Federal Democratic Republic of Ethiopia
Ministry of Health

Improving Human Resources Management in Health Sector to Improve Health Outcomes

Results and Lessons from Ethiopia

TECHNICAL REPORT

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Special thanks to the staff of the Federal Ministry of Health, Regional Health Bureaus, Zonal and Woreda Health offices and many health facilities for their time and willingness to take part in the interviews and share their experiences. We also thank the MSH Home office, especially senior leadership, for their generous support and technical guidance in preparation of this report.

Acronyms

BPR	Business Process Re-engineering
FMOH	Federal Ministry of Health
GOE	Government of Ethiopia
HRH	Human Resources for Health
HRM	Human Resource Management
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
RHB	Regional Health Bureau
SNNPR	Southern Nations Nationalities & People's Region
TOT	Training of Trainers
TWG	Technical Working Group
WHO	World Health Organization
WorHo	Woreda (District) Health Office
USAID	United States Agency for International Development
ZHD	Zonal Health Department

Executive Summary

According to the World Health Organization's 2006 World Health Report, Ethiopia had 0.247 doctors, nurses and midwives combined per 1,000 population, and was one of 57 countries with a health workforce crisis. With expanded investments in the last decade, including improved education systems focusing more on health workforce development, distribution and management of health professionals, the density of health professionals has increased to 0.74 per 1,000 population in 2017. Despite the progress, the country still needs to increase its investment in health workforce development and management to achieve sustained development goals and universal health coverage. Cognizant of this fact, Ethiopia has developed medium and long-term investment plans through health sector development strategies that also include actions to increase health workforce availability, distribution and performance. The Jhpiego-led, USAID-funded Strengthening Human Resources for Health (HRH) project has focused on long-term and medium-term goals for health sector human resources development priorities earmarked by health sector leaders and policy makers in Ethiopia. Management Sciences for Health (MSH) is a key partner of the consortium implementing the project which improves human resources management (HRM) systems and practices.

During the past five years, MSH staff and consultants worked with the Federal Ministry of Health (FMOH), the Food, Medicine and Healthcare Administration and Authority (FMHACA) and 11 Regional Health Bureaus (RHBs) to assess HRM capacity needs, develop plans, and provide technical support to implement a series of mutually reinforcing activities to strengthen HRM practices. MSH also implemented interventions to improve health workforce motivation and retention, increase access to and utilization of HR policies, improve stakeholder's collaboration at national and regional levels, and enhance staff training management. This report is the result of an internal review of the HRH project conducted by MSH to understand, consolidate, and document the key achievements, barriers and enabling factors for strengthening HRM in Ethiopia's public health sector. The review will also contribute to the overall program documentation and learning agenda, and determine the most promising practices to guide future HRM programming in similar settings.

The internal review applied the "Step-Wise Model," which outlines a qualitative process of assessing and analyzing program approaches, interventions and results. The information was gatherred by reviewing, synthesizing, and summarizing key issues from various reports developed by the HRH project including the initial HRM assessments, annual reports, mid-term regional reports and other key documents. The review team also conducted key informant interviews (KII) of 38 individuals from the HRH project staff, and the FMOH, RHBs, zonal and woreda health offices, and selected health facilities in each region. All interviews were recorded and analyzed using an HRM framework (taxonomy) developed by the team to distill common themes including successes, challenges, and lessons learned across the various HRM functions the project sought to strengthen.

As documented in this report, the HRH project conducted an HRM capacity assessment (a comprehensive HRM situation assessment) to identify HRM needs, and developed a three-year action plan; put the FMOH, RHB and FMHACA in the driver's seat, and involved key stakeholders during implementation planning to help navigate the complexities of human resources in the health sector. To provide sustained, on-site technical assistance and ensure the effective implementation of action plans, MSH hired and embedded one full time HRM officer in each of the 11 regional bureaus and city administrations. The project provided technical and financial support to the FMOH and RHBs, creating more than 1,300 new HRM positions and filling more than 95% of the newly created and existing

vacant HR positions. The project also developed an HRM in-service training curriculum, tools and guidelines for post-training follow up and mentorship/coaching, and trained more than 2,700 HR staff. It supported strategic and operational HR planning at national and regional levels, conducted training in performance planning, supportive supervision and feedback; identified and disseminated HRM policies and procedure manuals, and provided technical and financial support to strengthen HRH partnerships at national and regional levels. Finally, the project also generated evidence, supported decisions and practices to improve health workforce motivation and retention, and facilitated experience sharing within and outside of the country.

This review identified numerous enabling factors and barriers during HRH project implementation. Enabling factors include always starting with a comprehensive needs assessment, and prioritizing and pursuing partnerships that enable Ethiopian-led planning and capacity development, such as an active leadership role played by the HRH technical working group during the HRM in-service training curriculum development process. Also, developing and utilizing a needs-based HRM in-service training curriculum, maintaining strong collaboration among key stakeholders, and adopting a problem-driven focus while ensuring all program approaches analyze and adapt to the local context at whatever level is required, as evidenced in the post-training and mentoring activities. Using local trainers and applying a facilitative approach to capacity development and minimizing the perceived "project-led, do it for them" attitude or approach over an extended period was also identified.

Respondents said mobilizing and aligning multisectoral stakeholders and ensuring they remained committed to the process proved difficult for staff, who repeatedly mentioned the length of time it took to get stakeholders on board. Since it is equally difficult to create strong HRM systems and practices without stakeholder contributions, the project applied extra effort to engage the key stakeholders. One or more respondents expressed additional factors as key challenges moving forward: lack of HRM unit structure at zone and woreda levels (in some regions), low participation of zone and woreda political leaders and managers, low knowledge and appreciation of HRM among woreda and facility level managers, and lack of adequate financial support to sustain the mentoring and coaching program at the current level when the project ends.

The HRH project laid the foundation for stronger HRM practices in Ethiopia and has numerous lessons to learn from its implementation. Despite its success, shortage of the critical cadres such as doctors, nurses, midwives, health officers, pharmacy and laboratory technicians and anesthetists in health facilities against a rising population; low performance and productivity of health workforce; and inadequate skills remain key system challenges. Sustained political commitment and leadership, coherent long-term HRH strategies, institutional capacity, intersectoral leadership and governance, and flow of adequate resources from government and non-government organizations are critical to sustain and/or scale up the current success under the USAID-funded mechanism.

Context and Background

Ethiopia is one of 57 countries listed by the World Health Organization (WHO) as having a health workforce 'crisis'. The World Health Report 2006, which for the first time, was devoted to Human Resources for Health, estimated that Ethiopia had a density of 0.247 doctors, nurses and midwives per 1,000 population against the calculated threshold of 2.28/1,000 that was utilized to categorize a 'crisis'. In 10 years, that density has improved slightly and currently stands at 0.74 per 1,000 populations.

Aside from this stark WHO estimate on density, there is evidence of shortages across many other health cadres; geographical mal-distribution of the workforce with a heavy bias in urban centers; poor working conditions; a growing non-state sector (comprising local and international non-governmental organizations and private for-profit providers) which reportedly impacts upon attrition and internal brain-drain, the poor retention of the public sector workforce (especially for physicians); poor human resource management; inconsistent standards in training and examinations, and imbalances in gender across the professions.

In the past decade, the Government of Ethiopia has invested heavily in health systems strengthening, including ambitious supply-side workforce development efforts to dramatically increase numbers of health workers, including an "army" of 47,000 paid Community Health Extension Workers, resulting in significant gains in improving the health status of Ethiopians. For example, there were only three medical schools in the whole country twelve years ago. Today there are over 28 public and eight private medical schools with referral and teaching hospitals that have the capacity to produce over 2,000 doctors every year. Similar expansion in the pre-service education pipeline has been witnessed for other cadres as well.

However, the way health workers are trained, deployed, managed and supported is central to the quality of health services that they are able to deliver. There is also a growing recognition in many countries, including Ethiopia, that health systems at all levels, will not be successful in their efforts to keep populations healthy, reduce maternal and child mortality rates or end deaths from AIDS, malaria or TB, without strengthening the planning, management, retention, performance and productivity of the health workforce.

A rapid review of some of the older and even current national human resources policies and strategic plans[1] that have been produced by the Federal Ministry of Health over the last decade demonstrates an interesting pattern – as they all consistently highlight the following priority goals:

- Strengthening HRH management, with the re-organization of the Human Resource Directorate/functional units at FMoH, regional and local levels as well as development of a Human Resource Information System (HRIS);

[1] HSDP IV; Business Plan Re-engineering Exercise; National HRH Strategic Plan 2016-2025; Health Sector Transformation Plan

- Reform of staffing standards, workforce distribution and organization, with associated development of job descriptions, career pathways and implementation arrangements to support appointments and deployment;
- Reorientation of education system, training and skills development approaches with associated activities on curricula development, mentoring, distance learning, accreditation, regulation and licensing, especially for nurses, midwives and health officers;
- Enhanced motivation and retention of health workers, with associated financial and non-financial incentives;
- Improved policy, regulatory and financial frameworks, with due attention to costing the HR development plans and implementation arrangements to support domestic and external resource mobilization.

It is therefore noteworthy that the Jhpiego-led, USAID-funded Ethiopia Strengthening Human Resources for Health Project (May 2012 – September 2017 – with one year no-cost extension to September 2018) has aptly focused on some of these long and medium-term goals that are already earmarked as priorities by health sector leaders and policy makers in Ethiopia. Management Sciences for Health (MSH) is a key partner of the consortium in implementing the project.

The project is unique and comprehensive in its design as it combines essential, big-bucket elements of HRH, including pre-service education, in-service training and continued professional development - both aimed at improving numeric shortage of essential cadres and quality of education and training (Result Areas 2 and 3); improved human resources management systems and practices (Result Area 1) to strengthen recruitment, orientation, deployment, performance management, partnership and collaboration, strengthen HR staff training and on-the-job support; and generating evidence through operational research, monitoring and evaluation for evidence-based HRH policy and planning in the country (Result Area 4). MSH leads Intermediate Result (IR) 1 of the project – which we shall refer to in this report as the HRM Strengthening Program.

