS

5. References

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