Federal Democratic Republic Of Ethiopia
Ministry of Health

Human Resource for Health Strategic Plan (2009-2025)

July, 2015
Addis Ababa
Ethiopia

TABLE OF CONTENTS

Table of Contents 2
Acronyms 3
Executive Summary 5
Chapter 1: Background and Introduction 8
1.1. Demographic and Socio Economic Profile 8
1.2. Ethiopia Health Status 8
1.3. Policy and Planning Context 9
1.4.Rationale for the Development of HRH Strategic Plan 12
1.5.Rationale For The Revision OF THE Strategic Plan 13
1.6. Process of Developing and Revising the HRH Strategic Plan 14
1.7. Organization of the Strategic Plan 15
Chapter 2: Situational Analysis of Ethiopia HRH 16
2.1. HRH Leadership and Governance 16
2.2. Health Workforce Density and Distribution 17
2.3. Health Workforce Education and Training 17
2.4. Human Resources Management 19
2.5. HRH Policy and Legislation 21
2.6. Financing For Health Workforce 22
2.7. Partnerships For HRH 23
2.8. Achievements in the Implementation of the Strategic Plan (2009 – 2014) 23
Chapter 3: Strategic Direction 29
3.1. Vision, Goal and Objectives 29
3.2. Guiding Principles 29
3.3. Strategic Plan Outcome Areas 30
Chapter 4: Strategic Plan Outcomes, Objectives and Actions 31
Outcome 1: HRH Policy, Planning and Partnership Strengthened at all levels 32
Outcome 2: Health Workforce education and training capacity and Regulation improved 34
Outcome 3: HRH leadership and management capacity and practices are strengthened 38
Outcome 4: Utilization, retention and performance of the available health workforce optimized 39
Chapter 5: Implementing the HRH Strategic Plan 43
5.1. Coordination Mechanisms 43
5.2. Implementation Framework 44
Chapter 6:Implementation Matrix and Timelines 45
Outcome 1: HRH Policy, Planning and Partnership Strengthened at all Levels 45
Outcome 2: Health Workforce education and training capacity and Regulation improved 47
Outcome 3: HRH leadership, governance and management capacity and practices are strengthened 52
Outcome 4: Utilization, retention and performance of the available health workforce optimized. 53
Chapter 7: Strategic Plan Monitoring and Evaluation 59
7.1. M&E Approach 59
7.2. HRH Indicators 59
Chapter 8: Monitoring and Evaluation Matrix 60
Outcome 1 Indicators: HRH Policy, Planning and partnership Strengthened at all levels 60
Outcome 2 Indicators: Health Workforce education and training capacity and Regulation improved 61
Outcome 3 Indicators: HRH leadership, governance and management capacity and practices are strengthened ... 62
Outcome 4 Indicators: Utilization, retention and performance of the available health workforce optimized 63
Chapter 9: Costing and projection of HRH strategic plan 65
Annex 1: STaffing STandards .... **Error! Bookmark not defined.**
Annex 2: Assumptions for Facility Scale Up 72
Annex 3: HRH Requirement Projections (2015 and 2025) 72

Acronyms

AAU	Addis Ababa University
AHP	Allied Health Professional
APSB	Annual Public Service Bonus
ASEAN	Association of South East Asian Nations
BEOC	Basic Emergency Obstetric Care
BPR	Business Process Reengineering
CDC	Centers for Disease Control and Prevention
CEOC	Comprehensive Emergency Obstetric care
CME	Continuing Medical Education
COHHRD	Coordinated Health and Human Resource Development
CSA	Central Statistics Authority
DFID	Department for International Development
DHRM/ DHRDA	Directorate of Human Resource Management Directorate of Human Resources Development and Administration
DHFPL	Directorate of Health Facilities and Professionals Licensing
EEA	Ethiopian Economic Association
EFY	Ethiopian Fiscal Year
EMIS	Education Management Information System
ESS	Emergency Surgical Skills
FMoH	Federal Ministry of Health
FMHACA	Food Medicine and Health Care Administration and Control Authority
GDP	Gross Domestic Product
GHWA	Global Health Workforce Alliance
GoE	Government of Ethiopia
GP	General Practitioner
HERQA	Higher Education Relevancy and Quality Assurance
HEW	Health Extension Worker
HFS	Health Facility Survey
HIT	Health Information Technician
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNM	Health Need Method
HO	Health Officer
HR	Human Resource
HRD	Human Resource Department
HRDA	Human Resource Development And Administration Directorate
HRH	Human Resource for Health
HRM	Human Resource Management
HRIS	Human Resource Information System
HSDP	Health Sector Development program
HSEP	Health Service Extension Program
IESO	Integrated Emergency Surgical Officers
IRT	Integrated Refresher Training
IST	In-service training
ISCO	International Standard Classification of Occupation
MDG	Millennium Development Goals
MoFED	Ministry of Finance and Economic Development

M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTEF	Mid-Term Expenditure Review
NHA	National Health Account
NGO	Non-Governmental Organization
OGO	Other Governmental Organization
OPM	Operational Manual
PASDEP	Plan for Accelerated & Sustainable Development to end Poverty
PBC	Performance Based Contracting
PHCU	Primary Health Care Unit
PPD	Plan and Program Department
PPP	Purchasing Power Parity
PST	Pre- Service Training
RHB	Regional Health Bureau
SDP	Stock, Distribution and Profile
SNNPR	Southern Nations, Nationalities and Peoples Region
SSA	Sub-Saharan Africa
TVET	Technical and Vocational Education and Training
UK	United Kingdom
USAID	United States Agency for International Development
WHO	World Health Organization
WISN	Workload Indicator for Staffing Need

EXECUTIVE SUMMARY

The Human Resources for Health (HRH) Strategic Planning (SP) was initiated in 2008 and Version 4 National HRH Strategic Plan was developed in 2009. The aim of the HRHSP was to support the human resource requirements of the health sector in Ethiopia to achieve the Health Sector Development Program (HSDP) objectives, which were in line with health related Millennium Development Goals (MDG) and the Plan for Accelerated and Sustainable Development to End Poverty (PASDEP) in Ethiopia.

The human resources training/development targets in the HRH SP plan were implemented and targets were achieved through expansion of training facilities, increasing enrolment of students and increasing programs for various cadres of health professionals. For example, between 2009-2014:

- The number of medical schools has increased from 7 to 33 and Midwifery teaching institutions have also increased from 23 to 43;
- Annual enrollment in medical schools has increased from 200 to 4000 (twenty fold);
- The number of physicians in the country has increased to 4291 in 2014 from 1,540 in 2009;
- The number of midwives increased from 1,270 in 2009 to 9,250 in 2014

The draft HRH Strategic plan was reviewed with guidance and oversight from Federal Ministry of Health to document key achievements between 2009- 2014 , to align the HRH SP priorities and targets with that of HSDP-IV, Visioning 2035 and post-MDG agenda.

Situation analysis exercise conducted in late 2013 has shown that the human resources development and management challenges still exist despite significant strides made in the last few years. For example, one of the crude measures for health workforce availability is health workforce density and measured as health professionals to population ratio. This ratio has increased from 3 per 10,000 populations in 2009 to 7.6 per 10,000 in 2014. This doubling of the health workforce in 5 years is a remarkable progress. If the current pace is kept, Ethiopia will be able to meet the minimum threshold over the coming 5 years. The remaining challenges include:

- *Imbalances in geographical distribution and professional skills mix*: geographic imbalances and skills mix of the available health workforce are some of the key challenge to achieve health service coverage.
- *Human Resources Management*: The HRIS is not generating up-to-date data for planning and evidence-based management decision-making. Besides, targets related to health workforce motivation and retention have not shown remarkable improvements despite the incentives implemented by Federal Ministry of Health and Regional Health Bureaus.
- *Health Workforce Regulation*: structures and institutions are created for health workforce regulation but capacity of these institutions is at its infancy, and going forward, major investments in capacity development are required.

Eight strategic issues were identified for the revised HRH SP. These include:

- Improve education and training of health workers.
- Improve the imbalances in professional skill mix and geographic distribution
- Improve quality of pre-service education and In-service training

- Strengthening leadership and governance capacity of the health workforce.
- Optimizing the utilization, retention and performance of the available health workforce.
- Improving health workforce information and generation of evidence for decision-making.
- Strengthening HRH regulatory capacity
- Strengthening health workforce partnership and dialogue.

The strategic direction of this plan has been guided by the HRH vision, goal, objectives and guiding principles.

The vision of HRH to see adequate number of well qualified and committed health workers contributing to the health sector vision of Ethiopia.

The goal is to ensure that committed, skilled and motivated health workers are available to provide universal access to health care in Ethiopia

The Objectives are organized into four outcome areas. These outcomes fully address the strategic issues identified during situation analysis. The four outcomes include:

- HRH policy, planning and partnership strengthened at all levels;
- Quantity, Quality and equitable redeployment and distribution of the health workforce;
- Leadership, governance and human resources management capacity and practices at all levels of health system
- Attraction and retention of health professionals including measures for improving their commitment, distribution, performance, remuneration and their working andliving conditions.

Two to four strategic objectives were identified to achieve each outcome- thus a total of thirteen (13) strategic objectives were identified (section 3.4. SP in summary). Several strategic actions/interventions were identified for each strategic objective. Timeline for implementation was agreed and implementation plan matrix was developed (Chapter 6). Monitoring and evaluation procedures are incorporated into the Strategic Plan with M&E Matrix (Chapter 8).

Technical working group also estimated health professionals' requirements and financial inputs required to successfully implement the strategic plan. Accordingly, the result of the HRH projection for the base year (Year 2015) is estimated to be 147,669 health professionals of different categories. This number will progressively increases to 179,262 by 2020 and 235,837 by 2025. In addition, there will be 18,438 health management personnel by 2020 and the figure will increase to 22,805 by 2025**.** Details of the requirements for all major categories of HRH are also included (Annex 3). For example, the projected requirements:

- General medical practitioners will be 7,659in 2020 and 12,025 by 2025;
- Nurses (all categories), the number will be 51,798 and 63,325 by the year 2020 and 2025, respectively;
- Midwives (all categories) will be 11,640 in 2020 and 19,673 in the year 2025; and
- Anaesthesia professionals (all categories including anaesthesiologists and anaesthesia specialists) will be 2,987 and 5,542 for the years 2020 and 2025, respectively.

However, these projections need to be updated regularly as more evidence becomes available that reflects both the feasibility and the changing health care needs. This will be accomplished with the help of the built-in monitoring and evaluation procedures.

Implementation cost for the revised HRH SP was estimated under three major HRH domains: Policy, plan and legal framework; education and training, and HRH management. The estimated budget required to fully implement the HRH Strategic plan is list under each of these categories with overall budget of $6,174,054.62 at base year (2014-2015) while this figure rises to $9,090,391.75 by 2025. A detailedcost breakdown is depicted in Table 9.2.

CHAPTER 1: BACKGROUND AND INTRODUCTION

1.1 DEMOGRAPHIC AND SOCIO ECONOMIC PROFILE

Ethiopia is an ancient African country with over 80 ethnic groups and rich cultural heritage. It is a developing country with an estimated annual per capita income of USD 1455.423 (PPP)*. The population is growing at an annual rate of 2.6% and the 2014 projected population was 89.2 million, with about 74.5 million living and working in rural areas.

Table 1.1. Key demographic, socio-economic and health indicators i indicators

Basic Indicators	Levels	Remark
Demographic Indicators		
Total population (millions), 2014	89.2	Based on 2007 Census projection
Urbanized population (%), 2012	17.2	
Population Annual Growth rate (%), 1990-2012	2.9	
Life expectancy at birth (years) 2012	63	
Economic Indicators		
GNI per capita (US$) 2013**	570	
Population below international poverty line of US$1.25 per day (%) 2007-2011*	30.7	
Public spending as a % of GDP (2007-2011*) allocated to: health	2.6	
Public spending as a % of GDP (2008-2010*) allocated to: education	4.7	
Total adult literacy rate (%) 2008-2012*	39	

*Sources:*UNICEF, December 2013. http://www.unicef.org/infobycountry/ethiopia_statistics.html#0 Accessed on September 2, 2014*

***International Monitory fund; World economic outlook database, April 2014. http://www.imf.org/external/pubs/ft/weo/2014/01 . / Accessed on January 24, 2015*

The 1994 Constitution of the country introduced a federal government structure composed of nine Regional States: Tigray, Afar, Amhara, Oromia, Somali, Beninsghangul-Gumuz, Southern Nations and Nationalities and Peoples Region (SNNPR), Gambella and Harari and two City Administrations: Addis Ababa and Dire Dawa. The National Regional States and City Administrations are further sub-divided into approximately 801 Woredas (districts), which are the basic decentralized administrative units representing 125,000 to 150,000 people governed by an administrative council composed of elected members. Health care provision in Ethiopia is predominately public and it is through this decentralized structure that national health initiatives are implemented.

1.2 ETHIOPIA HEALTH STATUS

Ethiopia has made significant improvements in many health indicators. The country has reduced under-five mortality by two-third from the 1990 baseline three years ahead of the schedule; new HIV infections has gone down by more than 90%, and there is no malaria epidemics. The

malaria infection and death due to malaria has dropped by 67% and 48% respectively[1]. Recent reports has also shown that Ethiopia is on track to achieve MDG-5 (combat HIV/AIDS, Malaria and other diseases) and Contraceptive Prevalence Rate (CPR) increased from 29% in 2011 to 42% in 2014[2]. The great success registered is mainly due to a well-coordinated, extensive efforts and intensive investment of the government, partners and the community at large to strengthen and expand the primary health care. Table 1.2, below contains the status of some of the key health indices:

Table 1.2. Key Health Indicators

Health Indicator	Level	Remark
Households that have access to an improved source of drinking water.	54.5[3]%:	EMDHS 2014
Contraceptive acceptance rate among married women	41.8%	EMDHS 2014
Under-5 mortality rate (U5MR), 2012 (Gross)	68 per 1000 live births (M: 74, F: 62)	HSDP IV Annual Performance report (FMOH 2012/13) 204 (1990)
Infant mortality rate (under 1), 2012	47 per 1000 live births	121 (1990)
Institutional delivery	15.4% (63.0% urban versus 10.4% rural).	EMDHS 2014
Maternal mortality ratio	676 maternal deaths per 100,000 live births	
Population aged 15-49 that is HIV positive	1.5%	

Source: *Ethiopia Demographic Health survey, 2011; HSDP Annual Performance Report (2012/2013) UNICEF, December 2013.* *http://www.unicef.org/infobycountry/ethiopia_statistics.html#0*

1.3 POLICY AND PLANNING CONTEXT

Several policy and planning documents at the national and regional level bear influence on the HRH situation of the country. As a result, development and revision of the HRH Strategic plan was based on a number of policy and planning documents including Ethiopian Health Policy (1993), Health Sector Development Plan IV (2010/11 – 2014/15) and Visioning Ethiopia's Path Towards Universal Health Coverage Through Primary Health Care (March 2014) Visioning 2035, among others.

1.3.1 Health Policy of Ethiopia, 1993

The Health Policy of the transitional government of Ethiopia, 1993makes a number of recommendations regarding HRH. These recommendations include: Training of community based frontline and middle level health workers up to the appropriate professional standards and

[1]HSDP-IV Woreda-Based Health Sector Annual Core Plan EFY 2007 (2014/2015), page 1, FMOH, 2014. Addis Ababa
[2]Ethiopia mini-DHS, 2014

recruitment and training of these categories at regional and local levels. It also stipulates the training of trainers (ToT) formanagerial and supportive categories of workers to support the health service objectives, development of appropriate continuing education for all categories of workers in the health sector, and development of career structure and incentive mechanisms for all categories of HRH

1.3.2Health Sector Development Program (HSDP) IV, 2010/11 – 2014/15

To realize the objectives of the health policy, the government established the Health Sector Development Program (HSDP), a 20-year health development strategy implemented through a series of four consecutive 5-year investment program. HR Development and management has been a major component in all successive HSDPs. HSDP IV covers the period 2010/11 to 2014/15, and HRH is organized under a major Strategic Result 3 within HSDP-IV. The table 1.3, below summarizes the key HRH issues contained in HSDP IV.

TABLE 1.3. SUMMARY OF HRH COMPONENTS OF HSDP IV

Strategic Result 3	**Outcomes**	**Directions**	**Initiatives**	**Indicators**
Ensuring communities have access to health facilities that are well equipped, supplied, maintained and ICT networked as per the standards and are well staffed with qualified and motivated employees	• ensuring demand driven production of human resources • maximum use of the available resources in producing key categories of scarce health professions • improving intersectoral collaboration in HRD • enhancing private sector involvement • enhancing quality assurance in the training • utilization of appropriate ICT to enhance the quality and efficiency of medical education • improve geographic distribution of HRH • strengthen regulatory system • enhance cost effectiveness in the retention and motivation schemes	• Reinforcing and institutionalization of HRH legal frameworks in the context of the overall health policy • Achieve the balance towards production of the right number and skill mix of health workers • Improving the availability of key HRH categories at all levels through scaling-up the training of scarce professionals • Develop and institutionalize human resource management systems • Improving the motivation and retention of health workers through implementation of evidence based financial and non-financial incentives • Ensuring that in-service training are nee-based	• Scale up Training and development in line with staffing requirement • Effective and targeted staff retention mechanisms developed and implemented • Development, scale up and implementation follow up of web based HRIS • Establish an HRH leadership and management development center and relevant training programs and operational research • Regular review of HRH plan • Establish Continuous Professional Development Program (CPD) • Regular update of curricula for competence-based programs in pre-service education • Implement the agreed TA guideline	• Leadership development index • Distribution of HRH by geographical location by category • Percentage of critical gap filled by TA (Technical Assistance) • Number of trained & deployed health professionals by category • Proportion of institutions staffed as per standard • Health Workforce Density: from 0.7 per 1,000 to 1.7 per 1,000 • Physician to Population Ratio: from 1:37,996 to 1:5,500 • Proportion of PHCU that use Workload based staffing standard • Implementation of e-HRIS at regional level • Competency level for essential knowledge and skill (disaggregated by category)

Below is a list of other policy and planning documents that also have a bearing on HRH:

1.3.3 National In-Service Training (IST) Directive for the Health Sector, 2014

This directive aims at facilitating the delivery of standardized IST courses by local training institutions. The directive also defines the roles and responsibilities of various stakeholders including FMoH, FMHACA, Regional Health Bureaus, Zonal Health Departments, Local In-Service Training Institutions and Health Professional associations.