Over the last five years, MSH staff and consultants working on or supporting the project have partnered with Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), Zonal and Woreda (District) health offices as well as select academic training institutions and even the Food, Medicine and Healthcare Administration and Authority (FMHACA) to assess needs, develop plans and provide technical support to implement a series of mutually reinforcing activities in the following areas: improve HR structure and staffing at all levels; fill vacant HR positions and streamline recruitment, selection and orientation of new staff; large scale HRM skill building/in-service training for HR staff, with sustained post-training follow-up coaching and mentorship; collaborate with HRIS partners to improve personnel data collection and analysis including reorganizing facility level filing system; improve performance management system; and work climate improvement programs, including fostering links with ongoing 5S-KAIZEN Total Quality Management (TQM) exercises promoted by the Quality Improvement Directorate of the FMOH; strengthen staff motivation and retention strategies at regional and facility levels; improve access to HR policies and regulatory frameworks for Continuing

Professional Development (CPD); and establish regular HRH forums for tracking progress, sharing experiences and promoting opportunities for peer learning.

Purpose

Through document reviews and interviews with project staff and key stakeholders at all levels of the health system, the purpose of this assignment was to further understand, consolidate and document the barriers and enabling factors for strengthening human resource management in Ethiopia's public health sector. By distilling common barriers and success factors, this activity will contribute to the project's overall program documentation and learning agenda, and determine the most promising practices that can guide future HRM programming in similar settings. The Scope of Work (SOW) for the assignment is available as Annex 1.

Methodology

All project annual reports and other key documents including summary reports of initial HRM assessments were reviewed. Key informant interviews were also conducted with 38 individual including the project staff and selected stakeholders from Federal Ministry of Health, Regional Health Bureaus, Zonal and Woreda Health offices, and a few health facilities in every region. The interviews were conducted in person, by the consultant or designated staff in country. All interviews were recorded in note form and later analyzed using an inductive approach and against an HRM framework/taxonomy to distill common themes in terms of successes, challenges and lessons learned across the various HRM functions that the project sought to strengthen. The full list of persons met/interviewed is available as Annex 2 and the interview guide for the assignment is available as Annex 3.

Challenge Statement

Health care progress and the effectiveness of service delivery platforms is hampered when the human resource management (HRM) system that is required to manage, support and motivate health providers is either weak or even completely absent. MSH defines HRM as the integrated use of systems, policies, and management practices to recruit, maintain, develop and retain employees to support the organization in meeting its desired goals. HRM is essential in any organization, critically so when public health crisis and workforce shortages collide, as they now do in Ethiopia and other developing countries.

This report provides a synthesized summary of the process and approaches that the project applied to strengthen HRM functions at different levels of the Ethiopian public health sector. It also outlines some of the results and accomplishments, value created, as well as lessons learned and recommendations that will inform the design and implementation of similar initiatives in Ethiopia and other settings in the future.

Technical Approach

Figure 1 is a Step-Wise Model which outlines a qualitative process of assessing and analyzing the approaches the project used to plan and implement the HRM strengthening program.

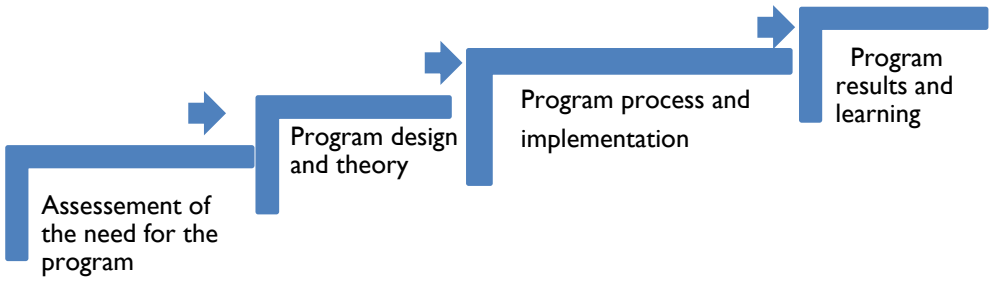


Figure1: A Step-Wise Model

Assessing the Need for the Program and Developing Action Plans

Over a five-year period from 2013 to 2017, MSH, partnered with the Federal Ministry of Health and the Regional Health Bureaus to provide technical assistance, and to co-design and implement a range of HRM interventions.

One of the many ways that any organization, both public and private, can move toward a strong, comprehensive HRM system is to gather information to help them plan for and implement improvements. The most foundational technical input the project provided was a comprehensive situational analysis and HRM capacity assessment in all the regions over a period of several months, using MSH's HRM Rapid Assessment Tool (3rd edition). This tool, approved by WHO, has been used to conduct similar assessments in many developing countries around the globe by determining areas of strength and areas needing improvement. The tool then prioritizes improvement areas and develops an HRM action plan to address the most urgent challenges. The tool allows organizations to take a holistic look at the HRM system, specifically the following five broad areas: human resource capacity, personnel policies and practices, human resource data, the performance management system, and training. Table 1 shows the 22 HR components that fall within these six areas and are the focus of the assessments.

Table 1: Human Resource Management Components

HRM Capacity	• HRM budget • HRM staff • HR planning
Personnel policies and practices	• Job classification system • Compensation and benefits system • Recruitment, hiring, transfer and promotion

	• Orientation program • Policy manual • Discipline, termination, and grievance procedures • Other incentive systems • Union relationships • Labor law compliance
Human resource management data	• Employee data • Computerization of data • Personnel files
Performance Management System	• Job descriptions • Staff supervision • Work planning and performance review
Training	• Staff training (in-service and CPD) • Management/leadership development • Links to external pre-service education

On the assessment tool, each component shown on Table 1 is followed by a description of four possible stages of development that range from just beginning to fully developed. The characteristics of the four stages provide useful information for developing a plan of action to improve the areas that need strengthening. In each region, the participatory assessments brought together multi-disciplinary, multi-agency teams from RHBs, civil service and finance bureaus to conduct the assessment, discuss the findings, prioritize areas of need and develop an action plan. Each regional assessment generated a comprehensive report with a corresponding HRM action plan (one per the nine regions and the two city administrations).

It is important to point out that the alignment and involvement of multi-agency teams to participate in these assessments is rather unique and perhaps the first of its kind, and the impact or value add this approach generated is discussed in later sections of this report. Typically, HRM assessments involve a small team drawn from different departments and at different levels in the same organization.

Staffing and Management Plan: To provide sustained, on-site technical assistance and ensure the effective implementation of action plans, MSH hired and embedded one full time HRM Officer in each of the 11 regional bureaus and city administrations. An expansive and highly populated region like Oromia was assigned two HRM officers. These are supported by two senior HRM advisors deployed at the central project office in Addis Ababa, alongside a senior team leader/principal technical advisor who provided overall technical leadership and strategic direction, and responsible for achieving and reporting of results/deliverables, and also interfacing with the project's, Jhpiego-led, senior leadership team. MSH has a total staff of 16 people who work closely with one another and the agencies they support to achieve results under IR 1 of the project. A small team in the MSH home office in the U.S.

also provides pro-active technical backstop, as well as routine financial/budgeting, contractual and administrative support to the in-country team to ensure effective implementation of activities/deliverables on time and within budget.

Program Design

Post-assessment, an important initial step was to review all the action plans and identify common HRM themes and functional areas that needed to be strengthened and factored into program design. Table 2 provides a summary of the HRM components/functional areas that were identified as common priority areas across all the regions during the assessments. These were the areas prioritized for implementation in the HRM strengthening program. These broad HRM functional areas will also serve as the basis for an additional layer of qualitative analysis and documentation in the results section of this report.

Table 2: Taxonomy of Human Resource Components

a) HRM Capacity Trained and dedicated HRM staff with a budget to conduct basic HR planning and implement HR functions and basic operations.	**b) HR Information System** Files, paper-based or online/electronic system that is used for personnel data capture, entry, data tracking and all the data requirements for HR planning, management, payroll and other operations.	**c) Staff Motivation and Retention** - A set of strategies, policies and practices used to attract, motivate and retain staff, including work climate and other financial and non-financial incentives.
d) Personnel Policy and Practice Set of policies and practices that govern how the organization plans manages and implements the following HR functions: compensation and benefits, recruitment, hiring, deployment, transfer, promotion, orientation, termination, grievances and harassment and workplace discrimination.	**e) Performance Management** The system, policies, and procedures, such as job description, work planning, supervision arrangements, performance appraisal/review, used by an organization to define and monitor the work that people do, and to ensure that the tasks and priorities of staff are in alignment with the mission and goals of the organization.	**f) Training and staff development** In-service training policy, priorities for continuing professional development, leadership and management, HRM skill development, and links to pre-service training.

Program Implementation

The following is a summary description of the essential steps and modalities the team used to plan and implement the HRM skill building and development program at different levels of the health system.

This was a major nationwide investment, requiring separate analysis and description of its implementation in more detail:

Putting Local Stakeholders in the Driver's Seat: HRH Technical Working Group

Even before the project started, there was an active and fully-functional HRH Technical Working Group (TWG) at the Federal Ministry of Health in Addis Ababa. The group, chaired by the Director of Human Resource Development and Administration, met regularly and had members drawn from FMOH, Ministry of Education, Federal Civil Service, Pre-service Training Institutions, as well as various NGOs, partner organizations and agencies active in the HRH space in the country. Any investments and studies that targeted the health workforce had to be discussed and approved by this group. The same was true for any HRH study reports and assessment findings.

The project team shared a summary of the assessment findings with the TWG who discussed and determined a universal gap shared by all the regions was in the area of HRM in-service training and skill development. They decided that a comprehensive curriculum, based on the priority themes and competency gaps identified during the assessment, should be developed, validated and approved to train a critical mass of staff with responsibility for HRM at the Regional, Zonal, Woreda and facility levels. The primary task of the TWG was to guide the process, assume overall ownership for this important initiative, track progress, and achieve results. In other words, from the onset the TWG assumed ownership and direct responsibility for this activity. With technical oversight, leadership and support from MSH senior staff[2], and after a period of three months, they generated a draft HRM in-service training manual. MSH's principal technical advisor[3] reviewed the manual and provided useful inputs.

The manual, complete with a separate facilitator guide, covers the following eight modules:

- **Module 1:** Global and National HRH Issues and Trends
- **Module 2:** Human Resource Policies
- **Module 3**: Human Resource Planning and Staffing
- **Module 4:** Human Resources Strategy Development
- **Module 5**: Training and Development
- **Module 6**: Performance Management
- **Module 7**: HRIS and Data-Driven Decision Making
- **Module 8**: Leadership and Management

Finally, each module of the manual and facilitator guide as well other training facilitation tools such as case studies, PowerPoint slides and pre-and post-test materials were reviewed and endorsed by the in-service training team in the FMOH.

