Medicus Mundi Schweiz
Gesundheit für alle

MMS Bulletin #104
Gesundheitspersonal: die Krise überwinden

Initiatives addressing Human resource for Health in the United Republic of Tanzania

Complexity can't be allowed to stand in the way of action

Von Helen Prytherch und Ricarda Merkle

Tanzania is a key partner country of the German Development Cooperation with support for the health sector being a priority focus. Experience indicates the inherent complexity of mobilising and coordinating a politically strong, multidisciplinary response for tackling human resource development. The need for long-term health systems based support and close collaboration with other processes such as decentralisation and civil service reform is clearly reflected.

The issue of Human Resources for Health is today acknowledged as one of the main detriments to the success of health sector reform in the United Republic of Tanzania. The challenges to meet the health related Millennium Development Goals and keep on track with the implementation of Global Fund proposals are also being increasingly traced back to the scarcity of this most precious of all resources. Whilst the topic has recently been catapulted into the limelight the problem has not suddenly appeared but has been developing over many years. With the default upon the national debt in the early 1990s the country was left with no other choice but to freeze employment in the public sector. This served to reduce health worker supply considerably and created a demographic gap in the age of health care workers.

According to a recent review by McKinsey & Company Tanzania is estimated to have 25,000 skilled health workers in the public, private as well as faith-based sector, of which only 1,900 are higher skilled medical staff. In Kenya and South Africa with similar population sizes the figure is 80,000 and 255,000 respectively. Shortages are highest among clinical officers and laboratory technicians (60%), followed by nursing cadres (50%) and doctors (40%). Furthermore, the distribution of staff between urban and rural areas is highly unequal. Whilst the rate of assistant medical officers per million people in cities totals 43, in less populated areas it is only 19. It should, at this point, be recalled that approximately 70% of Tanzania's population live in rural areas.

Coordination of diverging efforts in the area of Human Resources for Health remains a challenge for the Ministry of Health even within a well functioning SWAp mechanism. This can in part be explained by the large number of stakeholders working in Tanzania in the areas of health and HIV/AIDS, but also by the vertical approach used to address the three big killer diseases most particularly HIV. When it comes to Human Resources for Health the World Bank, WHO, CDC (funded by PEPFAR, President Bush's "President's Emergency Plan for AIDS Relief), USAID, the Global Fund, GTZ/InWEnt and JICA are just some of the key players at policy level, with the Clinton and Bill and Melinda Gates Foundations gaining increasing importance as well.

The Second Health Sector Strategic Plan July 2003 - June 2008 addresses Human Resources Development both as a priority area and as one of the nine key strategies making up the overall health sector reform. Added political weight was provided as the issues importance is mentioned in the Poverty Reduction Strategy Paper and was raised in the 2006 General Budget Support Review. The unique contribution the health sector has to make to the implementation of the National Multisectoral Strategic Framework for HIV has caused the challenges that result when staff are not available in the right places lower down the system to become a topic of national debate.

In recent years moves towards greater efficiency and a clearer division of roles within the health sector have been made. Whilst responsibility for training has remained at central level with the Ministry, local governments were made responsible for the provision of health services, including recruitment and hiring of health staff as part of the process of decentralisation. Heralded as an important step to devolve authority to a level closer to the populations being served, limited capacity at the newly formed local government level – and the call for new skills such as lobbying, amongst the more technical council health management teams have in fact hindered the implementation of rapid and flexible employment of staff in the short term. In 2005 the HRH situation was officially declared a crisis and the Ministry of Health passed a moratorium that for the next three years urgent measures need to be taken. An example here was the decision to assign 600 clinical officers graduating in 2005 to work across the country, bypassing the district recruitment process.

This reflects the way that human resources as a whole often finds itself at a difficult juncture between parallel reform processes. Decentralisation and health sector reform are both ongoing as too is a comprehensive reform of the public service whilst the training institutions for human resources are being affected by the reform process in higher education. Human resources for health needs also to take into consideration the fact that a substantial proportion of health service delivery and training is provided by non-state actors. In particular we refer here to voluntary associations such as the church but also to private practitioners. Together with the state these are the employers of health staff and dynamics of competition are increasingly seen to be at play. Brain drain is not only a problem across international borders, but within countries. In Tanzania a drain of health staff into non-governmental organisations in the context of Global Health Initiatives can also be discerned.