1.3.4 National In-Service Training Implementation Guide for the Health Sector

The purpose of the National In-service training Implementation Guide is to promote and guide standardization and institutionalization of in-service training in the health sector in Ethiopia. The guide aims at ensuring that in-service trainings are need based, standardized, institutionalized and updated in-service training database is available at all levels

1.3.5. HRH Commitment for Universal Health Coverage

The Federal Democratic Republic of Ethiopia constitution has given emphasis for equitable access of public services. The country has renewed its commitment to ensure Universal Health Coverage for its population at third Global HRH Forum held in Recife, Brazil (November 2013)- two broad commitments were:

- **Scale-up quality pre-service education of HRH focusing on those cadres in critical shortage** by expanding education for health workers to meet 100 % of the staffing standard considering the skill mix in all primary health care facilities, improving quality of health professionals education by implementing program level accreditation in both public and private training institutions and improving quality of health professionals education by instituting competency-based pre-licensure system for all health workers by 2017

- **Improve human resources for health planning and management capacity** by strengthening pre-service and in-service training of human resources for health managers

1.4. Rationale for the Development of HRH Strategic Plan

Ethiopia has witnessed considerable expansion in the Primary Health Care Units (PHCUs) through rehabilitation and upgrading of existing facilities as well as construction of new facilities. Overall, in terms of increasing access to health services, the progress registered in the 10years preceding 2009 was encouraging. However, with many health indicators remaining sub-optimal, it was clear that both coverage and quality of service need to be improved. The last 5 years has witnessed a marked improvement in the HRH. Despite all the progress from where we have started, there is a need to focus in further improvement of quantity, skills imbalance, geographic mal-distribution, low retention and low productivity.

Recognizing the magnitude of the need for improving the public sector services and the importance of making optimal use of scarce resources to meet those needs, the Federal Civil Service Ministry has introduced series of reforms: structural changes, improving the performance of the civil servants and monitoring tools. This has led to fundamental changes and radical redesign in the organizational structure and management of health services. To help this process,

the FMoH has used Business Process Reengineering (BPR) management tool as a methodology for streamlining work processes and systems and has started to use the Balanced Score Card (BSC) for monitoring. The HRH Strategic plan has been developed to respond to the changing health landscape in Ethiopia so as to address the challenges identified in HRH, respond to the reform agenda and help improve health outcomes in line with national and global priorities.

1.5 RATIONALE FOR THE REVISION OF THE STRATEGIC PLAN

Below are the main reasons for the2013/14 revision of the HRH strategic Plan:

- **Reflect HSDP IV Priorities and Targets**

The initial plan was completed before the finalization of the HSDP IV. It was therefore felt that the plan needed to be revised to take into consideration the strategic focus and priorities articulated in HSDP IV and other policy documents that impact intervention of HRH initiatives.

- **Review and Document Achievements Between 2009-2014**

A significant proportion of the initiatives and human resources development targets proposed in HRH Strategic plan (2009-2020) were started and achieved over the last 5 years but the plan has not been formally reviewed and documented. Thus it was important to look back, review and document achievements, and consolidate efforts to address the remaining initiatives to achieve the targets.

- **Align with Visioning Ethiopia's Path Towards Universal Health Coverage Through Primary Health Care**

The effort is underway to envision Ethiopia's Path towards Universal Health Coverage through Primary Health Care. The document produced in March 2014, visioning document identifies six strategic areas that highlight priority areas for continued investment to improve primary care. These strategies were informed by an in-depth situation analysis conducted in 2012, which documented successes and continued challenges faced by the health extension program. Each strategic area is supported by sub-strategies that offer more specific recommendations. The six priority strategic areas that have been developed include:

- Empower the community to play a significant role in the health sector
- Strengthen primary health care units (PHCU) within the larger health sector
- Ensure a robust Human Resources Development system that is commensurate with socio economic development of the country as Lower Middle Income Country by 2025 and a Middle Income country by 2035
- Engage the private sector in support of the MOH's vision
- Develop sustainable financing mechanisms
- Develop institutional capacity to be responsive to changing economic, social, environmental, technical, and epidemiologic context

All of the above strategies are relevant to this HRH strategic plan

- **Motivation and Retention**

It was recognized that the initial plan has addressed standardization of duty allowance for all health professionals and has tried to add risk allowance for limited cadres and house allowance

and top up for physician. But implementation of the federally approved incentives in the regional level is not uniform and the package also neither adequate nor inclusive/exhaustive.

1.6 PROCESS OF DEVELOPINGAND REVISING THE HRH STRATEGIC PLAN

Process of developing the Initial Plan

The FMOH recognizes that the successful implementations of the various health reforms are dependent on the availability of adequate number and skill mix of clinical, public health and administrative personnel. Thus it has selected HRH as one of the priority areas for reform (Business Process Reengineering). HRH planning, Training and Development, HRH Management, Certification and Licensing were areas of focus for reengineering.

Desk reviews and benchmarking were undertaken and series of consultations were made with RHBs, relevant departments at FMoH and other stakeholders. Feedback from the consultations showed the need to develop a comprehensive HRH Strategic Plan that guides HRH planning, management, training, motivation and retention. Hence, the FMoH in consultation with regional health bureaus and other stakeholders. . Various international and local consultants were involved both in the process of consultation as well as in the development of the HRH strategic document. Draft HRH Strategic plan 2009-2020 guided HRH planning and management efforts over the last four years.

In 2013, Revision of draft HRH Strategic Plan was initiated by FMoH. The MOHrevitalized HRH Technical Working Group (TWG). Terms of reference were developed and tasks were shared among TWG members to revise and update various components of the plan. This document is the result of the TWG work in 2013 and 2014.

Below is the list of HRH TWG members who have actively contributed to the revision of the document:

- Dr. Wendemagegn Enbiale (Director, DHRDA/FMoH)
- Dr. Shelemo Shawula (MSH, HRH Project)
- Dr. Birna Abdosh (Tulane University-Ethiopia)
- Dr. Samuel H/Mariam (USAID)
- Dr. Tegbar Yigzaw (Jhpiego, HRH Project)
- Dr. Damtew W/Mariam (Jhpiego, HRH Project)
- Dr. Sintayehu Tsegaye (FMoH)
- Mr. Mohammed Hussein (DHRDA, FMoH)

The revision of the strategic plan went through the following steps:

- TWG meetings to agree on the approach and outline key steps for revision and dissemination of existing draft strategic plan (Version 4)
- Review of Version 4 of the HRH Strategic Plan by the HRH TWG and consultants
- Development of a new situational analysis with input from the HRH TWG
- Development of Draft 5 HRH Strategic Plan
- Review of Draft 5 by the HRH TWG
- HRH TWG workshop to review Draft 5 and complete areas with gaps
- Development of the HRH Strategic plan Version 6
- Review of HRH Strategic Plan Version 6

- Development, Approval and Dissemination of the final version of the HRH Strategic Plan

1.7. ORGANIZATION OF THE STRATEGIC PLAN

The strategic Plan is organized into 9 main chapters as outlined in the table below.

TABLE 1.2: ORGANIZATION OF THE STRATEGIC PLAN

Chapter	Content
Chapter 1: Introduction and background	The chapter gives the broad background to the strategic plan including: • Ethiopia's Demographic and Socio-Economic Profile and health Status • Policy and Planning context • Rational and process of developing and revising the HRH Strategic Plan
Chapter 2: Situational Analysis	This chapter gives a comprehensive situational analysis of the Ethiopia HRH picture as of April 2014. The chapter also provides details on the key achievements made in the implementation of the strategic plan between 2009 and 2014
Chapter 3: Strategic Direction	The chapter summarizes the strategic direction of the HRH strategic plan including vision, objectives, guiding principles and strategic plan outcomes and strategic objectives. The chapter also contains a schematic of the HRH strategic plan in summary.
Chapter 4: Outcomes, Strategic Objectives and Actions	This chapter is the heart of the strategic plan. It is organized into four outcome areas. Under each outcome, there are strategic objectives and at the lower level are the strategic actions
Chapter 5: Implementing the strategic Plan	This chapter articulates approaches of implementing and coordinating the strategic plan across implementation levels and sectors
Chapter 6: Implementation matrix	This chapter gives the implementation timelines for the different strategic actions between 2014 and 2025
Chapter 7: Monitoring and evaluating the Strategic Plan	This chapter gives an overview of the approach to monitoring the HRH strategic plan
Chapter 8: M&E Matrix	This chapter gives key indicators, baselines and targets for each outcome area
Chapter 9: Strategic Plan Costing	This chapter gives the costs of implementing the strategic plan and also identifies financing gaps

CHAPTER 2: SITUATIONAL ANALYSIS OF ETHIOPIA HRH

This chapter was revised in April 2014 and gives an overview of the prevailing status of human resources for health in Ethiopia. Several publications and recent reports of the FMoH were also reviewed to obtain the current picture of the Ethiopian HRH landscape.

2.1. HRH Leadership and Governance

2.1.1. Leadership and Governance Structure at National and Regional Levels

Balancing the supply and demand of health workers is the focus of the strategic plan. Designing a comprehensive approach to various aspects of HRH such as policy and planning, financing, education, recruitment, HRH management systems and partnerships among private and public entities is mandatory to strengthen the HRH governance, leadership and management capacity. For continuity of policy direction and implementation oversight there is a need to increase motivation and retention of policy-makers and high-level professionals in country. Strengthening the overall governance capacity of HRH is also essential to improving the availability and performance of health workers including their recruitment, deployment, performance monitoring and evaluation.

Responding to the leadership, management and regulatory challenges of the HRH in the country, and to effectively address the human resource challenges in decentralized governance contextat federal and regional level, there are different units: Directorate for Human Resources Development and Administration (DHRDA); Federal and regional regulatory agencies; and regional human resource development and administrative support process owners. DHRDA is under the service provider arm of the FMOH and is responsible for various HRH management functions including HRH planning, overseeing pre and in-service training of priority cadres, personnel management, and deployment of professionals as well as undertaking various studies that guide the HRH planning process. The directorate also serves as a liaison with FMOE. The federal and regional regulatory agencies regulate health professionals' registration and licensing through its Directorate for Health Facility and Professional Licensing.

Human Resources Development and Administration Support Process owners are responsible for HRH planning, recruitment, deployment and personnel administration functions at Regional Health Bureaus. However, this structure is embedded into Civil Service Pool at Zonal and District Health Offices in many Regions. Health centers and Hospitals have HR staff within Administration and finance functions. The above mentioned HRH leadership and management structure does not extend below the RHB in many regions.

2.1.2. Leadership and Governance Capacity

Following the BPR there were reforms at federal and regional level for a betterment of the HRH leadership and management. But to address the growing demand and effectively address the HRH issues in the country there is a need to revise the existing structure and staffing the HR leadership and management with experienced personnel. Besides, current budget allocation for human resource needs to be increased to address specific problems such as workforce retention, capacity building, improvement of operational environment and infrastructural development. To this effect the MOH having responsibilities for HRH development and management in the country, it will work in partnership with other service providers and line ministries.

2.2. Health Workforce Density and Distribution

2.2.1. Health Workforce Density

The study done in 2010 by African Health Workforce Observatory (AHWO) revealed that the health worker density for all categories has been on the upward trend rising from 0.64 in 2003-2004 to 0.84 in 2008-2009. The total stock of health care workers at the beginning of the current strategic plan in 2009 was 66,316 and now stands at 107,928 giving a health worker density of 1.25 for 1,000 populations. Notwithstanding the rapid increase in production, recruitment and deployment of health workers, health worker density remains quite low. The situation is very severe in big regions as well as in underserved regions. The shortage of key health workers has persisted due to low training output and out-migration. Table 2.1, below shows the change in staffing of key health cadres during the first five years of the current strategic plan.

TABLE 2.1: HRH STOCKAND DENSITY

Health Workforce Stock (2008-2014)		
Professional category	**2008 (Draft HRH/WHO profile)**	**2014 (HRIS Data)**
Medical doctors	2,152	4,305
Health officers	1,606	7,721
Nurse	20,109	41,832
Midwife	1,379	9,244
HEW	30, 950	37,000
Others		12, 826
Total	**66,316**	**111, 628**

Health Workforce Density (2009-2014)			
Indicators	**2009**	**2014**	**International Bench Mark**
Total Health professional density	0.35 per 1000	0.71 per 1000	2.3 per 1000 (WHO)
A physician to population ratio	1 per 42,706	1 per 20,720	1 per 10000
A Nurse to population ratio	1 per 5, 000	1 per 2,132	1 per 5000
A midwife to population ratio	1 per 57000	1 per 9650	

Source: *MOH HRIS data, 2014*

2.2.2. Health Workforce Distribution

Distribution of available health professionals has been highly variable and unequal between urban and rural settings, among regions and within the regions. Some of the main reasons are that accessibility of basic services (road, electricity, telephone, water, education). Rural and hard-to-reach areas of Ethiopia were particularly underserved. For the last 5 years there were some initiatives to decrease the inequality specially inter and intra-regions, from the local pre service expansion to provision of incentives for those who will be working in hard to reach areas.

2.3 Health Workforce Education and Training

A country's capacity to provide sufficient human resources depends on HRH education and training capacity to produce and maintain skilled health workforce. Findings from key stakeholders' interviews and desk review of achievements of HRH strategic plan targets during HSDP-IV showed that Ethiopia made progress in both pre and in-service health education.

Pre-service Education

The government has expanded universities from 5 in 2003 to 33 in 2014. Out of 33 public Universities available to date, 27 have been providing four or more health science courses.

Annual enrollment in medical schools has increased 12,009 in 2014 from its baseline level 1462 in 2008/2009. Private training institutions have also expanded and their output of mid-level health care workers has grown steadily. The Government of Ethiopia has directed that the ratio of intake between natural science and social science be 70:30. This decision favors the enrolment of more health science students. Overall, the expansion of universities and colleges has contributed to a significant increase in the availability of most categories of health care workers with the exception of medical doctors, anesthesia professionals and some allied health care workers.

Concerns, however, remain regarding the quality of training as rapid expansion has overly stretched students to faculty ratio and diminished proportion of resources to students. As a way of addressing the problem most higher education institutions have established a quality assurance office, butthe attention given to quality has to be improved. Quality assurance structures need to be cascaded to the lowest academic units including health science programs. Higher education institutions do need a well-developed policies, procedures, guidelines and tools for internal quality assurance. In conclusion, higher education institutions do need to have robust and reliable internal quality assurance system that nurtures a culture of continuous quality improvement.

In-Service Training and Continued Professional Development

In-service training is an important function in the rapid scaling up of knowledge and competencies of health professionals. If efficiently linked to pre-service training, it can help to support career progression for health professionals and also strengthen institutional capacity. In January 2014, FMOH issued a directive and guidelines to support standardization and institutionalization of in-service training. Implementation of standardized in-service training at selected in-service training centers starts from January 2015. On the other hand, directives and implementation guidelines for continued professional development (CPD) was developed and approved. Accreditation of CPD courses and CPD providers will start soon.

Quality Assurance and Regulation of Health Education

- **Accreditation**

Accreditation is a mandatory requirement for higher education institutions in Ethiopia and is managed by –the "Higher Education Relevance and Quality Agency" (HERQA), an autonomous agency accountable to the Ministry of Education (MOE). Higher education institutions' programs are subject to accreditation every three years (article 76). Since 2013 MOH has started to work with HERQA and developed a document "The higher education quality assurance revitalization strategic document" for health professional education and also seven program level quality assurance standards. HERQA in collaboration with Universities, MOH and partners has developed two levels of quality assurance standards (accreditation & quality improvement) for medicine, health officers, nursing, midwifery, medical laboratory, pharmacy and anesthesia. Besides, the collaboration has also developed national internal quality assurance Implementation guideline.

To strengthen the momentum and regulatory system a structural reform is needed both from the regulatory agency to the university. Formal involvement of MOH from standard development to program level evaluation need to be created. Accreditation of health science training institutions needs also to cover practicum sites.

- **Quality Audit**

HERQA carries out institutional quality audit of all Health Education Institutions (HEIs) to ensure the appropriateness and effectiveness of an HEI's approach to quality, its systems of accountability and its internal review mechanisms. HERQA has audited and produced reports for almost half of the HEIs in the country. Besides, all HEIs expected to submit their self-evaluation documents as a precondition for institutional and program level quality audit along with their own quality enhancement plans on the basis of recommendations given in the audit reports produced by HERQA. One third of those who had undergone the audit process prepared self-evaluation documents and plans for improvement plans to HERQA for further follow-up.

Once they have been through the institutional or program level quality audit, HEIs are required to implement the recommendations set out in the quality audit reports but there are no provisions in the Proclamation, or in HERQA's guidelines, that outline the consequences of noncompliance. This is due to the absence of a 'carrot and stick' system that would encourage HEIs actively discharge their responsibilities and sanctions those HEIs which are noncompliant. There are also capacity constraints in conducting quality audits and weak follow up from HERQA to assess implementation of recommendations made in the quality audit reports.