[2] Shelemo Shawula (Senior HRH Management Advisor &Team Leaders) HRH Management and from Mesfin Kifle (HRH Management Advisor), HRH Country Office & Asfaw Demissie (Regional HRH Management Officer), SNNP Regional Health Bureau
[3] Ummuro Adano, Principal Technical Advisor and Global Technical Lead, HRH from MSH Headquarters

Training of Trainers and HRM Staff Training

Once the complete curriculum and accompanying resources were vetted and formally approved by the FMOH and ready for implementation, the project planned and supported a series of training of trainers (TOT) workshops in all of the regions. First, two-week national TOT workshops were held in Hawassa and Mekelle University's Ayder Hospital (at the local tertiary hospitals and colleges of health sciences in SNNP and Tigray Regions, respectively) for teams of 60 master trainers drawn from FMOH and RHBs. The master trainers were introduced to the content of all the modules, participatory delivery approaches and a practicum opportunity to prepare and teach back one of the modules as a team. This group of trainers was later deployed along with the HRH project staff to train other trainers in the various regions. The training manual was later translated from English into Amharic, Oromifa, and Tigrinya – the three major local languages.

The team of trainers fanned out and cascaded a series of five-day regional workshops for existing HRM staff, using the HRM manual. At the same time, several RHBs were recruiting new HRM staff and these too received training before they were deployed. By the end of September 2017, a total of 2,450 HR managers and staff had received HRM training in all RHBs, FMoH and the Federal Ministry agencies (e.g., FMHACA, Pharmaceutical Fund and Supply Agency and Ethiopian Public Health Institute), and the Federal Ministry Hospitals (at the national level).

Post-Training Follow Up Support and Mentoring

The project team developed an elaborate plan to provide post-training follow up support to all trained staff. Simple tools and methodologies such as a Knowledge, Skills and Attitudes Checklist are used to track progress on individual action plans and solve problems jointly by the staff who conduct coaching and the staff to be mentored. Other simple tools such as customized employee satisfaction survey and exit interview have also been institutionalized through these regular support visits to gather data and take performance management actions as appropriate.

A team consisting of two project staff and RHB staff go out every quarter - and in some regions every two months depending on budget availability - to review progress and offer support. The HR officers who were interviewed were overwhelmingly appreciative and full of praise for the post-training support. Many thought the follow up and mentoring support was more useful than the initial training describing them as practical and kept them refreshed, inspired and wanting to focus on the implementation of their action plans.

One respondent, an Afar HRM process owner, said, "Yes, we received close follow up and coaching from regional health bureau and HRH project staff mostly every quarter. We discussed progress and challenges based on the follow up check list and we developed plans of action for further action

depending on our priority challenges. There is no such kind of trend in other trainings but the HRM training is better in this regard. If there is no close coaching and mentorship, then it may be difficult for us to translate theoretical knowledge and skills into practice."

Results and Learning

In this section of the report, we will use the HRM components in Table 2 (page 12) to analyze and describe the results and learnings that emanated from each of those thematic interventions. We also provide pertinent responses to topical issues by interview respondents.

HRM Capacity

None of the ambitious HRH investment plans outlined in the National HRH Strategic Plan for Ethiopia (2016-2025) and the BPR exercise can move forward without a strong and sustained human resource management capacity at all levels – including facility level. GOE health officials readily acknowledge the importance and urgency of building this capacity to realize the outcomes, objectives and actions in the HRH Strategic Plan, particularly Objectives 3 and 4 that focus on strengthening HRH leadership, governance and HRM capacity and optimizing the utilization, retention and performance of the available workforce. However, enhanced HRH engagement to translate the revised HRH Strategic Plan into clear implementation plans is not noticeably forthcoming and the coordination and communication mechanisms will need to respond accordingly. Moreover, the HRH TWG that was quite active until two years ago, with convening power and playing a key coordination role, has not maintained the same momentum, with some of its functions now happening at the quarterly HRH Forums.

Over the last four years, the project has supported the FMOH to plan and implement a massive in-service training program for HR officers across the country using the standardized HRM In-service Training Manual. So far, a total of **2,752** staff has been trained against the project goal of **2,660**.

Table 3 shows a regional breakdown of the numbers trained in all regions since the start of the training program in the 2013/2014 financial year to date.

Table 3: Number of HR Staff Trained: 2014 - 2017

Region	2014			2015			2016			2017			Grand Total		
	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T
FMoH	22	7	29	26	5	31	0	0	0	0	0	0	48	12	60
Oromia	102	41	143	141	40	181	125	49	174	145	49	194	513	179	692
Amhara	20	10	30	42	52	94	57	40	97	45	15	60	164	117	281
Harari	22	6	28	42	12	54	22	6	28	15	4	19	101	28	129
Gambela	23	3	26	48	0	48	0	0	0	17	2	19	88	5	93
Somali	44	5	49	30	2	32	23	7	30	26	4	30	123	18	141
Tigray	23	9	32	51	13	64	0	0	0	20	5	25	94	27	121
Afar	14	6	20	27	1	28	41	8	48	21	1	22	103	16	119
Addis Ababa	24	26	50	47	19	66	22	36	58	48	51	99	135	132	267
Ben- Gum	30	7	37	16	13	29	14	6	20	41	15	56	101	41	142

Dire-Dawa	25	7	32	38	23	61	19	4	23	14	7	21	96	41	137
SNNP	7	22	29	230	44	274	149	14	163	96	9	105	482	89	571
Total	356	149	505	738	224	962	472	170	641	488	162	650	2047	705	2752

M=male F=female T=total

The vast majority of the trained HR officers were from Federal Ministry of Health, RHBs, and Zonal and Woreda Health offices while relatively small number of HR staff working in the hospitals and health centers were trained. Most hold Bachelor Degrees in social sciences while some are qualified health professionals. It is problematic that they are not HR qualified, which seems to be a contributing factor to high turnover because the HR roles have limited career options for them compared to other organizational functions related to their education qualification or professional backgrounds. Also, Ethiopia has a dire shortage of health economists and HRH managers. To address this skill deficiency, the FMOH has collaborated with three local universities – two public and one private – to develop and deliver two special master's degree programs: one in public health with a concentration in HR management and the other one with a focus on health economics. These courses were jointly developed by the faculty of the universities and technical project staff. The curriculum is flexible and students can take the course while still working.

The HRM course was expected to increase the availability of postgraduate training opportunities in HRH management. However, out of the first class of 40 students completing the HRM focused-program, only four were deployed in HRM positions in the public health sector. The rest joined other health programs like HIV/AIDS and other disease focus departments at different levels of the health system. Since the project subsidized the cost of the training for the students, it could be argued, at least based on deployment statistics, that this was not a good return on investment. Thus, the HRH project collected data on graduate deployment and shared with FMOH HR Directorate, resulting in a letter from the Ministry to the RHBs to reverse deployment, and assign the new HR-qualified staff to the HR Support Processes in the regions. However, this reverse deployment is still a work in progress that the HRH project will follow up with to ensure priority is given to the HR Support Process in the deployment of future graduates.

In the meantime, the Regional Health Bureaus have also created and filled a large number of new HR positions. Compared with the lackluster approach the same HRM capacity challenge has been addressed in other countries in the region, this positive and aggressive action by the Ethiopian health sector is not only commendable but actually unprecedented. The project played a major advocacy role and successfully forged a multi-sectoral collaborative effort that brought together several government agencies that had responsibility and the resources required to exert action. This investment in multi-sectoral collaboration was evident in the ways the project approached the planning and implementation of several activities, including the initial HRM assessments that involved multiple agencies and not just the health sector staff – and it is a major success factor that explains what the project has been able to accomplish. To date, a total of 1,182 government salaried HRM officer positions have been filled (out of 1,836 available positions) across all regions. More than 1,300 positions were new, created with technical and financial support of the HRH project. In addition, 3,307 HR positions have been filled at

health facility level (out of 5,032 available positions) – see Table 4 below. Selected Best Practice 1, which is available as Annex 4 describes the process and some of the enabling factors that may have contributed to this successful outcome.

Table 4: HR Positions Available and filled at RHB, ZHDs, WoHos and Health facilities by the end of September 2017

HR Position available and filled (RHB, ZHDs and WoHos)												
Indicators	**Regional Health Bureaus**											
	A.A	**Afa**	**Amh**	**Ben-Gum**	**D.D**	**Gamb**	**Har**	**Oro**	**SNNP**	**Somali**	**Tigray**	**Total**
HR Position Available	79	39	210	56	5	57	15	758	315	203	99	1836
HR Position filled	47	9	62	39	4	38	15	567	251	59	91	1182
% HR Position filled	59	23	30	70	80	67	100	75	80	29	92	64
HR Positions available and filled (At Health Facilities level)												
	A.A*	**Afa**	**Amh**	**Ben-Gum**	**D.D**	**Gamb**	**Har**	**Oro**	**SNNP**	**Somali**	**Tigray**	**Total**
HR Position Available	621	119	1278	156	14	101	26	1582	835	216	84*	5032
HR Position filled	306	98	1216	82	11	82	26	858	343	207	78*	3307
% HR Position filled	49	82	95	52.6	79	81	100	54	41	96	93	66

Key: Names of the Regions A.A=Addis Ababa; Afa=Afar; Amh=Amhara; Ben-Gum= Benishangul-Gumuz; D.D= Dire Dawa; Gamb=Gambella; Har=Harari;Oro=Oromia; SNNP=Southern Nations, Nationalities and Peoples Region; S0m=Somali; Tig=Tigray. * Only hospitals (no health centers included)

HRM in the Ethiopian health sector is reportedly still not valued and this lack of recognition has contributed to high levels of attrition even among the new HRM staff. While no study has been conducted to ascertain the degree and causes of attrition for this cadre, anecdotal evidence points to a couple of push factors, including: low salaries, lack of a discernible career pathway with opportunities for promotions, and lack of access to further education and professional development.

However, the HRM units require more than just the HR staff to be fully functional and effective. They also need a regular recurrent budget. Through project advocacy efforts and multi-sectoral collaboration nearly all the RHBs have begun to address this budget issue and to take action in order to make their HRM units fully operational and able to fulfill their mandates. Selected Best Practice 2, which is available as Annex 5, describes the process and results of such an initiative in the remote Afar Region.