In January 2006 the Government of Tanzania increased wages in the public sector – including for health staff. Faith-based institutions found themselves unable to match the salary rise and now report losing their staff to public service. Given the trend that the faith-based sector generally delivers health care in some of the remotest areas of the country it is ultimately the poor populations in such regions who are suffering as a result.

It must also be stated that despite the increase, salary levels are still considered to be insufficient to assure a minimal living standard and supplementary income sources continue to be sought by health workers. This can take the form of "under the table payments" for services rendered, of moonlighting in private practice whilst being on the public payroll or looking for continuous education and on the job trainings which reimburse travel costs and provide per diems at a level that stand in total disproportion to an average salary. It has been estimated that the costs for per diems and other hidden benefits could translate into a 13% rise in salaries for all health staff. Complex reality dictates that to tackle the issue of salaries the entire public sector has to be looked at. The difficulties of securing predictable funding for system running costs and of bringing "hidden additions" to staff salaries out into the open in a move to overall "good governance" stand in the way of a comprehensive approach being taken.

Vertical programmes feed into this unfavourable scenario. On the job training offers remains rather uncoordinated with development partners and NGOs funding certain priority areas and thus inducing an inequitable availability of training opportunities. Additionally, sometimes such large numbers of health staff are called to attend trainings that health centres and district hospitals are left without key staff to attend to the patients.

The way that non-comprehensive efforts can serve to magnify such imbalances is shown clearly by the Mkapa Fellowship programme. The objective of this programme is to increase the number of health staff in rural areas by providing additional salaries to people willing to relocate and work there. This includes incentives such as housing allowances and participation at international conferences. On paper it makes perfect sense. However, the result has been increased frustration on the part of health staff already working in such difficult areas. The process of selecting the new staff and their working stations has not been seen as transparent. Furthermore, it has resulted in those selected for the privileged conditions working side by side with similarly qualified Tanzanians earning the standard salaries.

Despite the odds however, both the Government as a whole and the Ministry of Health in particular are taking steps. A HRH taskforce has been established which includes representatives of several ministries (Health, Finance, Regional and Local Government (PMO-RALG), Public Service Management (PO-PSM)), WHO, World Bank, bilateral agencies and research institutions (National Institute of Medical Research). Furthermore, a new system to evaluate and appraise civil servants across the entire public sector has been launched. It includes the formation of measurable objectives for envisaged results, six monthly feedback, annual performance reports in cooperation with employees, etc. (OPRAS, Open Performance and Review Appraisal System). Though this is considered as a step in the right direction, rapid

and visible improvements are considered unlikely given the relatively underdeveloped performance-orientated organisational culture. For example technical supervision, which is supposed to be a tool to monitor professional performance, has remained checklist driven and at times also serves as a way to generate additional income via the travel allowances. Complaints of health staff regarding supervision include that mistakes are criticised at once - even in front of patients- but then there is little positive discussion about how changes could be made and sometimes no further feedback is received at all.

The Ministry of Health is addressing the skills mix of health staff by promoting the upgrading of lower cadres such as rural medical aides, medical attendants, maternal and child health aids and nurse assistants. The intention is to phase these cadres out over time as better skilled HRH become available. Concurrently the Ministry is continuing to train all cadres instead of falling into the temptation of only focusing on lower cadres, which are quicker and less expensive to train. Health Training Institutions have been encouraged to increase their student intake for pre-service training with some colleges that have hitherto trained clinical officers being considered for upgrading to assistant medical officers colleges. It is increasingly being recognised that assistant medical officers now form the backbone of the Tanzanian health system.

There is still much to be done to combine a strategic planning for the entire sector, within a comprehensive civil service wide approach. There are also calls for increased flexibility to overcome bureaucratic hurdles and consider how staff can be managed and used more efficiently – putting willing retired staff back to work or using part time options spread between working stations. Above all the realisation is there that just as the problem has not arisen overnight, its effects will continue to be felt for many years to come and achieving a solution will take a long term, enduring approach and an incredibly high level of political will from the Government and its development partners alike.

Both authors work at the Swiss Centre for International Health, a department of the Swiss Tropical Institute. Contact: Ricarda.merkle@unibas.ch

Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10
info@medicusmundi.ch

Suisse romande
Medicus Mundi Suisse
Rue de Varembé 1
CH-1202 Genève
Tél. +41 22 920 08 08
contact@medicusmundi.ch

Bankverbindung
Basler Kantonalbank, Aeschen, 4002 Basel
Medicus Mundi Schweiz, 4056 Basel
IBAN: CH40 0077 0016 0516 9903 5
BIC: BKBBCHBBXXX