- **Certification and Licensing**

Anyone who completed the training program based on training standard and curriculum will be certified with ***certificate of completion*** that has to be provided by the training institution. The second certificate is a *Certificate of Competence (COC) or Qualification*. The Ministry of Health in collaboration with Ministry of Education developed the training standard and assessment tool (qualification exam) for lower and midlevel training courses that has been in use since 2011. Accordingly, graduates from technical and vocational education and training programs including low and mid-level health workers have been required to sit for occupational competence assessment/ Certificate of competence (CoC) as a prerequisite for licensing and entry to workforce. *Certificate of Competence (COC) or Qualification* that is provided by independent institutions mandated to do that. CoC is valid for employment and licensing.

However, this assessment needs to be enforced consistently. In the other side there was no standard qualification or licensing exam for higher level or university graduates. The need for standard licensing exam has become stronger with mushrooming of education programs with varying curricula. The MOH and its regulatory agency are developing a national licensing examination to license all newly qualified graduates and also re-licenses serving health workers based on requirements stated in the national licensing legislation for each cadre.

2.4. Human Resources Management

2.4.1. Workforce planning

The Ministry of Health has been trying to guide HRH planning based on the targets set out in HSDP-IV and draft HRH Strategic Plan. Health facility staffing standards has been developed by FMoH/the regulatory agency. But because of weak HRIS it has been more or less difficult to forecast the HRH need based on staffing standards.

Health management structures have number of civil-service- approved, job grades and positions that was developed during health sector business process reengineering (BPR). Following BPR, more flexible staffing standards that were developed by the FMoH and/or Regional Health Bureaus are used to deploy health workers to various health facilities. The number of active positions for health care workers is guided by perceived workload at local levels such as health centers or hospitals. Challenges with this approach includes; variations in workload among same category of health facilities, the fact that minimum staffing standards are made based on the reality of health workers shortages and not actual requirements and finally in most regions at Woreda level there is limitation of budget to secure the position.

2.4.2. HRIS and Monitoring and Evaluation

Accurate and timely HRH information is essential to support planning and management of health workforce. eHRIS was introduced in Ethiopia since 2009. But the system has not been fully functional at various levels to produce a comprehensive national HR data. As a result to get timely and accurate information on staff dynamics and attrition, one focus issue of the strategic plan will be roll out of HRIS to the regions and lower administrative units.

2.4.3. Performance Management and Reward System for HRH

The Ethiopian civil service as implemented several health sector reform initiatives over the past few years. Decentralize (devolved) decision making to districts level, business process reengineering (BPR) and the Balanced Score Card were among the key reform agenda. The focus of all reform efforts is to enhance responsiveness of health care system to the client needs, improve access to health services, empower communities and create a culture of measuring and rewarding performance.

Performance management in the health sector is a collaborative effort between Ministry of Civil Service (MoCS) and MoH. The former develops performance management systems, implementation guidelines and standard operating procedures while MoH puts these into practice. Some of the systems that have been introduced to plan, monitor and improve performance and productivity of the health workforce are too complex for the prevailing management capacity at various levels of health system. As a result, inconsistent in implementation of performance management of the health workforce persist, and in most cases, promotion decisions are still based on years of experience and not performance.

2.4.4. Recruitment, Motivation and Retention of Health Workers

Under the current decentralized system, regions and Woredas have the mandate to identify and fill existing staff vacancies. This has given the lower administrative unite a sense of ownership and in ideal condition it increases efficiency and cultivates accountability. To get the maximum out of the existing decentralized system, and have an inefficient planning, recruitment and management process the strategy need to focus in enhancing the human resource management capacity. Budget ceilings on personnel emoluments limit recruitment of required number of staff for health facilities and/or management structures. Most Woreda health offices HR functions are managed in a pool system where a singular structure coordinates HR issues of the health sector along with other sectors. To exploit the advantage of the pool system and advocate for higher HR budgets especially for health workforce recruitment, placement and development need to be supported by building the Woreda health office managers management capacities.

The FMOH in consultation with RHBs has been studying the merits and barriers to implementing different packages of incentives to enhance the deployment and retention of key health professionals to rural and disadvantaged areas of the country. The packages being explored take into consideration various financial and non-financial incentives that some Regional States in Ethiopia have been able to put in place as a positive move for attracting and retaining selected health professionals. Some of the existing motivation and retention schemes include:

- Pre-deployment orientations are being provided to health professionals to improve their understanding of commitment to health sector vision, goal and objectives.
- Health workers are placed two steps higher on the civil service salary scale compared to other civil servants of equivalent rank.
- Health workers who have been deployed by the Ministry of health are exempted from paying cost sharing of their university (pre service) education.
- The mandatory service expected from Physician who is willing to work in emerging regions and hard to reach areas is half shorter than those who will serve in the main towns.
- Private wing practices (private practices in public facilities) in specialized and regional hospitals have created a fertile ground to generate additional income.
- Education and training opportunities (with government sponsorship) are available for health workers at all levels
- The existing career structure for health professionals has been reviewed; only final approval is pending.
- Financial incentives for health workers that were standardized in all regions have been initiated since 2013. These include duty, housing/house allowance, top up, risk/hazards, acting and position allowances.
- Other non-financial incentives such as housing, loans, transport facilities, anniversary schemes etc. have been proposed but are yet to be implemented as they require further review and approval by the relevant authorities.

2.5. HRH Policy and Legislation

2.5.1. Legislation on Planning of HRH

Ethiopia’s legislative requirements for HR planning fall under Article 12 of the Civil Service Proclamation No.515/2007. According to this proclamation FMoH is responsible for preparing and implementing short, medium and long term HR plans for the health sector.

2.5.2. Legislation on Professional Practice and Responsibility

Legislation on professional practice is critical for the regulation of health professionals as it defines the minimum requirements for registration and licensing, delineating scopes of practice, setting standards of education and ethical and competent practices. Regulation No. 76/2002 and some profession specific codes of ethics are in place to guide professional practice. With leadership from the regulatory body of the MOH, ethical code of conduct has recently been developed but has not been printed and disseminated.

2.5.3. Legislation on Education and Training

The Ministry of Education is mandated to assist in the development and implementation of higher education law. The existing legislation on the education of health professionals is governed by the Higher Education Proclamation No.650/2009, which is applicable to all public and private institutions. This proclamation requires all public higher education institutions to be

established by Regulation of the Council of Ministers or regional regulations. In addition, provisions governing accreditation of private institutions are found under the same law in Articles 74 and 75, which gives this power to the HERQA.

2.5.4. Legislation on HRH Management

Health professionals are civil servants governed by laws and regulations that govern civil service schemes in the country. The policy and legislative framework concerning HR management is currently addressed in the Civil Service Proclamation No. 515/2007, Federal Civil Servants Disciplinary and Grievance Procedure No. 77/2002 and other directives and operational guidelines. There are currently draft HRM directives and policies on job evaluation and grading, performance appraisal and time management, recruitment, promotion and transfer, remuneration and conditions of service, HR planning, HR development and HR Information System. While all these aspects of the HRM are in general addressed by the Civil Service Proclamation, except for the directive on recruitment, promotion and transfer the other aforementioned directives are in draft stage and have not been implemented.

Operational policies were formulated to design and implement task shifting at various levels of health systems. This enabled the country to address gaps in service delivery. Successful task shifting examples include introduction of Integrated Emergency Surgical Officers (IESO) from cadre of health Officers to perform life-saving surgeries where surgeons and Obstetricians are in short supply; building capacity of Health Extension Workers to attend normal deliveries and identify and refer high risks cases and a number of HIV/AIDS services provided by mid-level cadres. While acknowledging positive outcomes FMoH needs to continuously review, properly define and systematize according to the priority health needs that require tasking shifting. This will help to address both service demands and career paths of the practitioners.

2.5.5. Legislation on Research and Development of HRH

The existing legislation in Ethiopia concerning health related research is the Health and Nutrition Research Institute Establishment Regulation 4/1996. This Research Institute is established to conduct research on the causes and spread of diseases, nutrition, traditional medicines and medical practices and thereby support the activities for the improvement of health in the country to contribute to the development of health science and technology. In addition, the Higher Education Proclamation (No. 650/2009) states that one of the objectives of higher education institutions is to promote conduct and enhance research consistent with the country's priority needs.

However, the responsibility and legislative ground pertaining to research and development of HRH is not addressed in this regulation or any other relevant legislative documents.

2.6. Financing for Health Workforce

Ethiopian health sector is financed from various sources including the government, bilateral and multilateral donors and individuals out of pocket[4]. Ethiopian government finances the largest portion of activities in health services and management with only less than 20% contributions coming from private sector. A portion of this resource allocated towards health workforce planning, development and management. The public sector employs and remunerates all public sector employees; develop health infrastructure and provide for equipment and supplies to keep the health workforce performing, motivated and retained in the system.

[4] 5th National Health Account 2010/2011

Education and training is another major category of government's health sector spending. With rapid expansion of higher education facilities and increased intakes of medical and health sciences students, the annual budget for health workers education increased from 7.63 Billion Birr in 2006/07 ($1=8.5 Birrs) to 79 Billion Birr in 2010/2011 ($1=16.5Birr). Costs related to in-service training and professional development are not captured in the above figures and are mostly covered by donor funds. However, these costs will increasingly be met by the public sector or individuals out-of-pocket with standardization and institutionalization of in-service training and continued professional development (CPD).

2.7. Partnerships for HRH

Government of Ethiopia recognizes the contribution of the development partners and the private sector to the country's socio-economic development including achieving health goal for its population. The Private Sector, for profit and non-for profit, is an important player in the Health and Social Welfare functions. Private sector in Ethiopia is involved in a broad range of functions which include training, service delivery and research. As a result, Public Private Partnership (PPP) is taking root. However, the existing relationship is not institutionalized in a comprehensive manner. Important emerging trends worth noting are questionable quality of the health professional production in the private schools and a growing migration of skilled workforce from the Public to the Private Sector. Anecdotal evidence shows that health professionals join the private sector with some differences in their salaries and benefits compared to the government remuneration packages. This creates labor market opportunity for the health professionals while worsening health workforce shortage in public service and affecting service delivery and management for the poor and needy.

Private sector is contributing to HRH development through pre-service education of mid-level professionals (nurses, health officers, laboratory technicians and pharmacy professionals). Besides, about five private medical colleges have been established since 2009. They seek opportunities in public facilities as practicum sites. Unless managed well, this may compromise the quality of health care delivery by putting extra burden on health facilities as they also receive students from the public health science colleges and universities. Having graduated from the private training institutions, these professionals also seek employment opportunities in the government health facilities. Thus, close working relationship between FMoH/RHB and health facilities and the private sector training institutions is critical for successful training programs. Involving private sector in health sector human resources planning is a critical first step to develop a strong framework and foundation for collaboration.

Fostering partnership, improving dialogue among stakeholders such as education, finance and public service, regulatory bodies, professional associations, as well as the private sector and development partners for their involvement in HRH development at all levels partnerships is critical to improve HRH status of the country on medium and long-term. Advocacy at national, regional and global levels should continue in order to secure substantial financial investment in HRH development.

2.8. Achievements in the Implementation of the Strategic Plan (2009 – 2014)

The human resource for health (HRH) strategic plan of Ethiopia has been derived from one of the main strategies of the Health Sector Development Program (HSDP) IV. HRH projection for

the years 2009-2020 shows that the total requirements for all health workforce is estimated to be nearly 188,000 by 2020 which is more than threefold increase compared to the 2008 figure. Following the strategic plan an operational plan has been developed to improve an overall HRH development with particular emphasis for development of human resources for health critical for maternal and child health. Below is a list of key HRH achievements between 2009 and 2014.

2.8.1 Expansion of Human Resource Development Capacity and Output

Health science training institutions have been significantly expanded and five priority initiatives (medical education, midwifery, emergency surgical officers training, anesthesia and HEWs) introduced to address the HRH crisis in the country. With the coordinated human resource development programs, overall targets have been met for the community level and most of the midlevel health professionals. The targets were not met for medical doctors, midwives and anesthesia professionals.

Specifically the number of medical schools has risen from 7 in 2008 to 34 (of which 7 are private) and public midwifery schools have reached 49. As of 2012/2013 over sixty thousand health science students were enrolled in public higher education institutions; and an additional 15,834 in private higher education institutions. Annual enrollment of health science students in public higher education institutions reached close to 23,000 by 2014. In the same vein, annual intake of medical students rose by more than 20-fold from 152 in 2000 and to 3,537 in 2014. Graduation output from health training higher education institutions also increased by close to 16-fold from 1041 in 1999/2000 to 16,017 by 2012/2013.Table 2.2 shows expansion of the public medical school and their enrolments.

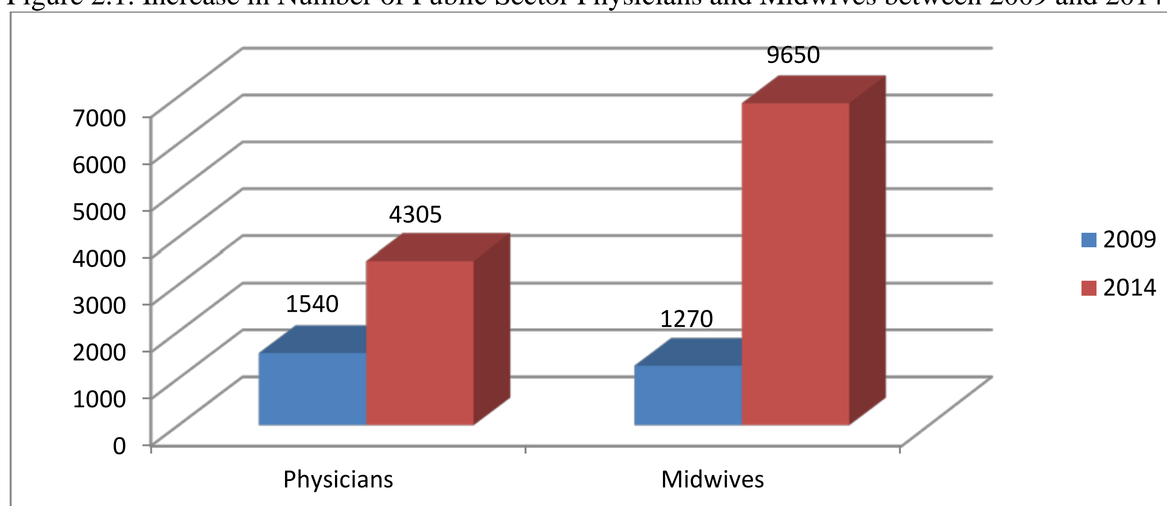
TABLE 2.2. NUMBER OF MEDICAL TRAINING SCHOOL ANNUAL ENROLLMENT BETWEEN 2008- 2014

University/Med. College	2008/9	2010/11	2012	2013	2014	Total
Adama University	93	105	164	125	171	658
Addis Ababa University	290	235	320	245	367	1457
ArbaMinch University	62	62	107	125	200	556
Bahir Dar University	96	102	105	140	150	593
Defense University	0	16	0	23	0	39
University of Gondar	212	200	100	245	403	1140
Haromaya University	108	188	225	225	340	1086
Hawassa University	258	125	258	252	394	1287
Jimma University	213	222	310	395	410	1550
Mekele University	184	175	323	252	298	1232
St. Paul Medical college	42	127	125	170	130	594
Adigrat University					115	155
Wochamo University					78	78
Debretabor University					53	53

Axum University			45	66	28	139
Wollo University			56	76	43	175
DebreMarkose University			50	72	41	163
DebreBirhan University			65	62	43	170
Ambo University			80	73	38	191
Welega University			60	60	25	145
Wolayta Sodo University			66	68	38	172
MedaWolabu University			52	64	17	133
Dilla University			68	48	18	136
Dire Dawa University			62	58	31	151
Yekatit 12 Hospital			85	72	57	214
Adama Hospital			56	76	47	179
YergAlem Medical college			59	65	32	156
Total	**1558**	**1557**	**2841**	**3105**	**3567**	**12,628**

Midwifery teaching institutions have increased from 23 in 2009 to 47 in 2014. In 2009 the number of physicians in the service was 1,540 and in 2014 it had increased to 4305. During the same period, the number of midwives increased from 1270 to 9240.

Figure 2.1. Increase in Number of Public Sector Physicians and Midwives between 2009 and 2014



Training of emergency surgical officers was started in 2009 in 3 universities and 10 affiliated sites with an intake of 43 students. By 2013 the training had been scaled up to 11 universities and 35 affiliated hospitals with an annual intake of 240 students. By March 2014, a total of **153 IESOs** had graduated and been deployed all over the country in **97** health facilities while **513** were **still undergoing** training.

In order to increase access to anesthesia services, the MoH took initiative, trained and deployed 96 Level 5 nurse anesthetists and 50 degree graduates. According to the report there were a total of 115 nurse anesthetists (2012/2013 intakes) being trained in seven health science colleges (in five regions) while 471 trainees are attending Bachelor of Science Degree programs in six

Universities (Addis Ababa, Jimma, Dilla, Gondar, Wolaita Sodo and Mekelle). The health extension program has deployed about 37,000 level 3 health extension workers all over the country (2 health extension workers for each health post). In the last two years, the Level 4 upgrading program has trained 3638 HEWs.

Regarding emergency medical training, 346 pre-hospital care providers have been trained in the last one year. The postgraduate program in emergency nursing has graduated its first batch in 2013. The first 5 physicians with specialization in Emergency Medicine have also graduated. Postgraduate training in Family Medicine has also been launched in Addis Ababa University in 2013 with 8 students. Health care management training in Hospital administration/health service management was started in 2009 while Masters Degrees in Human Resource for Health Management and Health Economics are due for launch in 2014.