Human Resource Information System (HRIS)

For almost a decade, Tulane University Technical Support to Ethiopia, through funding from Centers for Disease Control (CDC), supported the FMOH to develop an extensive HRIS that can become the foundation of a platform for high quality, routine information on the health workforce. This kind of data/information is essential to support policy, planning and improved service delivery. The HRIS

software that Tulane developed embodies several principles that are embraced by the broader health information system community:

- Web-based (for remote access and ease-of-use)
- Role-based security (for access control and security of private data)
- Open source (for adaptability, extensibility, and cost emphasis on capacity development)

The system also has unique advantages in that it has been custom developed for the Ethiopian context including special adaptation for the Ethiopian calendar and processes developed through the BPR.

However, while the HRIS itself is open source (in that its source code has been made available to the FMOH) according to available reports and interviews with project staff, the underlying technology itself is not open source, but a relatively expensive suite of Microsoft server technologies, and there have been challenges in the regions - most of these are reportedly related to access to passwords.

The HRIS system has been installed in all the nine regions and two city administrations, but with widely varying degrees of functionality. For example, regions such as Harari, where the system was initially pilot-tested and adequate training was provided to the users, seem to be doing rather well. In other places, especially at the hospital level, the system is reportedly not working at all. A primary hospital HRM work process head from the Wolaita Zone, SNNPR described the HR data system as needing "serious attention and needs to be strengthened, while an HRM process owner from Dubti Hospital in the Afar Region said, "HRIS is not functional, FMOH started to install it this year but it's not working since the desktop computer that we use is old and often attacked by viruses." This state of HRIS sub-optimal functionality was also echoed by nearly all of the senior HR staff at FMoH, RHBs and the regional Project staff.

The foregoing context and background is important since USAID had instructed the HRH project to avoid any role conflict and duplication of effort with Tulane and instead play a complementary role by assisting the regions and health facilities where the HRIS has been installed with data entry, cleaning and reporting so there is a mechanism or capacity in place to regularly gather, analyze or use health workforce data to make planning and management decisions at any level.

As a result, the HRH project has supported the following activities to strengthen the functionality and utilization of HRIS:

- The HRM in-service training manual includes a dedicated module on HRIS and data-driven decision making.
- Offered logistical (transportation, IT) and financial support to selected regions to support workforce data collection and data entry.
- Developed and disseminated a standard data capture template that was institutionalized and used for summarizing routine data and upward reporting by the regions on a semi-annual and annual basis.
- Strong and sustained advocacy that led to the creation and filling of additional Health Information Technician (HIT) positions down to the facility level. These are full time government salaried staff.

- Offered additional data quality and data use training for HITs.
- Streamlined the personnel filing system to facilitate easier access and input of data into the electronic system, especially in Oromia and Amhara.

In regions and facilities where the system is functioning optimally, the reports generated by the system are being used to make new staff recruitment and deployment decisions as well as carry out routine execution of other basic HRM functions such as leave management, cleaning/auditing the payroll, and some key BPR processes. HR reports are also shared and discussed at the quarterly HRH Forums that are now regularly held in the regions.

Selected Best Practice 3, which is available as Annex 6, describes the process and remarkable results obtained by RHB leaders in the Somali Region by using HR data and reports to identify and eliminate ghost workers on the payroll.

Staff Motivation and Retention

In Ethiopia, there is concern that low health worker motivation and productivity may be undermining the success of ambitious health sector reforms that the government has introduced over the past decade, as well as disease-focused health programs, including those supported by global health initiatives such as The Global Fund to Fight AIDS, Tuberculosis and Malaria, and the United States President's Emergency Plan for AIDS Relief (PEPFAR). Previous studies on this topic have tended to be small scale, region or even facility specific, and not nationally or cadre representative enough in their sample sizes.

Additionally, most of those studies have found that health workers in Ethiopia tend to be dissatisfied with many aspects of their job, especially their salary and benefits, access to training opportunities, and chances of promotion, without exploring the determinants and consequences of health worker motivation on retention – especially the intent to leave or stay on the job. To address this gap in evidence and also contribute to policy decisions and strategic options on optimizing staff motivation and retention, MSH provided short term technical assistance in 2013 to conduct a preliminary rapid retention survey documenting staff motivation and retention in the country. This exercise generated a report that was shared with the FMOH and led to a comprehensive national retention study that took several months to plan and carry out across the nine regions and the two city administrations. The purpose of the study was to identify the factors that influence workforce job satisfaction, motivation and retention that will assist the Federal Ministry of Health/Regional Health Bureaus to make evidence-based policy and management decisions regarding the retention of health workers in the public health sector.

Specifically, the study sought to answer the following questions: a) How satisfied are health workers with their job and what factors could encourage them to stay or leave their job? b) What do health managers perceive to be important job satisfaction factors for their employees and what do they think

about their organization's success in achieving workforce satisfaction? A total of 1,354 health professionals (doctors, nurses, midwives, health officers, and anesthetists) from 232 randomly selected public facilities (107 hospitals and 125 health centers), and 217 managers were included in the study, which identified three broad priority areas of concern for health workers:

- Improve salary and benefits.
- Increase opportunities for professional development and promotion.
- Improve work environment such as physical settings and amenities; medical equipment and supplies, work place safety, leadership and management practices, performance management and supportive supervision, among others.

The FMOH incorporated the three areas into the newly revised National HRH Strategic Plan (2016-2025) and the RHBs also took active steps to focus on and improve work environment, performance management, and supervision challenges. Details on the methodology and findings of the study are described in Annex 7. Selected Best Practice 4 available as Annex 8 provides a detailed description of a successful set of work climate improvement interventions in Amhara Region.

Personnel Policy and Practice

One of the key findings of the HRM Rapid Assessments conducted in the first year of the project (November 2012- February 2013), was that HR policies and procedures guidelines were not available or readily accessible to HR staff and health workers. As a result, the existing recruitment, deployment and disciplinary practices were often not in compliance with existing policies. HR managers and staff depended on their intuition, wisdom or memory/past experiences, or expert opinions of their colleagues to make HR decisions.[4] Also, there was no formal or structured orientation and induction program for new employees and inconsistent application where the practice existed.[5] These distortions and deficiencies caused considerable frustration among health workers – a factor that was also corroborated by the findings of the National Retention Study.

In the last five years, with collaborative efforts between respective regional health and public service bureaus, coupled with technical and financial support from the HRH project, it was possible to enhance awareness, availability, accessibility and utilization of HR policy documents including proclamations, guidelines and standard operating procedures. The project and the Regional Health Bureaus gathered, organized and bound the policy documents in each region. These were printed (where e-copies were available) or photocopied, and disseminated to various institutions in all regions. By the end of June 2017, a total of 732 HR policy packages, bound as a single document, were distributed to all RHBs and their lower governance structures. For example, in Harari and Oromia RHBs, the documents were collected from the regional public service bureau and different directorates in the RHB, and properly

[4] Ibid #3

[5] Human Resource Management Assessments in Ethiopia: Synthesis Report, Management Sciences for Health, September 10, 2013

sorted and bound together prior to distribution. The Harari package includes: Harari regional government civil service proclamation number 34/1996 E.C; the Federal Government's civil servants' retirement proclamation number 214/2003; Harari regional government disciplinary and grievance policy guideline number 18/1999; community health insurance proclamation number 690/2010; health workers compensation and benefit packages; and other relevant HRM policy documents.

Likewise, in Oromia, all of the documents were bound together and a reference copy was placed at the Human Resource Development and Administration (HRDA) Support Process Office in the RHB, 18 Zonal Health Departments and 12 Town Health Offices. As intended, these documents are currently serving as references for the day-to-day HR activities as well as addressing HR policy related misconceptions (Figure 2). The purpose of binding the documents together into a single "HR Policy Package" was to deter HR managers or other staff from removing individual documents or even taking them away when they are transferred to other locations.

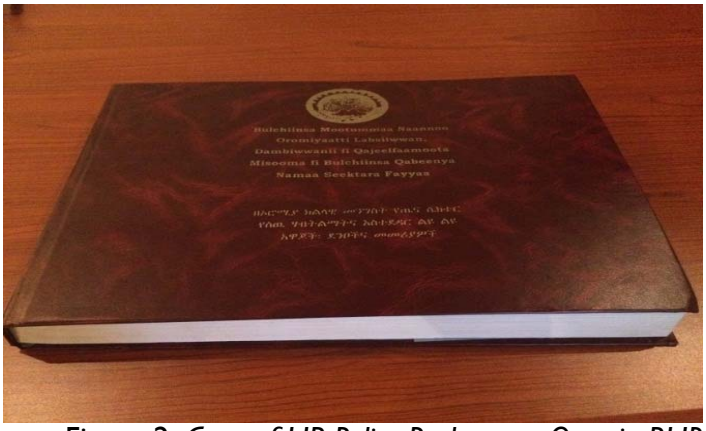


Figure 2: *Copy of HR Policy Package at Oromia RHB*

Moreover, the availability and utilization of policy documents was enhanced through targeted orientations or sensitization workshops on HR policy and procedure manuals, HRM in-service training, post HRM in-service training follow up visits, supportive supervision, as well as HRH forum and review meetings. The project also supported the preparation and distribution of employee orientation manuals at FMOH and the 11 RHBs. The employee orientation manual contains the key components of respective regional health care delivery systems and public service rules and regulations pertinent to the management of health workers.

Despite the progress that has been made, HR policy document shortages and limited expertise among HR staff to consistently apply HR policies and procedures, especially at woreda and health facility levels remain a lingering challenge. The inability of HRM staff to consistently and fairly apply HR policies to manage and support the health workers in their jurisdictions was mentioned as a gap by multiple interview respondents. As such, improving access to HR policy manuals and building HR staff capacity to improve consistent utilization and application of these policies and procedures at lower levels should be the focus of any future project activities, as it is important to tackle this critical skill gap.

Performance Management

HRH planners, policymakers and managers in Ethiopia recognize that qualified and motivated human resources are essential for adequate health service provision, and the HRM assessments revealed performance management as one of the major gaps in the workforce support system.

In this report, we consider performance to be a combination of staff being available (present and motivated) and staff being competent, productive and responsive. In this respect, the project made laudable efforts, in collaboration with RHBs and WoHos, to ensure all staff, especially at RHB and Woreda levels, had current/updated or new job descriptions and job expectations were clear, but very little else took place in respect to specific interventions to retain staff and improve their productivity, competence and responsiveness. Of note, although performance management was included as a module in the HRM In-service Training Manual, and staff received training on it, it did not seem to be prioritized for actionable programmatic implementation, apart from the work environment improvement activities described in the preceding sections of the report.

