

### Brief overview of the literature relevant to Human Resources for Health (HRH) in Ethiopia

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Even though modern health services in Ethiopia were introduced at the beginning of the 20<sup>th</sup> century, human resources development activities were started only after the Italian invasion, in the mid 1930s (1, 2). During the basic health services period, training was focused on health center teams, while the training of physicians and community health workers in increased numbers was emphasized during the primary health care period (3). Recent reforms leading to decentralization have necessitated capacity at peripheral levels with the consequence that resulted in rapid expansion of higher education in the country as well as increased involvement of the private sector in training activities (4, 5). In addition, commitment to the Millennium Development Goals (MDGs) has enhanced overall efforts in the expansion of primary health care coverage requiring accelerated levels in training of health workers (6).

Ethiopia is considered to have one of the lowest ratios of doctors to population in the world. In particular, with the recent expansion of health facilities across the country, severe shortages of health workers for staffing them have been witnessed. Furthermore, even though the threshold density below which high coverage (80%) of essential interventions, (including those necessary to meet MDGs) is estimated at 2.3 health workers (the definition of Health workers being all people primarily engaged in actions with the primary intent of enhancing health) per 1,000 people (7), with a total workforce of 65,744 (physicians, health officers, nurses, midwives and health extension workers that are deployed within the public sector) for a population of 81,911,074, there were only 0.80 health workers per 1,000 population in Ethiopia at the end of 2003 (EC) (8). A more recent (2012) analysis by the World Bank has also indicated problems in human resources for health in Ethiopia with regards to stock, distribution and performance that have

negative implications on access to health services, particularly maternal health services for the poor, and is likely contributing to high levels of neonatal deaths and maternal mortality ratios (9).

Even though the HRH problem is often oversimplified as a numerical shortage of healthcare workers, there are also other dimensions of the crisis (management, quality, location, and performance) that are not usually being effectively dealt with (10). Past reviews of human resource for health in Ethiopia with respect to challenges of achieving the MDGs have also found that there is shortage in number of different groups of professionals, maldistribution of professional between regions, urban and rural setting, and governmental and non-governmental/private organizations. These reviews have also indicated the lack of policy specific to human resource development for health as well as proper mechanisms to manage the existing health work force (11). A World Bank assessment of health worker performance in Ethiopia, based on data from focus group discussions, has attempted to outline both the nature of performance problems, as well as the possible structural reasons for these problems as they relate to human resource policies (12). Among the performance problems identified in this study were: absenteeism and shirking, salary augmenting practices (moonlighting) pilfering drugs and materials, informal health care provision, illicit charging, corruption malingering as well as poor handling of patients. These problems are ascribed to causes that are rooted in the ongoing transition from a command-and-control health sector, to a more pluralistic system, and the failure of government policies to keep pace with the transition toward a mixed model of service delivery. Even though public sector salaries weighted against GDP for physicians in the Ethiopian are said to be relatively higher when compared to other sub-Saharan African

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countries (13), their actual magnitude is very low. In addition to the very high salary gradient between the public and private/NGO sectors locally, salary levels are excessively low for physicians and nurses who have some degree of access to the international labor market. Despite such mismatch between performance and remuneration, a survey and experimental study to assess the development of intrinsic motivation on a sample of newly graduating physicians and nurses in Ethiopia has shown the majority of student physician and nurses as being intrinsically motivated (14). In addition to economic incentives, such intrinsic motivation is also shown to be among the major factors in health workers' decision to work in rural and public facilities (15).

With regard to training of specific categories of health workers, a study that assessed the first cohort of trainees in the Health Extension Program (HEP) (16) has also found that the training institutions (Technical and Vocational Educational Training Institutes (TVEIs)) assessed as lacking adequate facilities to receive the trainees. Teaching and learning conditions were also constrained with very little practical training. The selection of trainees was also found to be flawed, most being from *woreda* towns as opposed to the rural villages in which they were supposed to work. Trainees were also found not to have adequate orientation on their future job at recruitment, even though they expressed high level of commitment to work in rural areas. Similarly, assessment of the access to information, continuing education and reference materials among 60 Health Extension Workers (HEWs) distributed across 50 health posts within 27 *woredas* has shown that the HEW training modules were the only reference materials available at health post levels and that training in curative and delivery related subjects stand out in the future continuing education expectations of the health extension workers (17). Furthermore, assessment of the working conditions of the first cohort of health extension workers has shown challenges in harmonizing the staffing pattern at health post levels as there were no clear guidelines on relationship of HEWs with other health workers at community levels as well as

because of the general weakness of reporting and health management information system (18).