2.8.2 Improvement in Health Worker Density

As shown in the table below health worker density has increased steadily since 2009.

TABLE 2.3. HEALTH WORKERS' DENSITY INCREMENT BETWEEN 2008 AND2014

HRH Indicators	2008 Baseline	2014 status	Benchmark/target
Health professional density	0.34:1000	0.71:1000	2.3:1000 WHO recommendation
All Physicians	1: 36,558	1:20,720	1:10,000 WHO recommendation
Nurses	1:3,870	1:2,132	1:5,000 WHO recommendation
Midwife	1:57,000	1:9,650	1:6,759 HSDP IV target 1:5000 WHO recommendation
HEW	1:2544	1:2270	1:2,500 HSDP IV target

Source: FMOH Health sector development program IV, October 2010

2.8.3. Improvements in Service Delivery and Health Outcomes

A significant increase in the number and distribution of priority health care cadres has significantly contributed to improvements especially in maternal and child health services and outcomes in the last four years as shown in the table below.

TABLE 2.4: PERFORMANCE AND HEALTH OUTCOMES IN 2009 AND 2014

Health indicators	Baseline (2009)	Current Status (2014)
Latrine coverage	60 %	86%
Contraceptive acceptance rate	56%	63%
Antenatal care Coverage	68%	98.1%
Skill birth attendance	18 %	40.9 %
Fully immunized Children	66 %	82.9 %
Under 5 mortality	88	68

Source: FMOH 2013/14 HSDP IV Annual performance report

2.8.4 Policy Development

A key principle underpinning the health sector Business Process Re-engineering (BPR) was the improvement of the quality of health services through institutionalizing accountability and transparency. In the last 4 years, the BPR system has been operational with some encouraging results in decentralization and improvement of HRM. As part of this process, below are specific achievements in the provision of policy guidelines to support HRH development:

- A strategic document that focuses on health professional education was developed to revitalize the quality assurance system of higher education in Ethiopia in collaboration with HERQA.
- IST guidelines and directive was developed, endorsed and disseminated to standardize and institutionalize in service training for health care providers in the country.
- CPD implementation guideline was developed and endorsed to maintain and update health professional knowledge, skill and attitude.
- A national licensing exam policy document was developed to assess competence of new graduates from university programs before entry into the health service delivery system.

2.9. Strategic Issues for the Revised HRH Strategic Plan

The following strategic issues were identified to address:

1. *Strengthening leadership and governance of HRH*: Health work is defined to include not only technical skills and expertise directly responsible for creating and sustaining health but also the skills needed in support systems and the linkages that facilitate the application of technical skills. Human Resources Management is an integrated use of systems, policies, and management and leadership practices to plan, recruit, maintain and develop employees to create access to quality health care to all people. The health sector has a critical gap in effective human resources managers who have capacity and motivation to assess HRH needs, develop relevant policies, strategies and operational guidelines to ensure health workforce planning, development, recruitment and equitable distribution, career development, motivation, retention and performance. Strengthening the overall governance capacity of HRH is essential to improving the availability and performance of health workers including their recruitment, deployment, monitoring and evaluation.
2. *Strengthen education and training capacity:* The increase in investment and resources in expansion of health professional teaching institutions is already showing result in exponential increase in health professional graduation. But with the expansion of those teaching institution there is a critical need to build the necessary human and institutional capacity for quality improvement. Aligning the work of ministries of health, education and training institutions inevitably leads to synchronizing effort and maximizing impact in addressing the weak production capacity, ability to increase the health workforce training capacity in order to fill the gaps in quality and quantity.

3. *Enhance utilization, retention and performance of the available health workforce*: The different civil service reforms has shown some positive result in utilization, retention and

performance of the available health workforce in improving coverage, equity in access, quality and efficiency of health services. Moreover, expansion of lower and medium level health professional training center in every region plus deployment of health professional with mandatory service has led to more or less equal geographical distribution of the available health workers, resulting in minimizing the inequity between rural areas and urban areas. Despite this retaining skilled health workers especially in remote areas with the appropriate skill mix for health care remains a major challenge because of low salaries, unattractive remuneration, non-conducive working conditions and living environment.

4. *Build information and evidence base HRH planning and management*: There is great demand to enhance the capacity to collect, generate analysis, disseminate and use available HRH information. Furthermore, increase use of different data sources for evidence-based decision-making and policy development. Building the research capacity including documentation of best practices to inform and support policy direction is another area of focus. In general there is need to improve the overall capacity of the HRH information systems including research capacity and documentation of best practices to support decision-making.
5. *Increasing financial resources*: There is a need to increase the fiscal space for full funding of the national HRH plans at national, regional, local and health facility levels. Securing flexible non-salary HR budget and increasing salary budgets for the position needed at Woreda and health facility levels is crucial to attract and retain health workers in the health sector. Finding how best to increase and sustain HRH financing is absolutely necessary to improve health service delivery.

6. *Harnessing coordinated partnerships and dialogue*: In the recent years efforts have been made to increase involvements of government and non-government actors in HRH policy and planning efforts. However, much more needed to be done to involve all actors in a well-coordinated and planned manner. Competing interests within and between the stakeholders and partners coupled with insufficient harmonization and alignment of efforts increases the fragmentation and duplication of effort- in health workforce education, training and distribution. Recognition of the multisectoral nature of HRH helps to have a full picture of this problem but also the range of solutions available for the different aspects of HRH such as production, management, utilization and retention. The main challenge need to be addressed is, how to build synergy at country and regional levels by sustaining and formalizing mechanisms for intersectoral partnerships that include all stakeholders and partners.

7. *Enhance HRH regulatory capacity:* Comprehensive health workforce regulation system that includes licensure, accreditation, and certification, development of standards and scope of practice is mandatory to ensure public protection and efficient use of the health workforce. Accreditations of universities and programs, establishing licensing examinations, linking continuous professional development to re licensing will be the focus of this strategic document. There is need to reinforce the regulation and practice of health care workers to ensure health care delivery in the context of health reforms. Scopes of practice is nowadays well defined for each cadre of health professional however it has to be linked to health workforce regulation, development, and management and planning. Currently issues related with malpractices are being managed at the Federal level but it needs for a system of reviewing professionals' ethics and competence in a holistic view to ensure their fitness to practice at Federal, regional and institutional level.

Chapter 3: Strategic Direction

The strategic direction of this plan has been guided by the HRH Vision, Goal, Objectives and Guiding Principlesoutlined below.

3.1 Vision, Goal and Objectives

Vision

The vision of HRH Strategic Plan isto see adequate number of well qualified and committed health workers contributing to the health sector vision of Ethiopians

Goal

The goal of HRH Strategic Plan is to ensure that skilled and motivated health workers are available to provide universal access to health care in Ethiopia.

Broad Objective

To scale up the availability and strengthen the performance of the health workforce for improved health service delivery in the Ethiopia by strengthening planning, development and retention of health workers that will meet the diverse health care needs of the Ethiopian people.

Specific Objectives

The specific objectives of the Human Resources for Health (HRH) Strategic plan are:

- To strengthen HRH policy, planning and partnership in Ethiopia ;
- To ensure the number of health workforce improved to meet the minimum density threshold as recommended by World health organization
- To maintain an appropriate skill mix of health workers with competences relevant to the needs of the population by 2025;
- To ensure equitable redeployment and distribution of the health workforce
- To attract and retain health professionals including measures for improving their remuneration and their working and living conditions

3.2 Guiding Principles

This strategic plan is guided by the following principles:

Principle	Explanation
Countries' commitment	To support actions that contribute to a sustainablehealth workforce
System linkage	National HRH strategies should be harmonizedwith the relevant components of the health system and primary health care principles
Donor alignment	Donor supportshould be coordinated and aligned withcountry HRH plans;
Equity, accessibility and accountability	To ensure that all people, in all places, have accessto skilled health workers who are equipped, motivated and supported

Results-oriented	HRH strategies and actions aimed at achieving measurable outcomes; and
Multispectral engagement	Of all sectors and stakeholders includingthe communities to build the health workforce.

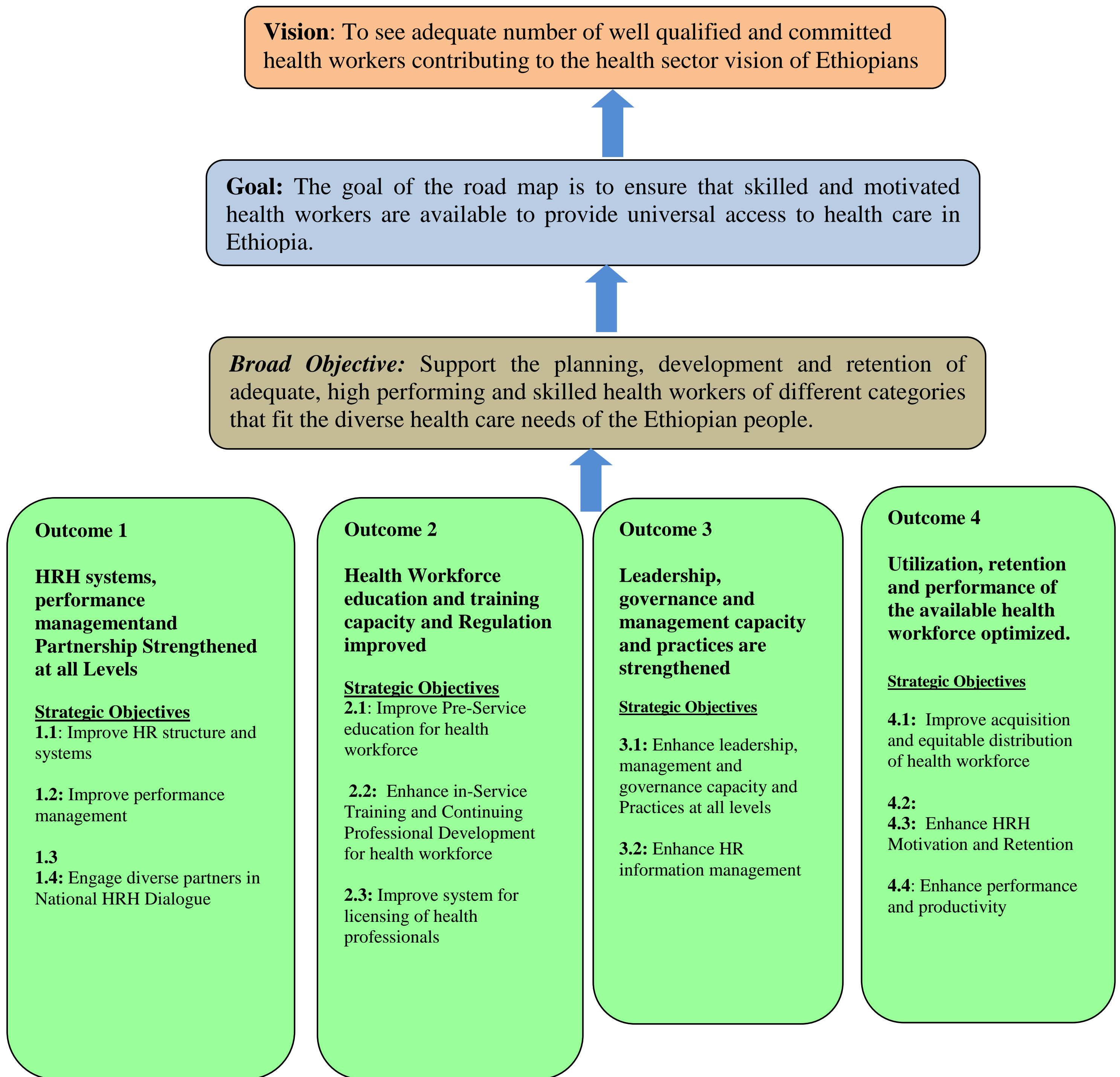
3.3 STRATEGIC PLAN OUTCOME AREAS

The strategic direction has been organized around thefour outcomes shown below.

- **Outcome 1:** HRH Policy,planning and partnershipstrengthened at all levels
- **Outcome 2:**Health workforce education, training and regulation is strengthened
- **Outcome 3:**HRH leadership, governance and management capacity and practices are strengthened
- **Outcome 4**:Utilization, retention and performance of the available health workforce optimized

For each outcome area, the strategic objectives needed to achieve the outcome are specified. Key strategic actions are defined under each strategic objective. It is expected that the detailed implementation activities falling under each strategic action will be developed as part of the operational planning process.

3.4 Strategic Plan in Summary



CHAPTER 4: STRATEGIC PLAN OUTCOMES, OBJECTIVES AND ACTIONS

OUTCOME 1: HRH POLICY, PLANNING AND PARTNERSHIP STRENGTHENED AT ALL LEVELS

This outcome addresses interventions aimed at strengthening HRH policy and planning at the federal and regional level so as to improve the HRH profile in respect to staffing, skills, distribution, retention and performance. These interventions fall under the following four Strategic Objectives:

- **SO 1.1**: Develop and implement an Appropriate HRH Policy and Legislative Framework
- **SO 1.2:** Strengthen HRH Planning at all Levels
- **SO 1.3:** Create a Gender Responsive and Healthy workforce
- **SO1.4:** Engage diverse partners in National HRH Dialogue

SO 1.1: Develop and Implement Appropriate HRH Policy and Legislative Framework

The following strategic Actions will be undertaken to support Strategic Objective 1.1

Strategic actions

1.1.1. Develop and implement across-the-board and profession-specific laws/code of ethics for the health professions, including medical practice, nursing, midwifery, Anesthesia, Laboratory, pharmacy and supplementary health professions.

1.1.2 Develop legislation to regulate pre and in-service training of health professionals with a clear role of FMoH

1.1.3 Develop legislation and guidelines to support confidentiality and appropriate use of personal information in HRH databases

1.1.4 Develop MOU's/policy guidelines on ethical recruitment and employment of health professionals with major recipient /destination countries.

SO1.2: Strengthen HRH Planning at all Levels

The HRH planning capacity at the federal, regional and facility level has been very limited. This plan proposes the following strategic actions to improve HRH planning.

Strategic Actions

1.2.1 Strengthen the planning capacity of the FMOH HRD&A Directorate and Regional Health Bureaus (Human Resource Core Process) through knowledge and skill development

1.2.2 Develop annual/biannual HRH operational Plans for the National HRH Strategic Plan

1.2.3 Support the development of comprehensive HRH plans for all regions, city administrations and large health facilities and programs aligned with the national HRH plans

1.2.4. Institute an integrated and sector-wide HRH planning, implementation and evaluation system that involves all relevant stakeholders.

1.2.5. Review and regularly update the Federal HRH strategic plan

1.2.6 Forge partnerships with government agencies, development partners and other stakeholders to mobilize the necessary support and resources to support the development, implementation and review of HRH plans
1.2.7 Train facility managers and heads on methods of determining staffing needs such as WISN
1.2.8 Update the national HRH requirement every five years using sound HRH projection methods

SO 1.3: Create a Gender Responsive and Healthy workforce

It is imperative that Ethiopia invests in creating a gender responsive and healthy workforce to attract and retain high performing health workers. This strategic objective will be supported by the following strategic actions:

Strategic Actions

1.3.1 Build the capacity of health mangers and policy makers on gender analysis and integration as an essential component of program design, implementation and review

1.3.2 Recruit gender officers/focal persons at regional, health facility levels and training institutions

1.3.3 Provide support on gender responsiveness to the public and private sector health training institutions
1.3.4 Set gender equity indicators and targets especially for higher level positions and enrollment to medical training institutions
1.3.5 Introduce mechanisms that support gender equity including affirmative action
1.3.6 Introduce comprehensive Occupational Safety and Health (OSH) programs including structures and staffing
1.3.7 Ensure all health workers have access to HIV and wellness workplace programs.

SO 1.4: Engage diverse partners in National HRH Dialogue

The development and implementation of the HRH Strategic plan is a collaborative endeavor that involves different stakeholders. Actors other than the public sector also play important roles in shaping the HRH agenda of the country. In Ethiopia, there are a number of private institutions for the training of health workers and also provision of health services. The following strategic actions will support the effective engagement of the private sector in the planning and management of the health workforce.

Strategic Actions

1.4.1 Include diverse partners (health professional associations, NGOs, private, donors) in the HRH Working Groups at the Federal and regional levels
1.4.2 Develop a common code of conduct governing the mobility of health workers between public and private sector institutions.
1.4.3 Introduce approaches for resource sharing between public and private institutions as relates to HRH (Service delivery and training)
1.4.4 Encourage the private sector to invest in the health sector and institute an incentive mechanism to attract private health providers to disadvantaged areas or population groups.