In Ethiopia and other low resource settings, most workforce performance problems can actually be attributed to unclear job expectations, inadequate supportive supervision, skills deficit, resource or equipment shortages or a lack of motivation. These causes are often rooted in a generally weak health system, low salaries, difficult working and living conditions and inappropriate training – all factors that are manifest in the Ethiopian health system.

Training and Staff Development

The project provided significant technical and financial resources to strengthen in-service training and capacity development for HR staff at all levels. When the project started, HR units in most regions, zones and woredas, where they exist, were underfunded and lacking staff with appropriate competencies in HR technical and leadership and governance skills to adequately fulfill their mandate and advocate for more attention to the health workforce. After the initial assessments, project staff worked directly with HR units or directorates to raise their profile, identity and visibility, and to improve the HR managers' technical, leadership, and governance skills, and advocacy and operational capacity, to achieve the following critical goals: (1) appropriate number of HR officer posts created, filled, and equitably distributed; (2) strengthen HR planning and management at all levels.

One of the key contributions the project made was to bring together the MOH, regulatory bodies, and training institutions, NGOs and partners to assess gaps and align training guidelines for HRM capacity development that led to the first-ever National HRM In-Service Training curriculum in the country, that was validated by the FMOH.

The HRM capacity development effort, as described in earlier sections of the report, is a major investment. The project adopted a traditional cascade training approach that rapidly transferred responsibility from project staff to government master trainers and regional trainers. This enabled the in-

service training program to reach thousands of staff across the 11 regions. All regions maintain basic paper-based training logs to keep track of who has been trained. The bulk of the training efforts are directed at improving the knowledge and skill base of the HRM staff, but some efforts are targeted at building the capacity for the organizational and logistical process necessary to successfully plan and administer such a cascaded staff development program.

However, there were no data to establish the cost efficiency of this cascade training model and whether it is sustainable – although there were reports that some RHBs used their own funds to support some of the training workshops for staff. A self-learning approach and other technology based options, where appropriate, could be explored to cut costs and expand coverage.

Of the 26 interview respondents who received this training, all of them rated it as "very relevant" to their overall efforts to strengthen the management of health workers and other staff, (on a scale of 1 to 5 in where 1 is "not very relevant" and 5 is "very relevant"). They also mentioned the sessions were participatory, with judicious use of small group discussions, role-playing, and plenary sessions.

These are some sample responses from the people who attended the training:

- *It was very useful and relevant to our work.*
- *Follow up coaching was very helpful.*
- *The program made us feel valued. Before, nobody invited us to any training.*
- *Before we received the training, HRM activities were run in a very traditional way. We now are very familiar about the importance of new staff orientation, staff motivation and retention, timely performance management appraisal for staff benefit, and the use of data-driven decision making.*
- *We are now able to clearly plan HRM activities and integrate into the overall institutional plan.*
- *The HRM training is the first of its kind and very helpful for our work.*

Moving forward, the RHBs, in collaboration with in-service training institutes, where they exist, should be the primary loci for HRM in-service training, quality control, advocacy, and providing resources to support staff development efforts. Each region should provide and support a pool of master trainers to initiate and coordinate the training on a regular basis and in the most cost effective manner and be able to respond to technical and logistical needs and conduct periodic evaluation and content updates.

Barriers and Enabling Factors

Respondents, at different levels of the system including project staff, also shared their perspectives on the barriers and enabling factors in the HRM strengthening process, as well as their recommendations for improving the process going forward.

Barriers

Respondents identified several challenges they experienced while planning and implementing the program. Aligning multi-sectoral stakeholders proved difficult for staff, who repeatedly spoke of the

time it took to get stakeholders on board and to ensure they remained committed to the process. One senior FMOH staff member stated: *"We knew we couldn't get far without the full support of FMOH, RHBs, Ministry of Education and Civil Service Bureaus, and keeping this momentum is still a challenge."*

An RHB staff member drew a link between challenges with stakeholder alignment and high turnover among HRM staff, and the direction and ownership of the HRM strengthening program overall: *"There are many stakeholders that need to be aligned well. But high turnover of HR staff and lack of proper direction from managers are some of the challenges we continue to face and should be improved."*

Several respondents mentioned the need for ongoing technical and financial support to keep the HRM strengthening process moving forward. The following challenges were raised by more than one respondent:

- *Lack of HRM Unit structure at zone and woreda levels.*
- *Low participation of zone and woreda political leaders and managers.*
- *Low knowledge and appreciation of HRM among woreda and facility level managers.*
- *Lack of adequate financial support to sustain the mentoring and coaching program at the current level when the project ends.*

Enabling factors

Perhaps one of the most critical elements that surfaced from the experiences of the project staff and key regional level respondents was the establishment of a multi-sectoral stakeholder approach to facilitate buy-in from key government agencies and partners.

An RHB project staff member said, "*During the initial HRM assessments, we made sure that we involved key decision makers from the RHB, regional civil service and regional finance bureaus in the whole process. They realized the challenges and worked together as a team to look for solutions."*

A senior FMOH staff member reported that having a senior champion like a State Minister was very beneficial to achieve buy-in and willing participation of stakeholders even at lower levels. The respondent explained that the State Minister, a person of influence, "*had worked on HRM issues before and understood the importance of HRM and fully supported the implementation of project activities, as well as communicated with high level stakeholders."*

Respondents also reported a number of enabling factors that facilitated the process of planning and implementing the HRM program. These could be summarized as follows:

- Prioritizing and pursuing partnerships that enable Ethiopian-led planning and capacity development – a notable example is the active leadership role played by the HRH TWG during the curriculum development process.
- Developing and utilizing a needs-based HRM in-service training curriculum. All of the respondents valued the importance of a comprehensive needs assessment as the best place to

start.

- Maintaining open communication and fostering a collaborative environment with HRH TWG, FMOH and RHB senior staff – this was considered key to gaining their participation and achieving buy-in.
- Adopting a problem-driven focus while ensuring all program approaches analyze and adapt to the local context, at whatever level is required – as evidenced in the post-training and mentoring activities.
- Using local trainers and applying a facilitative approach to capacity development and minimizing "project-led, do it for them" attitude or approach over an extended period.

A few respondents also touched on the importance of evaluating and learning from the HRM strengthening program, in order to benefit from the experience and continue to improve the process and the curriculum as well. An RHB staff member said, "*HRM training manual should include some concepts on HRH monitoring and evaluation and even some appropriate HRH indicators should be included.*"

Lastly, all of the respondents reiterated the importance of securing sustainable domestic financial support for the HRM strengthening process.

Discussion and Recommendations

The health workforce is one of the key non-financial resources that directly impact health system performance. In Ethiopia, despite the significant progress made under the USAID Strengthening Human Resources for Health mechanism, shortage of the critical cadres such as doctors, nurses, midwives, health officers, pharmacy and laboratory technicians and anesthetists in health facilities against a rising population; low performance and productivity of health workforce; and inadequate skills remain key system challenges. Other health resources including infrastructure and equipment are often dilapidated and are not fully functional despite great need.

Admittedly, there is also growing recognition that progress under targeted health interventions will not be sustained in the long-term if concurrent investments are not made to strengthen the health workforce – especially the system needed to plan, manage and support them. But most importantly, fostering transformational leadership and governance in the wider health system, especially at woreda and high volume facilities where most health workers are based will be instrumental to achieving accountability, responsiveness and improved development outcomes in health.

Moving forward, the significant successes of the HRH project need to be built on, scaled up and sustained. In this regard, there are a couple of big-picture strategic themes and parameters that warrant further discussion, exploration and action:

National HRH Strategic Plan: Timely implementation of the newly revised and updated National

HRH Strategic Plan, 2016-2025 that contains excellent strategic objectives and actions will require due consideration to the human resource management and technical capacities of government institutions and agencies. The project played a key advisory role and provided sustained technical assistance during an iterative and drawn out process of plan revision and finalization. There will be further development work required with RHBs and WoHos to cascade the planning, customization and implementation of critical elements of the plan to the decentralized levels, especially at facility level. More broadly, the FMOH needs to define the scope of the National HRH Strategic Plan implementation needs and the added value role of technical assistance – and that will enable further discussion and agreement. In other words, the HRH Strategic Plan should more explicitly guide and inform all future investments in HRH and HRM in the country than is the case at the moment.

***Professionalizing HRM*:** In many developing countries, including Ethiopia, most of the active roadblocks to changes in the health workforce policies and systems are 'human' and not necessarily technical- stemming from a lack of collaborative leadership, a problem-solving mindset and the effective alignment of stakeholders from several sectors to come together, plan, address challenges and foster change. The positive changes and progress that Ethiopia has made thus far can largely be owed to the realization among senior leaders that it is essential to establish multi-sectoral partnerships and foster strategic collaboration in order to create needed change in human resource management. The same spirit needs to be applied to push ahead the HRM professionalization agenda.

Senior FMoH and RHB staff that we interviewed indicated USAID and other development partners' support to provide additional, long-term technical assistance in HRH management will be appreciated. According to the Director of HR Development, Information and Planning at the FMOH, "*our biggest challenge is to professionalize HR Management so that HR officers can have a clear career pathway and we can attract and retain them.*"

The project has helped to lay the foundations for building HRM capacity at FMOH and RHB levels, but further down the system, deficiencies and weaknesses abound. In the long term, the quality and integrity of the HRM system in the public health sector can be improved only through professionalizing HRM. This will involve reformulating and consolidating the currently fragmented HR functions, and bringing all of the pieces together under the authority and influence of reinvigorated HR departments and units with expanded scopes, especially at woreda and facility levels. Additionally, HR staff must be HR-qualified specialists with clear career pathway and carrying out strategic HR functions, and not low-level generalists who are confined to playing a restricted and bureaucratic personnel administration role.

The FMoH has a taskforce that is currently collaborating with Federal Civil Service to develop a comprehensive job evaluation and grading (JEG) system for public servants, including health workers and HR staff. Once completed, this process would contribute to advancing the professionalization agenda for HR managers in the long term. Moving forward, professionalizing HRM and developing

institutional competencies in HRM, especially at woreda and facility levels, remains one of the most important unfinished agenda that requires attention to sustain the investments and positive gains that have been made thus far.