A review of medical doctors profile in Ethiopia with regard to production, attrition and retention (19) over the hundred years of the country's medical history has shown high annual attrition rate, fast population growth, governmental and non-governmental health institution expansion, low production and increased graduate enrollment over the recent years leading to extremely low physician-to-population ratio. According to this review, even though the government as well as the private sector has worked much in terms of health infrastructure expansion and health professional training, mechanisms for retention of medical doctors does not appear to have been properly sorted out. As a result, even despite salary equivalent top-up payments in some regions, more than 80% of the public hospitals outside the capital were under-staffed with physicians implying that the push factors are not correlated with remuneration alone. Brain drain is said to be a relatively recent phenomenon in the Ethiopian health sector workforce. With the advent of an increasing number of push factors, however, this trend has changed over the past couple of decades. About 50% of Ethiopians who went abroad and completed their studies did not return home during the past 10-15 years. For instance, between 1980 and 1991 only 5,777 students out of a total of 22,700 returned home (20). Health workers who migrated internally continue to serve the country's population, even though those with higher socio-economic status and usually urban residents. On the other hand, there also seem to be inefficiencies due to inappropriate and underutilization of highly trained health workers by the private sector institutions as well as vertical health programs (21).

Overall, major challenges in relation to human resources in the sector continue to be poor deployment and retention of health professionals, in addition to insufficient number in specific cadres of health workers such as midwives. Health personnel training activities have been expanded more recently as a result of new initiatives as well with the increased involvement of the private sector. However, there are

concerns over the quality of training. Even though evidence is scarce on quality of training, there is no doubt that the lack of strong quality control mechanism are among the critical issues in the face of the fast expansion of private as well as public training institutions. An analysis of the higher education reform efforts in Ethiopia indicates that even though enrolment expansion targets are likely to be met, the dynamics of expansion is shown as likely to generate difficulties in maintaining educational quality, as it is always challenging for a nation to maintain quality standards in the midst of rapid enrolment expansion, among other things (22). In addition to shortage of appropriate training resources within the training institutions, absence of well organized regulatory and monitoring mechanisms for the overall process may be contributing to the low level of quality in training. Lack of proper mechanisms for planning and management of human resources for health is also a contributing problem. Even though most graduates are intrinsically motivated for public service (as shown by a survey by the World Bank), the lack of conducive working conditions and favorable professional environment endanger the erosion of these intrinsic factors (14).

To address the challenges outlined above, the health sector has developed its human resources development framework that is going to be a basis for elaborate activities in human resources planning and management. A new department for human resources has also been established within the Federal Ministry of Health. The Health Sector Human Resource Development Framework (2006-2010) was finalized in September 2005 (21). The Framework was meant to provide a basis for detailed planning of the different interventions and active engagement of the health sector partners. It has highlighted the human resources for health needs of the country for the period 2006 – 2010 in the context of the sector's demand as well as the ongoing public services reform.

However, there is still a lot to be done to address the crisis in the situation of human resources. In addition to more accurate planning of the health

workforce, better management systems should be established in terms of improving motivation, ensuring adequate and regular pay, improving working conditions and enhancing professional values of workers. The country should also attempt to operationalize in its context the various initiatives and core principles developed by the World Health Organization. In particular, its future actions in the area of human resources for health should be within the framework of the "Working Lifespan" approach with the goal of getting the right workers, with the right skills, in the right place, doing the right things; and in so doing to retain the agility to respond to the crises, to meet current gaps and to anticipate the future. Attempt also should be made to address some of the basic causes of the human resources for health problems that are said to emanate from the political nature of most of the issues related to the subject (in that there is an urgent and very high need for political commitment and political management for taking up the HRH agenda forward and for scaling up the resources required for necessary interventions), from inefficient and inappropriate external assistance for this element as well as from lack of good governance (23). There is also a need to review the usual HR/population ratio method which is used as a model for planning human resources for health, with the claim that the training and development of technical health workers is attempted to be geared to the needs of the country (24). With the current strategies at place for financing health personnel training, the application of only this model does not seem to be cost-effective. One possible way of approaching the training strategy for health workers is to attempt to use a mix models for planning. Such an approach is also in line with the recommendation for exploring mechanisms to resource educating health workers at the regional level (25). Furthermore, to have a positive effect on health outcomes, the professional education subsystem must design new instructional and institutional strategies in view of the opportunities created by globalization, increased transfer of knowledge as well as professionals and patients across borders (26).

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