OUTCOME 2: HEALTH WORKFORCE EDUCATION AND TRAINING CAPACITY AND REGULATION IMPROVED

This outcome addresses the issue of production of adequate number and skill mix, creating a system for ensuring competency and continuous quality improvement of health workforce that Ethiopia requires and approaches to ensuring that after deployment health workers have access to quality and relevant in-service training and continuous professional development. Outcome 2 will be achieved through the following strategic objectives:

- **SO 2.1**: Strengthen Pre-Service education for health workforce
- **SO 2.2:** Strengthen In-Service Training and Continuing Professional Development for health workforce
- **SO2.3:**Strengthen accreditation and regulation of training institutions and health professionals

SO 2.1: Strengthen Pre-Service Education for Health Workforce

The aim of this strategic objective is to increase the output, quality and relevance of priority cadres and hence support improved staffing levels and increase the health worker to population density towards WHO recommendations of 2.3 per 1000. The specific strategic actions are:

Strategic Actions

2.1.1 Establish a system for alignment of health professionals curricula to address the country's evolving priority health needs

2.1.2 Increase the annual pre-service enrolment and output for priority health cadres in line with FMoH projections

2.1.3 Develop and implement strategies to increase annual health professionals enrolment and output for rural and hard-to-reach geographic areas

2.1.4 Expand enrolment and produce adequate number of family health team[5] from 1 centre to 4 centres

2.1.5 Upgrade level IV HEWs into family health nurses (Bachelor's level)

2.1.6 Upgrade level IV HEWs into family health midwives (Bachelor's level)

2.1.7 Produce appropriate professionals for Emergency Medical Services[6] (Physician, Nurse, Surgical Officer and Medical Technicians)

2.1.8 Strengthen the capacity of existing postgraduate training in Master of Public Health (MPH), hospital management and health systems management for health sector leaders and managers, and introduce new postgraduate training HRH Management, Health Economics /Financing

2.1.9 Expand clinical specialty programs by extending programs from the current level of 6 to 15

2.1.10 Double enrolment of postgraduate (clinical specialty) from the current level of 250 annual intake

[5] Current thinking on the composition of *Family Health Team*: family physicians, family health nurses, family health midwives, health extension workers and nutrition professionals based on PHC model

[6] Emergency Medical Services Team include: physician, Nurse, Surgical Officer and Medical Technician

2.1.11 Expand clinical subspecialty training centres from 1 to 5 centres and double the existing programs
2.1.12 Increase annual intake (of subspecialty) by three fold from the current level
2.1.13 Introduce forensic medicine in two centres
2.1.14 Introduce postgraduate program in trauma surgery
2.1.15 Introduce hospital-based specialty programs at 5 centres
2.1.16 Expand anaesthesiology and recovery specialty programs from current level of 1 to 3
2.1.17 Introduce neonatal nursing program
2.1.18 Establish centres of excellence for pre-service training for various professional areas
2.1.19 Build the capacity of problem-based innovative medical education programs to continue training physicians from a pool of BSC holders
2.1.20 Support shift to evidence-based curriculum and education models including but not limited to outcomes-based, integrated, community-oriented, active
2.1.21 Strengthen the capacity of exiting dental training institution for DDM, dental professionals and dental technicians
2.1.22 Increase the quantity and quality of mental health service professionals including psychiatrists, clinical psychiatry at Masters levels for BSc levels
2.1.23 Strengthen training of anaesthesia professionals at Universities and health science colleges
2.1.24 Strengthen midwives training at BSc and Masters Levels
2.1.25 Strengthen mid-level eye care workers and standardize the eye care professional category and training based on service need and standards
2.1.26 Review curricula of pharmacist, pharmacy technician and introduce supply chain management professionals training based on the desired roles and responsibilities of these professionals
2.1.27 Select potential regional training colleges and provide support to provide training of X-ray, biomedical and health informatics professionals,
2.1.28 Engage the private health sector in the training of health workers for which there is a critical shortage.
2.1.29 Establish a system to support public and private health workforce training institutions comply with minimum requirements and adhere to the quality standards
2.1.30 Strengthen health professionals training institutions networking, technical exchanges and peer support through associations, forums etc.
2.1.31 Establish networking of practicum sites (public, private and affiliates) for quality health professional training
2.1.32 Enhance capacity of higher education leadership to provide sustained support for health professional training
2.1.33 Increase number of faculties to meet quality standards set by HERQA (e.g. improve faculty to student ratio)
2.1.34 Improve teaching skills of faculty members and preceptors through systematic and planned faculty development programs
2.1.35 Provide management and support for health educators (e.g. workloads, sabbaticals, research, career advancement, mentoring, technical support, etc.)

2.1.36 Strengthen the infrastructure for effective teaching by establishing skills learning and simulation labs, ICT centres, etc.
2.1.37 Increase awareness and skills of health care professional graduates in gender mainstreaming in health sector
2.1.38 Establish Alumni offices to support teaching-learning programs
2.1.39 Improve networking and south-to-south collaboration among the pre-service education institutions
2.1.40 Establish platforms for collaborations among universities and regional health science colleges
2.1.41 Recruit on short-term basis, expatriate faculty for training of physicians and other priority cadres and also provide services until local capacity is built
2.1.42 Create strong partnership between universities and health science colleges with industries and practical sites for service delivery, consultancy and teaching
2.1.43 Establish Health Science Education Development Centre in all public and private higher education institutions with health programs to lead and coordinate internal quality assurance
2.1.44 Strengthen clinical education of health workers through development of manuals, guidelines, tools and standards
2.1.45 Develop guidelines for evidence-based selection of students into health training programs

SO 2.2: Strengthen In-Service Training and Continuing Professional Development for Health Workforce

To support Strategic Objective 2.2, the following strategic actions are proposed:

Strategic actions

2.2.1 Review and approve existing in-service training (IST) materials as per the national IST Implementation Guide and Directive
2.2.2 Ensure standardization and institutionalization of in-service training
2.2.3 Establish in-service training centres with appropriate geographical coverage
2.2.4 Establish ICT platforms to support delivery and management of in-service training through eLearning and pilot-test for the priority health trainings
2.2.5 Strengthen management and coordination of in-service training at various levels
2.2.6 Strengthen local capacity for the provision of ISTs using the three major modalities namely face to face, blended and electronic IST as per the need and relevance.
2.2.7 Develop and provide in-service trainings based on national priorities and findings of regular needs assessments (e.g. Immunization, maternal health, management, leadership, and other areas of need).
2.2.8 Work with health regulatory authorities to implement Continuing Professional Development (CPD) programs and link to career development and relicensing
2.2.9 Involve private sector and professional associations in in-service trainings and CPD rollout
2.2.10 Build capacity of IST and CPD providers

2.2.11 Create a system for regular communications between pre-service and in-service training programs

2.2.12 Develop and implement a system to link in-service training and CPD to impact on health service delivery and performance improvement

2.2.13 Mobilize local and international resources for the delivery of need based ISTs.

2.2.14 Strengthen the capacity of the Human Resource Processes of regional health bureaus to coordinate the IST standardization and institutionalization in the respective regions.

2.2.15 Establish and maintain a functional IST database/interface with HRIS/ at all levels for efficient implementation of the program.

2.2.16 Develop need based annual IST plan at national, regional, woreda, health facility and health training institutions.

SO2.3: Strengthen accreditation and regulation of education and training institutions and health professionals

Health workers are expected to provide quality health care to their clients and community at large. Their competency and compliance will be ensured through strengthened accreditation and licensing systems and practices. Accreditation will be applied to public and private pre-service training institutions, in-service training centers, practicum sites, training programs and in-service training materials. Graduates from the accredited institutions and training programs will be licensed and relicensed by meeting required professional standards. The strategic actions are**:**

Strategic Actions

2.3.1 Conduct quality audits of existing pre-service training programs in midwifery and other priority health cadres to develop and implement evidence-based quality improvement interventions

2.3.2 Define scope of practice for different health workers and monitor compliance

2.3.3 Establish a system for management of fitness to practice (health worker competence and ethical conduct) and link it to renewal of licensure

2.3.4 Ensure accreditation of health training institutions, programs and practicum sites offered by public and private education institutions in collaboration with HERQA and professional associations

2.3.5 Conduct regular audit of health professionals education programs and link audit results with positive and negative consequences including but not limited to ranking, reward and reaccreditation

2.3.6 Expand the capacity of the HRDA Directorate and FMHACA in professional licensing, relicensing and regulation

2.3.7 Develop/review implementation manual which details the requirements, scope, processes and other relevant matters for accreditation and licensing.

2.3.8 Establish a licensing/qualifying/exit exam to verify competence of new graduates for safe and effective practice prior to entry to the health workforce

2.3.9 Establish a system for strategic information on accreditation for CPD providers, health institutions, qualification examinations etc.

2.3.10 Create feedback loop system from accreditation and licensing systems to pre-service and in-service trainings institutions

OUTCOME 3: HRH LEADERSHIP AND MANAGEMENT CAPACITY AND PRACTICES ARE STRENGTHENED

Outcome 3, on strengthening Human Resources Management Capacity and Practices Strengthened will be achieved through the implementation of the following strategic objectives:

- **SO 3.1:** Strengthen the HRM Function and Practices at FMOH and Other levels
- **SO 3.2:** Establish a Comprehensive, Sector-Wide Human Resources Information System (HRIS)and Strengthen Data use for decision-making
- **SO 3.1:** Strengthen the HRM Function and Practices at FMOH and Other levels

This strategic objective aims at creating a health workplace in which staff are supported to function optimally. This objective will be achieved through the following strategic actions:

Strategic Actions

3.1.1 Upgrade and professionalize the human resources development and administration function at all levels of the health system to reflect its new and transformed role by increasing the number of qualified HRM staff and HRM budgets.
3.1.2 Adequately resource, furnish and equip HRM offices
3.1.3 Provide continuous HRM training to HR staff and line managers at national, regional, zonal, district and facility levels
3.1.4 Conduct periodic job analysis in order to regularly update HRH categories
3.1.5 Regularly review and update job descriptions for all staff
3.1.6 Review and Improve the implementation of a performance based evaluation system to support rewards, sanctions and other management decisions.
3.1.7 Undertake regular review of career structures for all cadres to provide clear career growth pathways
3.1.8 Integrate career planning into other HR systems such as performance appraisal, training and succession planning

SO 3.2: Establish a Comprehensive Sector-Wide Human Resources Information system (HRIS) and Strengthen Data use for decision-making

Almost all HRH decisions require that health managers and administrators have accurate and current staffing information. Given the diversity and geographic dispersion of the health workforce, there is need to have a system to collect, organize and disseminate HR data and information to support appropriate decision making. The data should be available to managers in different geographic locations in real time. The following strategic actions will support the establishment of a comprehensive HRIS:

Strategic Actions

3.2.1 Conduct an assessment of existing HRIS for its comprehensiveness and usability and develop plan of action based on the assessment
3.2.4 Scale up a comprehensive (planning, management, training, licensing) sector-wide HRIS (including private sector and training institutions) roll out that provides up-to-date HRH information to assist timely decision making at all levels of the health system.
3.2.5 Assign staff to manage HRIS at various levels of health system administration
3.2.6 Train system managers and users on the system
3.2.7 Integrate the HRIS into FMOH's data-warehouse structure including the eHealth platform

3.2.8 Encourage use of HRIS for decision making by availing customized reports to stakeholders

OUTCOME 4: UTILIZATION, RETENTION AND PERFORMANCE OF THE AVAILABLE HEALTH WORKFORCE OPTIMIZED

This outcome will be achieved through the following strategic objectives:

- **SO 4.1:** Improve health worker recruitment and deployment at all levels
- **SO 4.2:** Reduce inequity in geographic distribution and skill mix of health care Workers
- **SO 4.3:** Enhance staff motivation and retention
- **SO 4.4**: Enhance performance and productivity

SO 4.1: Improve Health Worker Recruitment and Deployment for Higher Staffing Levels

It is expected that staffing requirements will be reviewed at appropriate intervals to reflect any major changes in service standard, disease burden, workload, public expectation or other factors that have significant impact on the health care delivery system. This HRH strategic plan aims at increasing the health worker density from the existing level of 1.3 to 2.3 per 1,000 populations by 2025. This will be achieved through the implementation of the following strategic actions.

Strategic Actions

4.1.1 Develop/review and update recruitment, transfer and promotion guidelines to create modern and transparent human resource management system

4.1.2 Train HR and health managers on modern approaches to staff recruitment, selection and deployment

4.1.3 Implement orientation and induction programs for newly recruited staff at all levels

4.1.4 Develop tools to support effective selection and recruitment including e-recruitment

4.1.5 Establish system to recruit scarce health cadres from the Diaspora, volunteers and those who are retired but not tired of offering services.

SO 4.2: Reduce inequity in geographic distribution and skills mix of health Workers

Health workforce geographic inequity and skills mix will be addressed through the following strategic actions.

Strategic Actions

4.2.1 Identify factors that underlie the inequity of health workforce geographic distribution and skill mix in all regions

4.2.2. Build capacity of regional health bureaus and woredas to attract and deploy health professionals in hard-to-reach geographic areas

4.2.3. Conduct policy advocacy for special remuneration and incentive package in hard-to-reach areas (link with motivation and retention)

4.2.4. Sensitize health workforce to provide services for communities with the highest needs

4.2.5 Continue enforcing minimum public (the mandatory) service for selected priority health professionals

4.2.6 Revise task shifting to address skills mix and staffing at hard-to-reach geographic areas and critical human resources shortage

SO 4.3: Enhance staff motivation and retention

Health workforce motivation and retention will be enhanced by implementing the following strategic actions:

Strategic Actions:

4.3.1 FINANCIAL INCENTIVES: Design, cost and implement a set of monetary motivational and retention incentives at federal and regional levels.

i. Review the implementation challenges of nationally standardize duty, professional and risk allowances at all levels of health system.
   - *Revise and implement position allowance to cover for additional duties .*
   - *revise and implement professional risk (hazard) allowance*
   - *revise and implement transport, housing and telephone allowances*
   - *Revise and implement Salary top-ups especially for hard-reach areas/hard-to-retain cadres*

ii. Introduce an Anniversary Public Service Bonus (APSB) for health professionals who have continuously served in the public sector

iii. Standardize classification of hardship areas across regions as basis for standardization and implementation of hardship allowances

4.3.2 NON-FINANCIAL INCENTIVES: Design, cost and implement standardized a set of non-monetary incentive packages to enhance the public health sector's capacity to significantly attract and retain health workforce in the public sector and rural settings of Ethiopia. These incentives include:

i. Expand, establish and revise existing guidelines for private wings in public hospitals

ii. Provide houses or facilitate access to land and concessional bank loans for building housing and for the purchase of other essential personal effects for hard-to-retain cadres.

iii. Allow scarce professionals with more than 15 years of continuous service to own houses provided by the government

iv. Provide scholarships and training opportunities for staff who serve for specified periods in the public sector and especially in designated hard-to-reach areas

v. Permit leave without pay for high level health and management professionals.

vi. Pay for holiday for high level and management professionals

vii. Develop a mechanism for competitive research grant awards to researchers actively employed in the public health care system.

viii. Develop and update a database of health and management staff from which all health partners are persuaded to select experts on rotation to engage in short-term consultation.

ix. Institutionalize the temporary secondment or joint appointment employment opportunities in the UN agencies, bilateral, multilateral and NGO sectors as a reward to health and management staff for public sector contribution.

x. Provide sponsorship to scientific conferences, training and meetings for exceptional public service contributions

Provide free health care services to health workforce and their dependents at public facilities

4.3.3. Work Climate Improvement

I. Improve availability and distribution of HRM staff to professionalize HRM functions at all level of health system.

II. Building operational capacity of existing HR managers and staff in modern human resources management practices. In this effort, emphasis should be given to HR managers and staff at lower health management structure and health facilities.

III. Improve physical settings of health facilities including cleanliness, adequate work space, furniture and office supplies; power and water supplies, and internet connectivity

IV. Improve working conditions in the public health facilities in terms of availing equipment and supplies/drugs required for executing the jobs of the health professionals safely and efficiently

V. Improve work place safety measures to prevent health workers from occupational risks and hazards. Health workers are assets in this effort. Involve them in identifying local safety challenges and occupational risks as well as selection and implementation of locally appropriate (practical) risk reduction and safety measures.

VI. Strengthen performance planning, appraisal and reward system including acknowledging the health workers publicly for their contributions in the health facilities.

VII. Strengthen regular supervision and support system for all categories of health professionals- at all levels of health system.

4.3.4. Increase opportunities for professional development and promotion

i. Increase availability and distribution of need-based training health professionals and career development opportunities *[such as in-service training and merit-based access to further education for all health professionals. This may include developing and disseminating policy and procedures manual that guides how all health workers are selected for professional development and promotion opportunities.]*

ii. Involve health workers to increase transparency, accountability and fairness at all levels of health system in making decisions like the selection of health professionals for education, training, professional development and promotions

iii. Implement HR leadership and management development strategies including short- and long-term management and leadership training opportunities for health managers at all levels- but targeting especially facility and Woreda level HR managers.

4.3.4. Develop a comprehensive strategy to raise awareness, change attitudes and increase commitment of health workforce to serve communities with their professions
4.3.5. Conduct regular motivation and retention studies to assess the extent of the retention problem and design motivation and retention mechanisms

SO 4.4: Enhance performance and productivity of health workforce

Performance of tasks, quality and productivity of health workforce is very important to improve health outcome of Ethiopian population. Health workers need to be trained and supported to plan their job and meet performance expectations. System for participatory performance assessment, planning and improvement is a critical component of this strategic Objective. The following strategic actions will be implemented to enhance health workforce performance and productivity.