Human Resource Information System (HRIS): There is a direct correlation between successful workforce planning and management and the availability of a strong, reliable and well-functioning HRIS. As described earlier, the extensive investment in HRIS infrastructure – not through the HRH project – is at risk of being abandoned without continued support and effective transition to the GOE. Presently, in most places, the system is reportedly not functioning properly and it's not fully utilized. Apparently, many facilities and other parts of the health system are relying on manual registries and Excel spreadsheets to capture, manage, and report on workforce data. In all regions, the system has not been updated since initial installation and does not generate reports to answer HR planning and management questions or make workforce projections into the future. The data points needed to make workforce planning and management decisions are actually quite few. The functionality, utilization, and sustainability of HRIS can be enhanced by isolating those "must-have" modules in the current HRIS and incorporating them into an existing integrated system like HMIS that is linked to other service delivery systems, and which is already fully backed by the FMOH. That will decrease the labor and additional costs required to maintain a stand-alone HRIS; quickly aggregate and use data; and report on and analyze HR data as part of regular HMIS data review and analysis that goes on all the time. As a way forward, it is essential to conduct a technical analysis on the integration and interoperability of HRIS and HMIS. In other words, ownership and sustainability of HRIS lies in integration—not as a stand-alone system that seems to be also unsustainable in other countries where such a system has been installed.

Health Governance Structure: The project has made measurable strides in strengthening the institutional capacity of FMOH HRH Department and the RHBs, particularly in terms of bolstering their HRH policy, planning and stewardship functions. However, it is important to recognize that any investments in this realm have to be cognizant of the prevailing governance modalities resulting from Ethiopia's adoption of constitutional federalism and status as a Federal Democratic Republic; and the principle of mutual respect between Federal and Regional/State governments is explicitly stated in the federal constitution. Thus, national HRH policy and planning is subject to the dynamics of the political economy and ongoing interactions and creative tensions between the FMOH, RHBs and WoHos.

Of note, the Jhpiego-led project leadership team (all senior and experienced Ethiopians) has demonstrated an impressive ability to navigate the complexities and intricacies arising from this governance structure, and to doggedly advocate and optimize support for HRH across these different governance streams and across sectors as well. At the same time, discussions with senior project staff revealed that there was an operational and strategic assumption that if capacity is strengthened at FMOH and RHB levels, then these entities would, over time, be able to build or transfer capacity to the other lower levels of health governance such as WoHos and even health facilities.

However, there was no evidence or data to suggest that such "trickle down" or capacity transfer was actually taking place in discerningly significant ways or how long it may take for that to happen. As such, strengthening health governance at the lower end of the service delivery platform, especially in the context of HRH, should be considered a big part of the project's unfinished agenda.

What Difference Does Good HRM Make?: The quality of HRH monitoring mechanisms requires more attention. Even in low resource settings like Ethiopia, it is important to examine the potential contribution of organizational behavior research by investigating the relationship between investments in human resource management practices and effectiveness of patient care in hospitals. Even in developed countries, relatively little research has been conducted to explore these issues in health care settings.

For example, a study in England with a sample of 52 hospitals examined the relationship between the HRM system and health care outcome. The study revealed that, after controlling for prior mortality and other potentially confounding factors such as the ratio of doctors to patients, greater use of a complementary bundle of HRM practices had a statistically significant relationship with patient mortality – showing the importance of relevant HR management systems in hospitals as one important means by which to improve patient care. [6] While similar types of rigorous research may not be a priority or even feasible in the Ethiopian context, in the years ahead, it may be essential to conduct simple OR studies that explore the link between HRM investments and service delivery outcomes. The findings of such studies will help justify the value add and make the case for additional investments in workforce-related health systems strengthening.

Conclusion

In terms of the bigger picture, our analysis indicates that investment in the health workforce and corresponding policy development relies on some foundational pillars. These are: political leadership, coherent long-term HRH strategy, institutional capacity and inter-sectoral leadership and governance mechanisms. When all these pillars are aligned and effective, funding gets unlocked and plans get implemented. Based on our experience, it is also feasible to successfully strengthen HR management systems in low resource settings. Some of the critical success factors that we identified in the Ethiopian context, especially via the interviews, include:

- Notable leadership in addressing HRH - senior-level staff (at the level of directors and even ministers at FMOH, RHB) with deep appreciation and awareness of the importance of HR management for the delivery of good health and improved health outcomes.
- Heavy and sustained investment in multi-sector collaborative leadership, relationship management and engagement by senior and respected local project staff with deep

[6]Reducing Patient Mortality in Hospitals: The Role of Human Resource Management Available from: https://www.researchgate.net/publication/200130341_Reducing_Patient_Mortality_in_Hospitals_The_Role_of_Human_Resource_Management [accessed Oct 17 2017].

understanding of country's political economy – this could be the most important ingredient in the string of successes that this project realized.

- A committed and accountable HRH TWG that leads and owns the entire HRM strengthening effort.
- A comprehensive needs assessment exercise that brought together multi-agency teams to identify gaps in HRM components, skills and competencies, and a joint commitment to implement priority actions.
- A standard HRM In-service Training Manual, with facilitator guide, that is customized and translated into major local languages to meet the needs of the trainees, and used as basis for a unifying, country-led, explicit approach for institutionalized HRM capacity development.
- A low cost training delivery model that uses local trainers and government in-service training institutes as workshop venues instead of hotels or other costly outlets.
- A robust post-training follow-up mentoring and support program that stresses a problem-solving and action oriented learning approach to tackling challenges and achieving results.

Annexes

Annex I: Scope of Work

Background and Context

MSH is a member of a consortium of international and local Ethiopian partners implementing the USAID-funded and Jhpiego-led Strengthening Human Resources for Health (HRH) project. The overall purpose of the project is to improve the health status of Ethiopians by reducing infectious diseases and gender disparities in maternal and newborn mortality. The project seeks to accomplish this through evidence-based interventions directed towards improved human resources management (HRM) capacity and practices, increased number and competence of health workforce and improved capacity to generate and utilize evidence for HRH.

The HRH project has four intermediate result areas: 1. Improved human resources for health management; 2. Increased availability of midwives, anesthetists, health extension workers (HEWs) and other key non-clinical health workers; 3. Improved quality of education and training for health workers; and 4. Program learning and research conducted. MSH leads intermediate result area 1 (IR1): improved human resources for health management. The project started in May 2012, and has received a one year no cost extension until September 2018. MSH will conclude its activities on the project in June 2018.

Under IR1, the project has implemented several interventions over the last 5 years. The project has also documented and disseminated its interventions, achievements, challenges and lessons through a variety of reports and publications including quarterly reports, technical briefs, national retention study and manuscripts, infographic newsletter, and mid-term review and report. However, there are still opportunities to review the process and results of HRH Management, the success/facilitating factors and major challenges to draw lessons that shape implementation of HRM in similar settings.

Overall objective

The primary objective of this activity is to conduct an in-depth review of the suite of HRM strengthening interventions that have been implemented in the project and document summary results, challenges and lessons learned.

The interventions covered both HRM policy and practice areas that seek to improve health workers' performance and productivity and also impact motivation and retention. This kind of documentation serves several purposes: a) offers an opportunity to gain a better understanding of how different HRM interventions can improve performance, under which circumstances and for which groups of health workers, b) helps to inform/guide the transferability of results, and c) shares the results of the project's technical leadership as an implementer of effective HRM interventions and sustainable solutions in resource-poor settings.

Ummuro Adano, MSH Principal Technical Advisor, Global Technical Lead, Human Resources for Health, will lead this effort, working closely with the MSH Senior Technical Advisor, Shelemo Shawula

Kachara and his local team. The MSH performance, learning and impact (PLI) unit will provide input to the analytical framework developed to conduct the review and provide comments on the draft technical report. They will also support the development of strategic communications products that emerge from the exercise (e.g., selected best practices, lessons learned document, technical brief).

Specific activities:

1. Gather and review all relevant previous reports, publications and technical briefs.
2. Meet MSH and FMOH staff, gather their input and develop a simple taxonomy of HRM themes/function areas that succinctly capture the types of interventions that the project supported/implemented.
3. Use the taxonomy as the analytical frame for documenting the results, challenges and lessons learned for each HRM theme/function area.
4. Develop interview protocol and conduct interviews with HR officers in the regions, and staff of RHB, Woreda health offices and selected health facilities.
5. TDY for Ummuro Adano to Ethiopia for two weeks to carry out the above activities.

Outputs and deliverables:

1. Brief trip report, based on MSH or project-specific standard format.
2. A detailed technical report that includes key achievements, success factors, challenges, lessons and recommendations to improve the design and delivery of HRM strengthening interventions.

Annex 2: List of People Interviewed

	Name	Position/Title	Organization/Affiliation
1.	Dr. Getachew Tolera	Director, Directorate of HR Development, Information and Planning	FMOH, Addis Ababa
2.	Mohammed Hussein	Senior HR Policy Advisor	FMOH, Addis Ababa
3.	Akrem Abdusemed	HRM Technical Officer*	Oromia RHB
4.	Molla Belay	HRM Technical Officer*	Amhara RHB
5.	Bizeualem Gashaw	HRM Technical Officer*	Amhara RHB
6.	Abraham Yimenu	HRM Technical Officer*	Afar RHB
7.	Jemal Ibrahim	HRM Technical Officer*	Benshangul-Gumuz RHB
8.	Abraham Melaku	HRM Technical Officer*	Dire Dawa City HB
9.	Martha Alemayu	HRM Technical Officer*	Harari RHB
10.	Firew Tafesse	HRM Technical Officer*	Addis Ababa City Administration HB
11.	Farid Musa	HRM Technical Officer*	Somali RHB
12.	Asfaw Demissie	HRM Technical Officer*	Southern Nations, Nationalities and People's RHB
13.	Jock Bol	HRM Officer	Gambella RHB
14.	Haile Desta	HRM Technical Officer*	Tigray RHB
15.	Ben Tegegne	HR Focal Person	Addis Ababa City Administration HB
16.	Meskerem Bekele	HR Unit Head	Addis Ketema Sub-city Health Office
17.	Alem Wakenie	HR Unit Head	Zewditu Memorial Hospital, Addis
18.	Hannah Tilahun	HR Unit Head	Bela (Woreda 4) Health Center, Addis
19.	Imana Lelisa	HRM Coordinator	Wolisa Woreda Health Office, Oromia
20.	Tesfaye Dadi	Head, Employee Benefit Sub Process	Oromia RHB
21.	Naod Degefu	Zonal HRM Officer	South West Shoa Zonal Health Office
22.	James Bol Bel	Deputy Head	Gambella RHB
23.	Aromochan Ojulu	Head, Health Office	Gambella Town Administration Health Office
24.	Salih Luqud Adem	Senior HRM Officer	Afar Regional Health Bureau
25.	Alemseged Alula	HR Officer	Amibara Woreda Health Office, Afar Region
26.	Shewangizaw Abera	HRM Coordinator	Dire Dawa RHB
27.	Hela Humed	HRM Process Owner	Dubti Hospital, Afar
28.	Mesfin Bekele	HRM Department Training Coordinator	SNNP RHB HRM Work Process Department
29.	Bergene Durcho	Hospital HRM Work Process Head	Bolosso Bombe Hospital (Wolaita Zone) SNNP
30.	Tadewos Geta	HRM Work Process Head	Bolosso Sorre Woreda Health Office (Wolaita