Strategic Actions:

4.4.1. Introduce regular performance planning, monitoring and improvement programs for health care workers at all levels (based on Balanced Score Card)
4.4.2. Establish a comprehensive work climate assessment and improvement programs at all levels of health system
4.4.3. Establish and implement a system for performance appraisal, reward and recognition
4.4.4. Introduce performance-based financing schemes for health care workers and facilities
4.4.5. Conduct regular supportive supervision, mentorship and regular feedback at all levels
4.4.6. Introduce effective time management systems for health care providers
4.4.7. Create link between performance and professional development
4.4.8. Conduct productivity surveys in selected health facilities

CHAPTER 5: IMPLEMENTING THE HRH STRATEGIC PLAN

5.1 COORDINATION MECHANISMS

The implementation of this HRH strategic plan will require the support of multiple stakeholders at the federal and other levels. It is therefore critical to establish HRH working groups at the federal and other levels. Overall leadership of the implementation of this plan will fall under the Director of Human Resources Development and Administration at FMoH. To fully implement this strategic plan, it is anticipated that all regions and lager health facilities and programs will develop their own HRH strategic plans. Key implementation stakeholders include:

- Federal Ministry of Health
    - Directorate of Human Resource Management
    - Directorate of Health Facilities and Professionals Licensing (DHFPL)
    - Other FMoH Directorates
    - Health Professionals Council
- Ministry of Education
    - Higher Education Relevance and Quality Agency (HERQA)
    - Higher Education Directorate
    - Technical Vocational Education and Training Agency
    - Other relevant FMoE Directorates
- Health Training Institutions
- Regional Health Bureaus
- Woreda Health Offices
- Health Facilities
- Professional Medical Associations
- Private Sector
- Partners

The implementation of this strategic plan will be supported by the following activities and approaches:

- **Routine Work by FMoH, FMoE and RHB Staff**

It is expected that a number of staff from FMoH, FMoE and RHBs will spend a significant amount of their time supporting the implementation of this strategic plan. It also expected that their roles in supporting this plan will be spelt out in their job descriptions and that this will form part of the basis for their annual performance evaluation

- **HRH TWG Meetings**

The implementation of this strategic plan will constitute a key agenda item of the HRH TWG meetings at FMOH and RHB levels

- **Support From Stakeholders Partners**

Key stakeholders including Ministries of Education, Civil Service, Finance and Economic Development; bilateral and multilateral donors, non-government and civil society organizations and private sector health providers and training institutions will be mobilized to support the implementation of this plan

- **Work plan Development and Review Meetings**

Detailed annual work plans and budgets will be developed to support the implementation of this plan. Regular review meetings will also be held to evaluate implementation and make recommendations on changes in implementation approaches.

5.2 IMPLEMENTATION FRAMEWORK

<table>
<tr><th colspan="2">Implementing Sector/Organization</th><th>Roles and Responsibilities</th></tr>
<tr><td rowspan="3">FMoH</td><td>Directorate of Human Resource Management</td><td>• Provide overall leadership in the implementation of the strategic Plan
• Support regions in the development of own HRH plans
• Oversee monitoring and evaluation of the plan</td></tr>
<tr><td>Directorate of Health Facilities and Professionals Licensing (DHFPL)</td><td>Licensing of health facilities and professionals</td></tr>
<tr><td>Other FMoH Directorates</td><td>• Provide support in HRH Operational planning
• Participate in performance management</td></tr>
<tr><td rowspan="2">FMoE</td><td>Higher Education Relevance and Quality Agency (HERQA)</td><td>Accreditation and quality audit of Health Training Institutions</td></tr>
<tr><td>Health Training Institutions</td><td>Provision of Pre and In-Service training</td></tr>
<tr><td colspan="2">Regional Health Bureaus and Woreda Health Offices</td><td>• Recruitment and management of staff
• Licensing of lower level health workers</td></tr>
<tr><td colspan="2">Health Facilities</td><td>Management of Staff</td></tr>
<tr><td colspan="2">Health Professional associations</td><td>Provision and accreditation of Continuing Professional Development courses; development of accreditation and quality improvement standards and accreditation and audit visits; development of licensing exam</td></tr>
<tr><td colspan="2">Private Sector</td><td>• Recruitment and management of health workers
• Training of health workers</td></tr>
</table>

CHAPTER 6: IMPLEMENTATION MATRIX AND TIMELINES

The table below provides the implementation Matrix of the HRH Strategic Plan.

OUTCOME 1: HRH POLICY, PLANNING AND PARTNERSHIP STRENGTHENED AT ALL LEVELS

Strategic Objective	Strategic Actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
SO 1.1: Develop and Implement an Appropriate HRH Policy and Legislative Framework	**1.1.1** Develop and implement across-the-board and profession specific laws/codes of ethics for the health professions, including medical practice, nursing, midwifery, Anesthesia, pharmacy and supplementary health professions.						
	1.1.2 Develop legislation to regulate training of health professionals with a clear role of FMoH						
	1.1.3 Develop legislation and guidelines to support confidentiality and appropriate use of personal information HRH databases						
	1.1.4 Develop MOU's/policy guidelines on ethical recruitment and employment of health professionals with major recipient /destination countries						
SO 1.2: Strengthen HRH Planning at all Levels	**1.2.1**Strengthen the planning capacity of the FMOH HRD&A directorate through knowledge and skill development						
	1.2.2 Develop annual HRH operational Plans						
	1.2.3 Support the development of comprehensive HRH plans for all regions, city administrations and large health facilities and programs						
	1.2.4 Institute an integrated and sector-wide HRH planning, implementation and evaluation system that involves all relevant stakeholders						
	1.2.4 Review and regularly update the Federal HRH strategic plan						
	1.2.5 Forge partnerships with government agencies, development partners and other stakeholders to mobilize the necessary support and resources to support the development, implementation and review of HRH plans						

Strategic Objective	Strategic Actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	1.2.6 Train facility managers and heads on methods of determining staffing needs such as WISN						
	1.2.7 Update the national HRH requirement every five years using sound HRH projection methods						
SO 1.3: Create a Gender Responsive and Healthy workforce	**1.3.1**Build the capacity of health mangers and policy makers on gender analysis and integration as an essential part of program design, implementation and review						
	1.3.2 Recruit gender officers and focal persons at regional and health facility levels						
	1.3.3 Provide Support on gender responsiveness to the public and private sector health training institutions						
	1.3.4 Set gender equity indicators and targets especially for high level positions.						
	1.3.5 Introduce mechanisms that support gender equity including affirmative action						
	1.3.6 Introduce comprehensive occupational safety (OSH) programs and ensure staff have access to Protective Personal Equipment (PPEs)						
	1.3.7 Ensure all health workers have access to HIV workplace programs						
SO 1.4: Engage diverse partners in National HRH Dialogue	**1.4.1**Include diverse partners (NGOs, private, donors) in the HRH Working Groups at the Federal and regional levels						
	1.4.2 Develop a common code of conduct governing the mobility of health workers between public and private sector institutions.						
	1.4.3 Introduce approaches for resource sharing between public and private institutions as relates to HRH (Service delivery and training)						
	1.4.4 Encourage the private sector to invest in the health sector and institute an incentive mechanism to attract private health providers to disadvantaged areas or population groups.						

OUTCOME 2:HEALTH WORKFORCE EDUCATION AND TRAINING CAPACITY AND REGULATION IMPROVED

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
SO 2.1: Strengthen Pre-Service training of the health workforce	**2.1.1** Establish a system for continuous alignment of health professionals curricula to address to the country's priority health needs						
	2.1.2 Increase the annual pre-service enrolment and output for priority health cadres in line with FMoH projections						
	2.1.3 Develop and implement strategies to increase annual health professionals enrolment and output for rural and hard-to-reach geographic areas						
	2.1.4 Expand enrolment and produce adequate number of family health team (including family: physician, family health nurses, family health midwives, health extension, and nutrition professionals worker based on PHC model) (from 1 centre to 4 centres)						
	2.1.5 Upgrade level IV HEWs into family health nurse (BSC) program						
	2.1.6 Upgrade level IV HEWs into family health midwives (BSC) program						
	2.1.7 Produce appropriate professionals for Emergency Medical Services (Physician, Nurse, Surgical Officer and Medical Technicians)						
	2.1.8 Strengthen the capacity of existing postgraduate training in hospital management, Master of Public Health (MPH) and health systems management for health sector leaders and managers, and introduce new postgraduate training HRH Management, Health Economics /Financing						
	2.1.9 Expand clinical specialty programs by extending programs from the current level of 6 to 15						
	2.1.10 Double enrolment of postgraduate (clinical specialty from the current level of 250 annual intakes).						
	2.1.11 Expand clinical subspecialty training centres from 1 to 5 centres and double the existing programs						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	2.1.12 Increase annual intake (of subspecialty) by three fold from the current level						
	2.1.13 Introduce forensic medicine in two centres						
	2.1.14 Introduce postgraduate program in trauma surgery						
	2.1.15 Introduce hospital-based specialty programs at 5 centres						
	2.1.16 Expand anaesthesiology and recovery specialty programs from current level of 1 to 3						
	2.1.17 Introduce neonatal nursing program						
	2.1.18 Establish centres of excellence for pre-service training for various professional areas in all 31 universities						
	2.1.19 Provide support for quality audits of all existing pre-service training programs (internal audit every year and external audit every three years) to develop and implement evidence-based quality improvement interventions						
	2.1.20 Build the capacity of problem-based innovative medical education programs to continue training physicians from a pool of BSC holders						
	2.1.21 Support shift to evidence-based curriculum and education models including but not limited to outcomes-based, integrated, community-oriented, active learning						
	2.1.22 Strengthen the capacity of exiting dental training institution for DDM, dental professionals and dental technicians						
	2.1.23 Increase the quantity and quality of mental health service professionals including psychiatrists, clinical psychiatry at Masters levels for BSc levels						
	2.1.24 Upgrade nurses to anesthesia professionals in 5 centers						
	2.1.25 Strengthen midwives training at BSc and Masters Levels						
	2.1.26 Strengthen mid-level eye care workers and standardize the eye care professional category and training based on service need and standards						
	2.1.27 Review curricula of pharmacist, pharmacy technician and supply chain management professionals training based on the						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	desired roles and responsibilities of these professionals						
	2.1.28 Select potential regional training colleges and provide support to provide training of biomedical and health informatics professionals						
	2.1.29 Engage private health sector in the training of health workers for which there is a critical shortage.						
	2.1.30 Establish a system to support public and private health workforce training institutions to comply with minimum requirements and adhere to the quality standards						
	2.1.31 Strengthen health professional training institutions networking, technical exchanges and peer support through associations, forums etc.						
	2.1.32 Establish networking of practicum sites (public, private and affiliates) for quality health professional training						
	2.1.33 Enhance capacity of higher education leadership to provide sustained support for health professional training						
	2.1.34 Increase number of faculties to meet minimum criteria set by HERQA (e.g. improve faculty to student ratio)						
	2.1.35 Improve teaching skills of preceptors and faculties through effective and clinical teaching skills trainings						
	2.1.36 Provide management and support for health educators (e.g. workloads, sabbaticals, research, career advancement, mentoring, technical support, etc.)						
	2.1.37 Strengthen the infrastructure for effective teaching by establishing skills labs, simulators, ICT etc.						
	2.1.38 Increase awareness and skills of health care professional graduates in gender mainstreaming in health sector						
	2.1.39 Establish Alumni offices to support teaching-learning programs						
	2.1.40 Improve networking and south-to-south collaboration among the pre-service education institutions						
	2.1.41 Establish platforms for collaborations among universities						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	and regional health science colleges						
	2.1.42 Recruit on short-term basis, expatriate faculty for training of physicians and also provide services until local capacity is built						
	2.1.43 Create strong partnership between universities and health science colleges with industries and practical sites for service delivery, consultancy and teaching						
SO 2.2: Strengthen in-service training and continued professional development for health workforce	**2.2.1** Review and approve existing in-service training (IST) materials as per the national IST Implementation Guide and Directive						
	2.2.2 Ensure standardization and institutionalization of in-service training						
	2.2.3 Establish in-service training centres with appropriate geographical coverage						
	2.2.4 Establish ICT platforms to support delivery and management of in-service training through eLearning and pilot-test for the priority health trainings						
	2.2.5 Strengthen management and coordination of in-service training at various levels						
	2.2.6 Strengthen local capacity for the provision of ISTs using the three major modalities namely face to face, blended and electronic IST as per the need and relevance.						
	2.2.7 Develop and provide in-service trainings based on national priorities and findings of regular needs assessments (e.g. Immunization, maternal health, management, leadership).						
	2.2.8 Work with health regulatory authorities to implement a Continuing Professional Development (CPD) programs and link to career development and relicensing						
	2.2.9 Involve private sector and professional associations in in-service trainings and CPD rollout						
	2.2.10 Build capacity of IST and CPD providers						
	2.2.11 Create a system for regular communications between						

Strategic Objective	**Strategic actions**	**Implementation Timeline**					
		2014/15	**2016/17**	**2018/19**	**2020/21**	**2022/23**	**2024/25**
	pre-service and in-service training programs						
	2.2.12 Develop and implement a system to link in-service training and CPD to impact on health service delivery and performance improvement (service quality assessment)						
	2.2.13 Mobilize local and international resources for the delivery of need based ISTs.						
	2.2.14 Strengthen the capacity of the Human Resource Processes of regional health bureaus to coordinate the IST standardization and institutionalization in the respective regions.						
	2.2.15 Establish and maintain a functional IST database/interface with HRIS/ at all levels for efficient implementation of the program.						
	2.2.16 Develop need based annual IST plan at national, regional, woreda and health training institutions.						
SO 2.3: Expand the Capacity of Health Training Facilities	**2.3.1** Conduct quality audits of existing pre-service training programs in midwifery and other priority health cadres to develop and implement evidence-based quality improvement interventions						
	2.3.2 Define scope of practice for different health workers and monitor compliance						
	2.3.3 Establish a system for management of fitness to practice (health worker competence and ethical conduct) and link it to renewal of licensure						
	2.3.4 Ensure accreditation of health training institutions, programs and practicum sites offered by public and private education institutions in collaboration with HERQA and professional associations						
	2.3.5 Conduct regular audit of health professionals education programs and link audit results with positive and negative consequences including but not limited to ranking, reward and reaccreditation						
	2.3.6 Expand the capacity of the HRDA Directorate and						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	FMHACA in professional licensing, relicensing and regulation						
	2.3.7 Develop/review implementation manual which details the requirements, scope, processes and other relevant matters for accreditation and licensing.						
	2.3.8 Establish a licensing/qualifying/exit exam to verify competence of new graduates for safe and effective practice prior to entry to the health workforce						
	2.3.9 Establish a system for strategic information on accreditation for CPD providers, health institutions, qualification examinations etc.						
	2.3.10 Create feedback system from accreditation and licensing systems to pre-service and in-service trainings institutions						

OUTCOME 3: HRH LEADERSHIP, GOVERNANCE AND MANAGEMENT CAPACITY AND PRACTICES ARE STRENGTHENED

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
SO 3.1: Strengthen the HRM Function at FMOH and Other levels	3.1.1 Upgrade and professionalize the human resources development and administration function at all levels of the health system to reflect its new and transformed roles by increasing the number of qualified HRM staff and HRM budgets.						
	3.1.2 Adequately resource, furnish and equip HRM offices						
	3.1.3 Provide continuous HRM training to HR staff at national and other levels						
	3.1.4 Conduct periodic job analysis in order to regularly update HRH categories						
	3.1.5 Regularly develop and update job descriptions for all staff.						
	3.1.6 Review and Improve the implementation of a performance based evaluation system to support rewards, sanctions and other						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	management decisions.						
	3.1.7Undertake regular review of career structures for all cadres to provide clear career growth pathways						
SO 3.2: Establish a Comprehensive, sector-wide Human Resources Information system (HRIS)	3.2.1 Conduct an assessment of existing HR information systems for its comprehensiveness and usability and develop plan of action						
	3.2.2 Scale up a sector-wide HRIS (including private sector and training institutions) roll out that provides up-to-date HRH information to assist timely decision making at all levels of the health system.						
	3.2.3 Assign staff to manage HRIS at various levels of health system administration						
	3.2.4 Train system managers and users on HRIS						
	3.2.5 Integrate the HRIS into FMOH's data-warehouse structure						
	3.2.6 Encourage use of HRIS for decision making by availing customized reports to stakeholders						

OUTCOME 4: UTILIZATION, RETENTION AND PERFORMANCE OF THE AVAILABLE HEALTH WORKFORCE OPTIMIZED.

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
SO 4.1: Improve Health Worker Recruitment and Deployment for Higher Staffing Levels	4.1.1. Develop/review and update recruitment, transfer and promotion guidelines to create modern and transparent human resource management system						
	4.1.2 Train HR and health managers on modern approaches to staff recruitment, selection and deployment						
	4.1.3 Implement orientation and induction						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	programs to newly recruited staff at all levels						
	4.1.4 Develop tools to support selection, recruitment and deployment including e-recruitment and deployment tools						
	4.1.5 Establish system to recruit scarce health cadres from the Diaspora, volunteers and retired but not tired of offering services.						
SO 4.2: Reduce Inequity in Geographic Distribution and skills mix of health Workers	4.2.1 Identify factors that underlie the inequity of health workforce geographic distribution and skill mix in all regions						
	4.2.2. Build capacity of regional health bureaus and woredas to attract and deploy health professionals in hard-to-reach geographic areas						
	4.2.3. Conduct policy advocacy for special remuneration and incentive package in hard-to-reach areas (link with Motivation and retention)						
	4.2.4. Sensitize health workforce to provide services for communities at highest needs						
	4.2.5 Continue enforcing minimum public (the mandatory) service for selected priority health professionals						
	4.2.6 Revise task shifting to address skills mix and staffing at hard-to-reach geographic areas and critical human resources shortage						
SO 4.3: ENHANCE STAFF MOTIVATION AND RETENTION	4.3.1. FINANCIAL INCENTIVES: Design, cost and implement a set of monetary motivational and retention incentives at federal and regional levels.						
	i. Review the implementation challenges for nationally standardize duty, professional and risk allowances at all levels of health system.						
	ii. Introduce an Anniversary Public Service Bonus (APSB) for health professionals who						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	have continuously served in the public sector						
	iii. Standardize classification of hardship areas across regions as basis for standardization and implementation of hardship allowances						
	4.3.2. NON-FINANCIAL INCENTIVES: Design, cost and implement standardized a set of non-monetary incentive packages to enhance the public health sector's capacity to significantly attract and retain health workforce in the public sector and rural settings of Ethiopia. These incentives include:						
	i. Expand, establish and revise existing guidelines for private wings in public hospitals						
	ii. Provide houses or facilitate access to land and concessional bank loans for building housing and for the purchase of other essential personal effects for hard-to-retain cadres.						
	iii. Allow scarce professionals with more than 15 years of continuous service to own houses provided by the government						
	iv. Provide scholarships and training opportunities for staff who serve for specified periods in the public sector and especially in designated hard-to-reach areas						
	v. Permit leave without pay for high level health and management professionals.						
	vi. Pay for holiday for high level and management professionals						
	vii. Develop a mechanism for competitive research grant awards to researchers actively employed in the public health care system.						
	viii. Develop and update a database of health and						

Strategic Objective	Strategic actions		Implementation Timeline					
			2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
		management staff from which all health partners are persuaded to select experts on rotation to engage in short-term consultation.						
	ix.	Institutionalize the temporary secondment or joint appointment employment opportunities in the UN agencies, bilateral, multilateral and NGO sectors as a reward to health and management staff for public sector contribution.						
	x.	Provide sponsorship to scientific conferences, training and meetings for exceptional public service contributions						
	xi.	Provide free health care services to health workforce and their dependents at public facilities						
	4.3.3. Work Climate Improvement							
	i.	Improve availability and distribution of HRM staff to professionalize HRM functions at all level of health system.						
	ii.	Building operational capacity of existing HR managers and staff in modern human resources management practices. In this effort, emphasis should be given to HR managers and staff at lower health management structure and health facilities.						
	iii.	Improve physical settings of health facilities including cleanliness, adequate work space, furniture and office supplies; power and water supplies, and internet connectivity						
	iv.	Improve working conditions in the public health facilities in terms of availing equipment and supplies/drugs required for executing the jobs of the health professionals						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	safely and efficiently						
	v. Improve work place safety measures to prevent health workers from occupational risks and hazards. Health workers are assets in this effort. Involve them in identifying local safety challenges and occupational risks as well as selection and implementation of locally appropriate (practical) risk reduction and safety measures.						
	vi. Strengthen performance planning, appraisal and reward system including acknowledging the health workers publicly for their contributions in the health facilities.						
	vii. Strengthen regular supervision and support system for all categories of health professionals- at all levels of health system.						
	4.3.5. Develop a comprehensive strategy to raise awareness and change attitudes of health workforce to serve communities with their professions						
	4.3.6. Conduct regular motivation and retention studies to assess the extent of the retention problem and design motivation and retention mechanisms						
SO 4.4: Enhance performance and productivity of Health Workforce	4.4.1 Introduce regular performance planning, monitoring and improvement programs for health care workers at all levels (based on Balanced Score Card)						
	4.4.2 Establish a comprehensive work climate assessment and improvement programs at all levels of health system						

Strategic Objective	Strategic actions	Implementation Timeline					
		2014/15	2016/17	2018/19	2020/21	2022/23	2024/25
	4.4.3 Establish and implement a system for performance appraisal, reward and recognition for performance (harmonize with outcome three)						
	4.4.4 Introduce performance-based financing schemes for health professionals and health facilities for priority health issues						
	4.4.5 Conduct regular supportive supervision, mentorship and regular feedback at all levels						
	4.4.6 Introduce effective time management systems for health care providers						
	4.4.7 Create link between performance and professional development						
	4.4.8 Conduct productivity surveys in selected health facilities						

CHAPTER7: STRATEGIC PLAN MONITORING AND EVALUATION

7.1 M&E APPROACH

- The Director of Human Resources Management, FMoH will appoint an officer with responsibility for monitoring and evaluation of the strategic plan. The HRH TWGs at federal and regional levels will hold an annual meeting to evaluate the implementation of the strategic plan
- A formal interim evaluation of the plan will be conducted in 2020
- In 2025 an end of term evaluation of the plan will be carried out
- M&E findings together with recommendations will be distributed widely to stakeholders
- Special studies such as the retention study will be carried out to track outcome and impact level HRH indicators
- FMoH in conjunction partners will provide requisite training in HRH M&E

7.2 HRH INDICATORS

M&E activities will be guided by the indicators and targets given for each outcome area– in Chapter 8. In additional to the indicators given under each outcome area, It is proposed that higher level indicators (outcome and above) be developed and tracked. These indicators could include:

- HRH financing – disaggregated by category and region
- Pre-service training completion rates
- Out-migration rates – disaggregated by cadres and recipient country
- Health worker productivity - disaggregated by category and region

CHAPTER 8: MONITORING AND EVALUATION MATRIX

The tables below give the indicators, baselines and performance targets for the HRH strategic plan. The 2025 targets will be set later based on evaluation findings and any changes in the focus of the plan in later years.

OUTCOME 1 INDICATORS: HRH POLICY, PLANNING AND PARTNERSHIP STRENGTHENED AT ALL LEVELS

Strategic Objective	Indicators	Baseline, Year and Source	Performance Targets (Cumulative)	
			2017	2025
SO 1.1: Develop and Implement an Appropriate HRH Policy and Legislative Framework	Number of comprehensive and profession specific health regulatory laws /codes of ethics developed (medical, nursing, pharmacy, midwifery, anesthesia and supplementary)	None	3	6
	Legislation to regulate training of health professionals with a clear role of FMoH in place	None	In-service training regulation	Both in-service and pre-service training regulation
	MOU's on ethical recruitment and employment of health professionals with major recipient /destination countries	Not applicable	To be determined based on number of target countries	To be determined based on number of target countries
SO 1.2: Strengthening HRH Planning at all Levels	Number of HR/Health managers trained on HRH planning	To be added	To be determined	To be determined
	Annual National HRH Operational Plan in Place	Not Applicable	Developed annually	Developed annually
	Number of Regions/City Administrations with comprehensive HRH Plans	None	8	11
	Number of Regions/City Administrations using WISN(or equivalent) to determine staffing levels	None	5	11
SO 1.3 Create a Gender Responsive and Healthy	Number of regions with gender officers and focal persons assigned	At national level only?	5	11

workforce	Number of regions that have introduced a comprehensive Occupational safety and Health (OSH) program	Not applicable	8	11
SO 1.4: Engage diverse partners in National HRH Management	Number or percent of members in HRH Working groups from outside the public sector	Not applicable	To be determined	To be determined

OUTCOME 2 INDICATORS: HEALTH WORKFORCE EDUCATION AND TRAINING CAPACITY AND REGULATION IMPROVED

Strategic Objective	**Indicators**	**Baseline, Year and**	**Performance Targets**	
			2017	**2025**
Strategic Objective 2.1: Strengthen Pre-Service Training of health workforce	No. of health professionals curricula reviewed	Not Available	To be determined	To be determined
	No. of students enrolled for pre-service training for specified priority cadres annually (disaggregated by cadre, gender and region)	Not Available	To be determined	To be determined
	No. of students graduating from pre-service training for specified priority cadres annually (disaggregated by cadre, gender and region)	Not Available	To be determined	To be determined
	Proportion of courses on priority diseases (disaggregated by cadres)	Not applicable	To be determined	To be determined
	Student to faculty ratio, per cadre and health education institution	Not applicable	To be determined	To be determined
	Annual no. of graduates, per cadre and health education institution	Not applicable	To be determined	To be determined
	Workforce generation ratio	Not applicable	To be determined	To be determined
SO 2.2: Strengthen In-Service Training and Continuing Professional Development for health workforce	Proportion/ No. of standardized and approved training curricula	Not applicable	100%	100%
	Number of local training institutions delivering standardized ISTs (disaggregated by region)	Not applicable	35	45
	Proportion of local in-service training institutions who are accredited by health regulatory authorities as CPD providers(disaggregated by region)	Not applicable	85%	100%
	Proportion of regions with need based annual IST	Not	100%	100%

Strategic Objective	Indicators	Baseline, Year and	Performance Targets	
			2017	2025
	plan	applicable		
	Availability of functional IST data base at all levels	Not applicable	100%	100%
	No. of health workforce received standardized in-service training annually (disaggregated by cadre, regions)	TBD	TBD	TBD
	Number of institutions who have annual IST plan in place (include FMoH, agencies and regional health bureaus)	TBD	TBD	TBD
	Availability of budget for in-service/CPD	TBD	TBD	TBD
	Percentage of in-service training financing contributed by local sources(disaggregated by region)	Not applicable	15%	25%

OUTCOME 3 INDICATORS: HRH LEADERSHIP, GOVERNANCE AND MANAGEMENT CAPACITY AND PRACTICES ARE STRENGTHENED

Strategic Objective	Indicators	Baseline, Year and Source	Performance Targets	
			2020	2025
Strategic Objective 3.1: Strengthen the HRM Function and practices at FMOH and Other levels	HRM structure that reflects all HR functions in place	Not Available	Structure in place	Structure in place
	Percentage of established HRM positions filled	Not Available	75%	100%
	Number or % of Health Managers trained in HRH	Not Available	To be determined	To be determined
	% of health workers with current job descriptions	Not Available	75%	100%
	% of health workers undergoing annual performance appraisal on time	Not applicable	To be determined	To be determined
Strategic objective 3.2: Establish a Comprehensive Sector wide Human Resources Information system (HRIS)	Number of regions with a functional and comprehensive HRIS	Not applicable	100%	100%
	Number of staffs trained on HRIS (disaggregate by staff category and region)	Not applicable	To be determined	To be determined
	Number of comprehensive national HRIS reports produced	Not applicable	One per year	One per year

OUTCOME 4 INDICATORS: UTILIZATION, RETENTION AND PERFORMANCE OF THE AVAILABLE HEALTH WORKFORCE OPTIMIZED

Strategic Objective	Indicators	Baseline, Year and Source	Performance Targets		
			2017	2020	2025
Strategic Objective 4.1: Improve Health Worker Recruitment and Deployment at all levels	Stock of health workforce (disaggregated by cadres and regions)	1.3/1000	1.5/1000	1.9/1000	2.3/1000
	Number of new health workers deployed annually (disaggregated by cadre, gender and region)	Not Available	To be determined	To be determined	To be determined
	Proportion of available positions filled with qualified health workers disaggregated by cadre and region	Not Available	80%	100%	100%
	Number of HR and health managers trained in HRM including recruitment and selection practices	Not Available	To be determined	To be determined	To be determined
	Number of health workers recruited from the diaspora	Not Available	To be determined	To be determined	To be determined
	Number of retired health workers re-contracted	Not applicable	To be determined	To be determined	To be determined
Strategic Objective 4.2: Reduce Inequity in Geographic Distribution and skill mix of health care Workers	Staffing levels/vacancy rates for hard-to-reach geographic areas disaggregated by cadre and region	Not Available	To be determined	To be determined	To be determined
	Number of new health workers recruited annually for hard-to-reach areas disaggregated by cadre, gender and region	Not Available	To be determined	To be determined	To be determined
Strategic Objective 4.3: Enhance Staff Motivation and Retention	Number of Retention studies conducted	Not applicable	1	1	1
	Number of regions that are implementing evidence-based incentive package	Not applicable	6	11	11
	Annual health worker attrition rates disaggregated by cadre, age and region	Not available	To be determined	To be determined	To be determined
	Employee satisfaction levels	Not applicable	To be	To be	To be

Strategic Objective	Indicators	Baseline, Year and Source	Performance Targets		
			2017	2020	2025
			determined	determined	determined
	Number of staff that receive recognition awards disaggregated by cadre and region	Not applicable	To be determined	To be determined	To be determined
Strategic Objective 4.4: Enhance performance and productivity	Percentage of health management structures (RHB, ZHD and Woreda Health offices) who have individual staff performance plan and appraisal annually (disaggregated by levels)	Not applicable	50%	70%	95%
	Percentage of health facilities who have individual staff performance plan and appraisal annually (disaggregated by levels)	Not applicable	50%	70%	95%
	Proportion of health facilities and management structures who conduct work climate assessment and implement WCI programs	Not applicable	To be determined	To be determined	To be determined
	Annual health workforce loss rate	Not applicable	To be determined	To be determined	To be determined
	Provider productivity[7]	Not applicable	To be determined	To be determined	To be determined
	Rate of absenteeism[8]	Not applicable	To be determined	To be determined	To be determined
	Dual employment[9]	Not available	To be determined	To be determined	To be determined

[7] Means (Relative no. of specific tasks performed among health workers)
[8] Means (Days of absenteeism among health workers)
[9] Proportion of HRH currently employed at more than one location.

Chapter 9: Projections of Health Workforce Needs and Costing

1. Facility Scale up plan (the population norm approach has been used in the OHT)

One of the major assumptions for health workforce projects is the pace of health facilities scale up (expansion). Based on the population norm approach the expected number of facilities by the year 2020 and 2025 is shown in Table 9.1. As indicated below achieving the proposed facility scale up for primary hospital will be challenging if not impossible within the given time frame (increasing the number of primary hospitals from 163 to 1087 in just five years). The feasibility of the proposed facility scale-up plan need to be revisited as this will affect the HR plan and training; meaning whether the emphasis should still be task shifting or revert to conventional training categories. The current projection is based on these numbers and this might unnecessarily inflate the HR requirement and hence distort the HR plan related to training and deployment of HRH categories specifically designed to address local need through innovative approach such as ESO and HO.

Table 9.1. Population-based health facilities expansion in 2015, 2020 and 2025

	Baseline year 2015	2020	2025
Facilities delivering interventions			
Health Post	15,877	21,741	21,741
Health Center	3,542	4,348	4,348
Primary Hospital	163	1,087	1,087
General Hospital	73	109	109
Specialized Referral Hospital	22	36	36

2. Staffing Standard for health facilities

Based on Food, Medicine, Healthcare Administration and Control Agency (FMHACA)developed health facility standards, Draft HRH Strategic Plan, and opinion from professionals for those categories not included in these documents, the major change on the staffing plan considering the epidemiologic transition for some of the major HRH categories by the year 2025 is summarized as follows.

Currently, the country has an improved HRH status (relatively not in a crisis), there is an emphasis on conventional (standard) HRH categories rather than developing country-specific new cadres and task shifting. Standard health professionals

Medical Doctors: Medical Doctors (GPs) will be availed in all urban and rural health centers. Family Physicians will be assigned at Primary Hospital levels. Specialized Referral Hospitals will have at least 1-2 sub specialists for major sub-specialty disciplines (see projection Table for the type of sub-specialties included)

Health Officers: Health officers will be largely replaced by GP and Family physician at Primary Hospital level (there will only be 1-2 health officers at Primary hospital and Health center levels)ESO deployment will be limited to primary hospital levels.

Tool: The OHT estimates the requirement for the year 2025 and then distributes over the years preceding 2025 in a uniform incremental manner, doesn't consider private sector

Chapter 9: Costing HRH STRATEGIC PLAN

Salaries and benefits of health workforce

Salary and benefit is estimated based on the assumption that the facilities' scale up proceed as per the plan and all the new and existing facilities will be staffed as per the minimum staffing standard. This approach may potentially lead to overestimation of costs of salary and benefit as the HRH requirement on which the cost estimation is based exceeds the HRH availability. Thus, it is not generally important to put 10 years' cost related to salary, rather it suffices to show the yearly increase of the cost related to salaries and benefits.

It is important to review the available fiscal space –not just for the HR component but the overall flow of resources to the health sector as HR is just one input.

Resources for motivation and retention schemes

Incentives, motivation and retention mechanisms based on organizational policy**.**

Educational and training Costs

This category includes the costs for pre-service education, in-service training and continued professional development. Pre-service education inputs from the health sector for such areas of training conducted by regional health science colleges and hospital based residency programs. Some of the costs under the education and training section maybe covered by the education sector might unnecessarily inflate the overall cost on health sector. Major costs under this category include cost of establishing learning resource center (ICT + minor renovation), faculty development (IST), establishing/strengthening QA units, QA Training, enhancing skill labs, availing e-readers (Tablets) and post graduate training on medical education and effective teaching.