			Zone), SNNPR
32.	Aynalem Lemma	HRM Work Process Head	Wolaita Zone Health Dept., SNNP
33.	Gimja Gido	HRM Work Process Head	Chencha Woreda Health Office, Gamu Gofa Zone, SNNP
35.	Tibebu Endale	HRM Work Process Head	Gamu Gofa Zone Health Dept, SNNP
36.	Asido Afa	HRM Work Process Head	Arba Minch Town Health Office (Gamu Goffa Zone), SNNP
37.	Gebreamlak Gebremariam	HRM Work Process Head	Tigray RHB
38.	Abdi Hussein	Regional HR Planning Officer	Somali RHB
39.	Mamo Tura	Hospital HRM Lead	Kebridahar Hospital, Somali
40.	Mustafa Ahmed	HRM Lead	Jijiga Woreda Health Office
41.	Zeine Abose	HRM Technical Advisor	HRH Project, MSH Addis Ababa
42.	Mesfin Kifle	HRM Technical Advisor	HRH Project, MSH Addis Ababa
43.	Dr. Shelemo Shawula	Principal Technical Advisor (HRM Team Leader)	HRH Project, MSH Addis Ababa
44.	Dr. Damtew Woldemariam	Chief of Party, Ethiopia HRH Project	Jhpiego, Addis Ababa
45.	Dr. Tegbar Yigzaw	Deputy Chief of Party, Ethiopia HRH Project	Jhpiego, Addis Ababa

**MSH staff seconded to the Regional Health Bureaus.*

Annex 3: Interview Guide

General Information

Date: _____

Interviewee's name: _____

Interviewee's title: _____

Interviewee's organization: _____

Interviewee's role/responsibilities in HRM strengthening: _____

_____

Interview Questions

We will begin by discussing the training that the HRH Project provided on HRM, using the standardized and FMOH-approved curriculum.

1. Over the last five years, did you or your staff attend any of the HRM training workshops?

2. How many trainings/workshops did you or your staff participate in?

3. What was the duration of the training(s)?

4. Were other stakeholders trained (for example, members of professional associations or health facilities)?

5. Did you receive certificates upon completing the training?

I would like you to use a rating scale to answer the following question. One (1) is "not very relevant" and 5 is "very relevant." You may also answer "N/A" if the question is not applicable.

6. On a scale of 1 to 5, how would you rate the relevance of the training(s) to your overall efforts to strengthen the management of your health workers and other staff?

7. Did staff who were trained receive coaching or follow up after the training?

Now, please use the same rating scale as before, where 1 is "not very relevant" and 5 is "very relevant." You may also answer "N/A" if the question is not applicable.

8. On a scale of 1 to 5, how would you rate the relevance of the coaching to the overall HRM strengthening process?

Now I will ask you some questions about different steps that may or may not have been part of the HRM strengthening process in your organization/zone/woreda.

9. Was a HRM needs assessment conducted to identify gaps in HRM in your region/zone/woreda?

***If "no" to question 11, skip question 12 and proceed to question 13.*

Please use the same rating scale as before, where 1 is "not very relevant" and 5 is "very relevant." You may also answer "N/A" if the question is not applicable.

10. On a scale of 1 to 5, how would you rate the relevance of the HRM needs assessment to the overall HRM strengthening effort or process?

11. Were core competency areas identified for HRM in-service curriculum content (e.g. based on the needs assessment)?

***If "no" to question 11, skip question 12 and proceed to question 13.*

Please use the same rating scale as before, where 1 is "not very relevant" and 5 is "very relevant." You may also answer "N/A" if the question is not applicable.

12. On a scale of 1 to 5, how would you rate the relevance of reviewing existing manuals, modules and other HRM resources to the overall curriculum development process?

13. Was there an established process for introducing the new HRM in-service course/program in your zone/woreda/region?

***If "no" to question 13, skip question 14 and 15, and proceed to question 16.*

Please use the same rating scale as before, where 1 is "not very relevant" and 5 is "very relevant." You may also answer "N/A" if the question is not applicable.

14. On a scale of 1 to 5, how would you rate the relevance of the phased approach (TOT, regional training etc.) to the overall implementation of the training program?

15. Considering the various steps that we have discussed, in your opinion, what is the "best" sequence of steps for conducting such a large scale training process?

Now I will ask you some questions about the "HRH Technical Working Group" and key stakeholders in the HRM strengthening process.

16. Was there a "Technical Working Group" to plan and oversee the development and implementation of the HRM in-service curriculum?

****If "no" to question 16, skip questions 17 – 18 and proceed to question 19.*

17. How were the members of the "HRH Technical Working Group" identified and designated?

18. What was the specific role of this TWG?

Please use the same rating scale as before, where 1 is "not very relevant" and 5 is "very relevant." You may also answer "N/A" if the question is not applicable.

19. On a scale of 1 to 5, how would you rate the relevance of the "Technical Working Group" to the HRM strengthening process?

20. Was the HRM curriculum co-created by key stakeholders (for example, from the Federal Ministry of Health, Federal Ministry of Education, Public Service, universities, training institutions, professional associations, NGOs, development partners, or health facilities)?

****If "no" to question 20, skip question 21 and proceed to question 22.*

21. How was this co-creation process managed (for example, was it formal or informal, pre-planned or spontaneous)?

22. Was agreement/buy-in at the highest level of decision makers achieved (for example, from the Federal Ministry of Health, Ministry of Education, universities, training institutions, professional associations, or health facilities)?

****If "yes" to question 22, proceed to question 23 and skip question 24.*

****If "no" to question 22, skip question 23 and proceed to question 24.*

23. What were the enabling factors to achieving buy-in?

24. What were the barriers to achieving buy-in?

25. In your opinion, how did decision makers/key stakeholders (*not* the members of the "TWG") influence the approval/validation of the HRM curriculum?

We will conclude with some questions about the HRM strengthening process overall.

26. What is the current status of HRM strengthening in your organization (for example, have adequate number of HR staff, have enough staff received training in the core curriculum, have vacant HR positions been filled, do all staff have job descriptions, has HRIS been updated/installed, has work climate improved?)

27. What are you doing or planning to do to make the program financially and technically sustainable?

28. In your opinion, what were the enabling factors for HRM strengthening overall?

29. In your opinion, what were the barriers for HRM strengthening overall?

30. In your opinion, is there something that either did not work or failed to meet your expectations?

31. Based on the experience in your setting, how do you think the HRM strengthening process could be improved?

32. Do you have anything else you would like to add that we have not yet discussed?

33. Do you have any questions for us?

Thank you very much for your time!

Annex 4: Selected Best Practice 1

Brokering Policies and Politics for Human Resources for Health: Intersectoral Collaboration Pays Off in Ethiopia

The way health workers are planned, managed and supported affects the quality of health services they are able to deliver. At the same time, adequate HRM capacity remains one of the critical missing factors in current efforts to meet the goals of national and global health system strengthening efforts, including global initiatives such as Ending Preventable Maternal and Child Deaths, 90-90-90 and AIDS Free Generation.

Countries require a critical mass of managers and leaders, at all levels, who view themselves as HR policy and knowledge brokers. They must take responsibility for creating links between various government ministries and with the different organizational actors who influence HR decisions—unions, registration bodies and education and training institutions. These strategic intersectoral linkages are essential for developing and maintaining a fair, equitable and effective HR system that provides opportunities for staff development and the environment in which motivation and job satisfaction can be enhanced. This in turn can result in improved quality of services.

Yet in many resource-constrained countries, including Ethiopia, there are several common and disturbing patterns:

- Government human resources for health (HRH) policies, practices and procedures that are bureaucratic and spread across different government entities.
- Many HR departments are poorly staffed or not staffed at all and are often weak and ineffective.
- Most senior health sector leaders do not view the HR department as a strategic partner.

Moreover, in Ethiopia, any efforts to strengthen human resource planning and management has to account for the prevailing political economy, especially the governance modalities resulting from Ethiopia's adoption of constitutional federalism and status as a Federal Democratic Republic (FDR). There are nine states (often referred to as 'regions') and two administrative cities representing the federation.

Thus, national HRH policy and planning is subject to the dynamics and ongoing interactions between the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs) Zonal Health Departments and Woreda Health Offices (WHOs), where the latter are responsible for managing and delivering primary health care (PHC) services.

MSH, as a key partner on the USAID funded Strengthening Human Resources for Health has made

specific technical contributions to shape and advance the human resources management (HRM) professional development and governance agenda. According to the project baseline survey conducted in 2013, only 51% of 87 Zonal Health Departments and 49% out of 835 Woreda Health Offices (districts) in Ethiopia had a functional HR unit and dedicated staff. This was perceived to be a major amplifier of the HRH crisis in the country.

To strengthen HRM in the health sector by improving HR governance structure and staffing at decentralized levels, the HRH project facilitated participatory HRM capacity assessments at Federal Ministry of Health and Regional Health Bureaus. The exercise was guided by HRM Rapid Assessment Tool (3rd edition) developed by MSH for health organizations. In the Oromia region (the largest region with the highest number of health workers), HRM capacity assessment was conducted by multidisciplinary teams of experts from the regional health, civil service and finance bureaus - the three sectors that have a significant influence on HRH – with the assistance of project staff. The teams identified and agreed that lack of governance structure and dedicated HRM staff was a major cause of human resource management challenges observed in the health sector, leading to delayed recruitment, mal-distribution and ineffective supervision. The regional health bureau developed a proposal for HRM organizational structure and staffing levels with an estimated budget to fill these positions; civil service approved and the finance bureau reviewed the proposed budget and solicited buy-in from the cabinet for approval. All of the 1,300 additional new HRM positions identified were permanent and fully salaried from government sources and more that 95% of new HRM positions were filled by June 2017.