Table 9.2: Major components and sub-components for HRH Strategic Plan budget estimation

HRH Domain	Sub Component	Year	
		2014- 2015	**2016-2025**
1. Policy, plan and legal frameworks	Development of various manuals and guidelines	$126,716.49	$633,582.47
	Dissemination Workshop	$58,621.63	$293,108.15
	Printing	$70,000.00	$350,000.00
	Sub Total	***$255,338.12***	***$1,276,690.62***
2. Education and Training	Establishing Learning resource center (ICT + minor renovation)	$1,433,250.00	$2,149,875.00
	Faculty Development (IST)	$97,474.23	$146,211.34
	Establishing/Strengthening QA units	$320,400.00	$480,600.00

	QA Training	$82,853.09	$124,279.64
	Enhancing Skill Lab	$1,800,000.00	$2,700,000.00
	Availing e-readers (Tablets)	$345,600.00	$1,728,000.00
	Sub Total	***$4,079,577.32***	***$7,328,965.98***
	Training of HRM focal persons at Regional and Federal levels	$29,242.27	$292,422.68
	HRM & HR planning tools training and institutionalization including WISN	$389,896.91	$3,898,969.07
	Computers, printer, scanner, camera & other access to scale up HRIS up to Woreda	$1,100,000.00	$3,795,000.00
3. HRH Management	Installation & training	$320,000.00	$1,104,000.00
	Sub Total	***$1,839,139.18***	***$9,090,391.75***
	Grand Total	**$6,174,054.62**	**$9,090,391.75**

ANNEXES: AVERAGE STAFFING STANDARDS

Annex I: Staffing Plan/Target by 2025

No	Occupational Group	Health Post	Health Center	Primary Hospital	General Hospital	Specialized Referral Hospital
	Service Provider					
1	Ambulance & Emergency Service Providers	0	0	7	7	12
2	Anesthetist-TVET Level	0	0	2	2	4
3	Anesthesia Professional	0	0	1	7	11
4	Anesthesia Professional Specialist	0	0	0	2	4
5	Anesthesiologist	0	0	0	2	5
6	Clinical Pharmacist	0	1	2	7	10
7	Clinical Psychologist	0	0	0	2	3
8	Dental Hygienist and Therapist	0	0	0	0	0
9	Dental Surgeon	0	0	1	2	6
10	Dental Technician	0	0	0	2	4
11	Dental professionals	0	0	2	3	6
12	Dermatopathologist				0	2
13	Dermatovenerologist				2	5
14	Dietician	0	0	1	3	3
15	ENT Specialist	0	0	0	2	5
16	ESO	0	0	1	0	0
17	Emergency and Critical Care Nurse Professional				4	11
18	Emergency and critical care medicine specialist	0	0	0	2	7
19	Family Physician	0	0	5	0	0
20	Forensic Pathologist	0	0	0	1	4
21	General Medical Practitioner	0	1	4	18	45
22	General Surgeon	0	0	0	5	10
23	General Surgeon and Cardiothoracic Surgeon	0	0	0	0	2
25	General Surgeon and Endocrine Surgeon	0	0	0	0	2
26	General Surgeon and Gastrointestinal Surgeon	0	0	0	0	2
28	General Surgeon and Neurosurgeon	0	0	0	0	2
29	General Surgeon and Pediatric Cardiac Surgeon	0	0	0	0	2

30	General Surgeon and Pediatric Surgeon	0	0	0	0	2
32	General Surgeon and Plastic & Reconstructive Surgeon	0	0	0	0	2
33	General Surgeon and Transplant Surgeon	0	0	0	0	2
34	General Surgeon and Urologist	0	0	0	0	2
35	General Surgeon and Vascular Surgeon	0	0	0	0	2
36	Health Extension Workers Level III	1	0	0	0	0
37	Health Extension Workers Level IV	1	0	0	0	0
38	Health Officer	0	2	1	0	0
39	Interenist and Geriatric medicine specialist				2	5
40	Internist	0	0	0	4	10
41	Internist and Adult Endocrinologist	0	0	0	0	2
42	Internist and Adult Interventional Cardiologist	0	0	0	0	2
43	Internist and Cardiologist	0	0	0	0	2
44	Internist and Gastroenterologist	0	0	0	0	2
45	Internist and Hematologist	0	0	0	0	2
46	Internist and Infectious Disease Specialist	0	0	0	0	2
47	Internist and Intensivist	0	0	0	0	2
48	Internist and Nephrologist	0	0	0	0	2
49	Internist and Neurologist	0	0	0	0	2
50	Internist and Oncologist	0	0	0	0	2
51	Internist and Pulmonologist					2
52	Interventional Radiation Therapist	0	0	0	0	3
53	Maxiofacial Surgeon	0	0	0	2	5
54	Medical Laboratory Technician	0	2	2	16	22
55	Medical Laboratory Technologist	0	1	4	4	12
56	Medical Physicist	0	0	0	0	4
57	Midwife TVET level	0	2	2	5	8
58	Midwife professionals	0	1	2	8	16
59	Neonatal Nurse	0	0	0	3	5
60	Neurosurgeon				2	4
61	Nuclear Medicine Technician					4
62	Nurse Professional	0	2	3	47	81

63	Nurse TVET Level	0	3	20	49	89
64	OR Nurse	0	0	0	3	5
65	Obstetrics and Gynecology Specialist	0	0	0	5	10
66	Obstetrics and Gynecology Specialist and Gynecologic Oncologist	0	0	0	0	2
67	Obstetrics and Gynecology Specialist and Perinatologist	0	0	0	0	2
69	Ophthalmic Assistant/Nurse				2	5
70	Ophthalmologist	0	0	0	2	5
71	Ophthalmologist and Cornea Specialist	0	0	0	0	2
72	Ophthalmologist and Glaucoma Specialist	0	0	0	0	2
75	Ophthalmologist and Pediatric Ophthalmologist	0	0	0	0	2
76	Ophthalmologist and Retina Specialist	0	0	0	0	2
77	Optometrist	0	0	0	3	5
78	Orthopedics Surgeon	0	0	0	3	7
79	Pathologist	0		0	2	4
80	Pediatrician	0	0	0	4	8
81	Pediatrician and Endocrinologist	0	0	0	0	2
83	Pediatrician and Hematologist	0	0	0	0	2
85	Pediatrician and Intensivist	0	0	0	0	2
86	Pediatrician and Neonatologist	0	0	0	0	2
87	Pediatrician and Nephrologist	0	0	0	0	2
88	Pediatrician and Neurologist	0	0	0	0	2
89	Pediatrician and Oncologist	0	0	0	0	2
90	Pediatrician and Pediatric Cardiologist	0	0	0	0	2
93	Pediatrics and Child Health Nurse	0	0	0	2	5
94	Pharmacist	0	1	2	7	10
95	Pharmacy Technician	0	2	4	12	15
96	Phyiotherapist				2	5
97	Physiotherapy Technician				2	4
98	Plastic and Reconstructive Surgeon					2
99	Prosthetics-Orthotics Professional	0	0	0	3	6
100	Psychiatric Nurse	0	0	1	2	3
101	Psychiatrist	0	0	0	2	4
102	Psychiatrist and Addiction	0	0	0	0	2

	Psychiatrist					
103	Psychiatrist and Child and Adolescent Psychiatrist	0	0	0	0	2
104	Radiograper TVET	0	0	1	3	4
105	Radiographer-BSC	0	0	1	6	12
106	Radiologist	0		0	2	4
107	Radiopharmacist	0	0	0	0	4
108	Rehabilitation Technician	0	0	1	3	5
109	Social worker	0	0	1	2	5
110	Speech and Language Pathology Professional	0	0	0	1	4
	Health Service Management					
	Biomedical Engineer			1	2	2
	Biomedical Technician			1	3	4
	Environmental Health Science Professional			1	2	3
	Epidemiologist					
	Field Epidemiologist					
	Health Care and Service managers		0	1	1	1
	Health Inforamatic Specialist				1	1
	Health Information Technician (HIT)		1	3	5	15
	Occupational Health and Safety Professional			1	2	3
	Public Health Specialist Generalist				1	1
	Statistician					1

Annex 2: Assumptions for Facility Scale Up Plan

Health Facility Type/Level (Public Sector)	Baseline year 2015	2020	2025
Facilities delivering interventions			
Health Post	15,877	21,741	21,741
Health Center	3,542	4,348	4,348
Primary Hospital	163	1,087	1,087
General Hospital	73	109	109
Specialized Referral Hospital	22	36	36

Private Hospital

	Gen Hospitals	MCH Hospitals	Orthopedic Hospitals	Cardiac Hospital
2014	46	8	1	2
2025	83	11	4	5

Private Ambulatory Facilities

	Higher Clinic	Specialized Clinic	Whole sale & Drug Retail outlets	Diagnostic Centers
2014	471	101	573	11
2025	531	114	646	16

Annex3: HRH Requirement Projections

HRH Category	2,020	2,025
Health service providers		
General Medical Practitioner	7,659	12,025
General Surgeon	556	905
General Surgeon Sub Specialty	360	720
General Surgeon and Endocrine Surgeon		
General Surgeon and Gastrointestinal Surgeon		
General Surgeon and Neurosurgeon		
General Surgeon and Pediatric Cardiac Surgeon		
General Surgeon and Pediatric Surgeon		
General Surgeon and Plastic & Reconstructive Surgeon		

General Surgeon and Transplant Surgeon		
General Surgeon and Urologist		
General Surgeon and Vascular Surgeon		
Neurosurgeon	181	362
Internist	462	796
Internal Medicine Sub-Specialty	396	792
Internist and Adult Endocrinologist		
Internist and Adult Interventional Cardiologist		
Internist and Cardiologist		
Internist and Gastroenterologist		
Internist and Hematologist		
Internist and Infectious Disease Specialist		
Internist and Intensivist		
Internist and Nephrologists		
Internist and Neurologist		
Internist and Oncologist		
Internist and Pulmonologist		
Internist and Geriatric medicine specialist		
Obstetrics and Gynecology Specialist	522	941
Obstetrics and Gynecology Sub-Specialty	72	144
Obstetrics and Gynecology Specialist and Gynecologic Oncologist		
Obstetrics and Gynecology Specialist and Perinatologist		
Pediatrician	410	724
Pediatrics and Child Health Sub-Specialists	288	504
Pediatrician and Endocrinologist		
Pediatrician and Hematologist		
Pediatrician and Intensivist		
Pediatrician and Neonatologist		
Pediatrician and Nephrologists		
Pediatrician and Neurologist		
Pediatrician and Oncologist		
Pediatrician and Pediatric Cardiologist		
Ophthalmologist	232	398
Ophthalmology Sub-Specialists	144	216
Ophthalmologist and Cornea Specialist		
Ophthalmologist and Glaucoma Specialist		
Ophthalmologist and Pediatric Ophthalmologist		
Ophthalmologist and Retina Specialist		
Optometrist	254	507
Orthopedics Surgeon	300	579

Pathologist	194	362
Forensic Pathologist	126	253
Dermatovenerologist	199	398
Dermatopathologist	36	72
Radiologist	201	362
Psychiatrist	196	362
Psychiatrist and Addiction Psychiatrist	36	72
Psychiatrist and Child and Adolescent Psychiatrist	36	72
ENT Surgeon	210	398
Family Physician	2,174	4,348
Anesthesiologist	203	398
Anesthetist-TVET Level	1,370	2,536
Anesthesia Professional	1,232	2,246
Anesthesia Professional Specialist	182	362
Maxiofacial Surgeon	199	398
Dental Surgeon	241	434
Dental Technician	181	362
Dental professionals	1,392	2,717
ESO	1169	2174
Health Officer	8,051	9,783
Midwife TVET level	7,176	11,703
Midwife professionals	4,464	7,970
Nurse Professional	12,846	19,996
Nurse TVET Level	38,952	43,329
Neonatal Nurse	254	507
Emergency and Critical Care Nurse Professional	416	832
Ophthalmic Assistant/Nurse	199	398
OR Nurse	304	507
Ambulance & Emergency Service Providers	4,530	8,804
Clinical Pharmacist	3,822	7,645
Pharmacist	5,025	7,645
Pharmacy Technician	9,963	14,892
Radio pharmacist	72	144
Pediatrics and Child Health Nurse	199	398
Emergency and critical care medicine specialist	235	470
Interventional Radiation Therapist	54	108
Medical Laboratory Technician	8,997	13,406
Medical Laboratory Technologist	5,610	9,564
Medical Physicist	72	144
Radiographer TVET	779	1,558
Radiographer-BSC	1,474	2,173

Nuclear Medicine Technician	72	144
Physiotherapist	199	398
Physiotherapy Technician	181	362
Prosthetics-Orthotics Professional	272	543
Psychiatric Nurse	796	1,413
Rehabilitation Technician	797	1,594
Clinical Psychologist	163	326
Social worker	742	1,485
Speech and Language Pathology Professional	132	253
Dietician	761	1,522
Health Extension Workers Level III	27,370	21,741
Health Extension Workers Level IV	12,870	21,741
Subtotal	**179, 262**	**235, 837**
Health management personnel		
Biomedical Engineer	979	1,464
Biomedical Technician	2,029	2,530
Environmental Health Science Professional	1,929	2,425
Epidemiologist	93	81
Field Epidemiologist	1,724	1,746
Health Care and Hospital Administration Specialist	1,726	2,224
Health Economist	83	70
Health Information Specialist	237	229
Health Information Technician (HIT)	7,395	9,317
Health M&E Specialist	314	294
Occupational Health and Safety Professional	1,929	2,425
Subtotal	**18,438**	**22,805**
Grand Total	197,700	258,462

Annex 4: Task shifting- Concept and recommended Approach for HRH SP Period

The demand for health care is on the rise and expected to rise more due to increased population and changing pattern of diseases as the result of urbanization, industrialization, globalization, climate change, larger population of aging people. These effects will be more pronounced as Ethiopia progress to middle-income country. Dealing with infectious diseases, reduction of maternal and child mortality will continue while the effort to address chronic and non-communicable diseases need to be intensified. Therefore, strengthening the health system has a pivotal role so that it is capable of delivering a wide range of health services on scale much larger than the present.

There are compelling data to show a direct correlation between the number of people with access to health services and the number of health-service providers. Clearly, strong and effective health systems depend on having enough people, with the right skills, in the right place. Availing adequate and skilled health workforce takes long time and is expensive. Task shifting can be is an approach that bridges the gap till the health system develops enough workforce desirable skill mix. However,

Task shifting is a means of redistribution of tasks among team of health workforce in which specific tasks are performed by relatively less qualified health workers with appropriate training in the absence or shortage of highly qualified health workers. This approach helps to make more efficient use of the available human resource for health there by improve access to particular services of interest for which the task shifting is done. However, task shifting alone cannot be the answer to the ever increasing health workforce need. Hence, it should be planned, implemented and monitored alongside the overall HRH strategies to meet the demands of the people. It is proposed as an efficient approach with a sizable investment but should not be seen as a substitute for other investments in HRH.

Task shifting should only be considered in case of critical shortage of health workforce to deliver essential health services and/or deploying the proper human resource for health for a particular service is exorbitantly expensive or takes a great deal of time.

The following are recommendations on adopting task shifting with some modification from WHO's recommendation and guideline on task shifting to provide HIV services[10]:

A.Adopting task shifting as a public health initiative

1. Task shifting should be implemented alongside other efforts to increase the number of skilled health worker.

2. In all aspects concerning the adoption of task shifting, relevant parties should endeavor to identify the appropriate stakeholders who will need to be involved and/or consulted from the beginning.

3. Human resource analysis should be undertaken or updated that provide the demography of current HRH in both public and non-state sectors, the need for particular service of interest, the gaps in service provision, the extent of task shifting is already exist and the existing human resource quality assurance mechanisms.

B. Creating an enabling regulatory environment for implementation

4. The existing regulatory frameworks (laws, proclamations, regulations, directives, policies, guidelines…) need to be taken into account and undertake revision as necessary. This would enable the health workers to practice according to the extended scope of practice and associated health facility standards.

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[10] Task shifting Global Recommendation & Guideline, treat, train & retain ;WHO 2008, page 2

5. A fast-track mechanism of revising regulatory approach should be in place that can simultaneously pursue long-term reform that can support task shifting on a sustainable basis within comprehensive & nationally endorsed regulatory framework.

C. Ensuring quality of care

6. Roles and associated competency levels should be defined for existing workforce that are extending their scope of practice and for those workforces that are being newly created under task shifting approach.

7. A systematic approach of harmonizing, standardizing and competency based-training should be adopted that foster need-based human resource development with systems of accreditation

8. Training programmes and clinical educational support for health workers should be tied to certification, registration, licensing, re-licensing and career progression mechanisms

9. Supportive supervision and clinical mentoring should be regularly provided to health workforces with extended scope of practice through task shifting. Professionals who are tasked with providing supportive supervision or clinical mentoring to task-shifted health workforce should themselves be competent, preferably with the standard qualification and experience, and have appropriate supervisory and mentoring skills.

D. Ensuring sustainability

10. Task shifting approaches should be appropriately planned with costing, adequately financed and implanted. The plan needs to indicate exit strategy of task shifting harmonized within the comprehensive long-term HRH strategy so that some task shifted health workforce will not be floated or left in silo as the number of health workforce with standard qualification increase.

11. Incentives need to be considered (financial or non-financial) to retain and enhance the performance of health workers with new or increased responsibilities that commensurate with available resource in a sustainable manner. It should be recognized that health services can only be provided by voluntary basis on a short term or part time basis. Hence, adequate wages and/or other appropriate incentive mechanisms need to be in place to sustain task shifting till adequate health workforce is ready to takeover.

E. Organization of the clinical care services

12. The health care delivery system need to be organized taking into account health workforce demography, disease burden, and analysis of existing gap in service delivery.

13. Efficient referral, consultation and mentoring network need to be in place to support health workforce with extended scope of practice through task shifting.

14. A team based approach should be encouraged to complement knowledge and skill

Examples?

Program area	Service delivery area	required standard HR	Available HR as per the standard	Reason for task shifting	type of proxy HR that can carry out the task	training required	Regulatory issues	benefit adjustment	Sustainability	Potential gaps by task shifting	possible solution to address the gaps
TB	FNAC for Tuberculosis	Pathologist	inadequate	*Inadequate num *Expensive to deploy pathologist	Laboratory technologists	histopathology (modular or regular)	*scope of practice may need to be revised *Procedure may need to be allowed at lower level/Pr. Hospital	?	make it part of training for BSC lab personnel or specialty lab professional	quality	need to develioop SoP; supervision & Qa using pathologists; regular referesher training
FP	LAFP choices (Implanon insertion)	nurses at community level	inadequate	*Inadequate num *Expensive to deploy nurses	HEWs	training on implanon insertion	*scope of practice may need to be revised *Procedure may need to be allowed at lower level/Pr. Hospital	?	upgrade the HEWs to level IV & V	skill of removal	link with HC/hospitalss for removal
Maternal health & Acute abdomen	C/S; ectopic pregnancy, ovarian torsion, IO, Appendicitis,	Obstetrician	inadequate	*Inadequate num	Hos	yes		?	postgraduate masters training +specialize in gyn/ob	quality	need to develioop SoP; supervision & Qa using gynecologits; regular referesher training
					GPs	yes		?	part of pre-service training &specialization to Gyn/ob		