Main Lessons: To the best of our knowledge, this is the first time the MSH HRM Assessment Tool has been adopted by a multisectoral team to conduct HRM capacity assessment and the findings used to plan and take actions. In Ethiopia, intersectoral action focused on improving human resource governance and planning for HRM staff positions was a major force multiplier that generated positive outcomes. Therefore, intersectoral planning, collaborative leadership and action is essential for a coordinated and financed response to the health workforce crisis, and the Ethiopia experience has policy level guidance and recommendations that can be applied in other low and middle income countries where HRM policy and planning functions and responsibilities remain ineffectively fragmented and scattered across different government agencies.

Annex 5: Selected Best Practice 2

Allocation of Recurrent Budget to Support Human Resources for Health Management Functions: Ownership in Action in Afar Region, Ethiopia

In Ethiopia and other developing countries, health workforce salaries and benefits account for a high proportion of the public sector annual recurrent budget assigned to the health sector. However, critical HRM functions such as human resource planning, staff recruitment, orientation and deployment, training and professional development, performance planning and supportive supervision are often not adequately funded or included in the regular budget allocation process. Such planning and financing oversight has resulted in inordinately delayed recruitment and deployment of health workers, inadequate supervision of staff and weak HR units that fail to meet their goal of ensuring the availability of an adequate number of well-qualified and motivated health workers, in the right places and who are ready to deliver quality health care services to the population.

The Afar Region, structured into five zones and 29 Woredas (districts), is one of the emerging regions located in the Northeast of Ethiopia. The region, inhabited by predominantly Muslim pastoralist community, has poor health and economic indicators – a challenge that is compounded by the harsh environment, poor infrastructure and a shortage of skilled health workers. For example, the region's contraceptive prevalence rate stands at 14%, the second lowest in the country, with a national average of 42%. [7]

The USAID funded Strengthening Human Resources for Health Project used MSH's HRM Rapid Assessment Tool to conduct a HRM assessment workshop that brought together a multi-agency team of 17 key Regional Health Bureau and Regional Civil Service staff. During the training, lack of regular funding to support the human resources for health unit was identified as a critical gap, amongst other challenges. The team utilized the consensus building exercise in the tool to discuss, reach consensus and agreed to prioritize and advocate for an operational budget activity for the HRH unit in the action plan that they developed.

"HRM was neglected for a very long time and we delivered very limited activities to support service delivery due to lack of sufficient non–salary budget to carry out necessary HRM functions," said Salih Lu'ugud, the HRM Process Owner at the Afar Regional Health Bureau about the challenge he faced this way. "The HRM assessment workshop helped us to clearly identify our gaps and propose remedial actions."

After the workshop, Salih presented the action plan they had developed to the senior leadership team at the Regional Health Bureau, and elicited the support of the other workshop participants to help him advocate for his priority activity in the action plan. This resulted in an allocation in the amount of

[7] Ethiopia Mini-demographic and Health Survey, 2014

150,000 ETB (USD 7,500) to support HRM related activities in 2013/2014 fiscal year. This amount was doubled the following 2014/2015 fiscal year and has since been held at a steady rate, demonstrating the continued commitment of the RHB to efforts to strengthen routine HRM practices in the region.

Regular and reliable availability of a non-salary budget allocation has enabled the Human Resources Development and Administration Support Process to improve the speed and efficiency of recruitment, orientation and deployment of health professionals at various levels; support planning and delivery of in-service training for HR managers and staff; improve coordination of in-service training for health professionals; and support regular supportive supervision and performance review meetings at regional and sub-regional levels for improved access and quality of health care. These inputs will provide strong support and motivation to the health workforce that is providing critical HIV/AIDS, maternal child health, malaria, and other services to the Afar population.

Annex 6: Selected Best Practice 3

Somali Region Improved Access to Services by Strengthening Human Resource Management Systems

Weak human resource management systems have been identified by a number of studies over the years as a major challenge that remained unaddressed within Ethiopia's health workforce crisis. The country's Regional Health Bureaus are taking several steps to improve access to high-quality health services by focusing on the health workforce and, in particular, the systems used to manage these valuable assets. The USAID funded Ethiopia Strengthening Human Resources for Health (HRH) Project (2012-2018) is also helping the Government of Ethiopia refine the HR management systems needed to create an enabling environment for health workers to perform effectively. This includes training a cadre of skilled HR managers at all levels that can develop, implement, and manage the necessary HR functions. MSH is a key partner on the project and responsible for providing technical assistance and support to strengthen HR management systems.

The Somali Region in Eastern Ethiopia comprises nine zones and has a population of approximately 4 million, the majority of whom are pastoralists and agro-pastoralists with limited access to good quality health services, particularly for women and children. In this region, one important outcome has been the discovery of a large number of people on the payroll who were no longer working. MSH staff provided technical assistance to the Somali Regional Health Bureau in the capital city of Jigjiga to conduct a comprehensive HRM assessment that included a review of the HR information system and payroll system which revealed 423 "ghost workers"-- individuals who receive a salary but are not actually working – and costing the bureau approximately 24,237,900 Ethiopian Birr per year (more than $1.2 million USD.)

In response to the findings, the RHB worked with the regional finance and economic development bureau and eliminated all of the ghost workers in the initial phase of payroll cleanup and decided to reinvest the savings to strengthen and scale up the HRM governance system at Zonal, Woreda (district) and facility levels to safeguard the integrity of the system and eliminate waste. This included creating and filling 180 HR officer positions in its health offices and one position in each health center. The remainder of the savings was used to build new health centers and to hire additional nurses and health officers to increase access to health services at the primary health care level, especially family planning, safe motherhood, immunization and other health prevention services.

"We had a major problem with ghost workers and without a strong and effective HRM system, we simply cannot meet our health goals in this remote region which already has so many challenges," said Ferrid Musa, Regional HRH Management Officer and technical associate at the Regional Health Bureau.

Annex 7- Job Satisfaction and Retention of Health Workers in Ethiopia: A Technical Brief from a National Survey

BACKGROUND

Ethiopia has made significant improvements in many health indicators in the last decade. Under-five mortality has decreased by two thirds from the 1990 baseline. Recent reports have also shown that Ethiopia is on track to achieve Millennium Development Goal (MDG) 5 (combat HIV/AIDS, malaria and other diseases). Accordingly, new HIV infections have dropped by more than 90%. No major epidemics reported in the country since 2003/2004 and malaria-related admission rates are projected to decrease by 50–75% by 2015 in Ethiopia based on a study in 41 hospitals[8]. According to Global TB Report by the World Health Organization[9], Ethiopia has achieved all the three targets set for tuberculosis prevention and control. Mortality and prevalence due to Tuberculosis has declined by more than 50% and incidence rate is falling significantly[10]. The decline in mortality was profound since 2005 on wards partly due to TB/HIV collaborative activities including initiation of ART service for free. The contraceptive prevalence rate (CPR) has increased from 29% in 2011 to 42% in 2014[11]. This progress is mainly due to the coordinated efforts and substantial investment of the government, partners and the community at large to strengthen and expand primary health care.

At the same time, the health system is limited by a shortage of health workers, an inequitable distribution of the available health workforce between urban and rural as well as public and private sectors, and weaknesses in human resource management including health workforce planning, acquisition, maintenance, motivation, performance management and productivity. These issues need to be addressed in order to sustain the improvements in health indicators and continue to make strides in the overall health system strengthening.

THE STRENGTHENING HUMAN RESOURCES FOR HEALTH PROJECT

The *Strengthening Human Resources for Health (HRH) Project* is a five year (2012–2017) bilateral cooperative agreement, funded by USAID, with the overall goal of improving the human resources for health status in Ethiopia. To achieve this goal, the JHPIEGO-led consortium of Management Sciences for Health (MSH), the Ethiopian Midwives Association (EMA), the Ethiopian Association of Anesthetists (EAA), and the Open University (OU) are working closely with the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), Food, Medicine and Health Care Administration and Control Authority (FMHACA), Federal Ministry of Education (FMOE), Higher Education Relevance and Quality Agency (HERQA), Universities and

[8] World Malaria Report 2014, W/HO. PP 50 (as quoted in Health Sector Transformation Plan-HSTP 2015/16-2019/20
[9] Global TB report, WHO 2014: pp 50(Table 3.1)
[10] Global TB report, WHO 2014: pp 50(Table 3.1)
[11] Federal Ministry of Health (2014): Health Sector Development Program (HSDP)-IV Woreda-Based Health Sector Annual Core Plan Ethiopian Fiscal Year (EFY) 2007 (2014/2015), page 1. November 2014. Addis Ababa. Ethiopia

Regional Health Science Colleges. Together, they are addressing challenges related to health professional education and training, including the quality of pre-service education (PSE) and in-service training, human resources planning, management, motivation and retention, health workforce regulation and partnerships for human resources for health in the country.

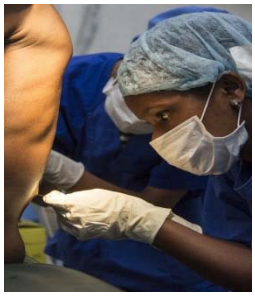
JOB SATISFACTION AND FACTORS AFFECTING HEALTH WORKERS MOTIVATION AND RETENTION IN ETHIOPIA'S PUBLIC HEALTH SECTOR

Over the last few years, the health and education sectors in Ethiopia have collaborated to roll out an unprecedented expansion of health workers' education and training capacity in the country. Since

motivation along with competence and resources is a prerequisite for effective health worker and health system performance, understanding factors that affect motivation is important. However, there is a limited amount of literature and evidence on job satisfaction, motivation and retention[12] of health workers in Ethiopia. Hence, it is essential to develop the evidence base on the factors that can improve the health professionals' desire to stay or those that drive them away from the profession. Such an evidence base forms a solid foundation to design and implement appropriate motivation and retention strategies to create a high performance and stable health workforce.

STUDY PURPOSE AND OBJECTIVES

The purpose of the study was to identify the factors and approaches to workforce job satisfaction and retention that will assist the Federal Ministry of Health and Regional Health Bureaus in Ethiopia to make evidence-based policy and management decisions to improve motivation and retention in the public health sector. Specifically, the study sought to answer the following questions:



a) How satisfied are health workers with their job and what factors could encourage them to stay or leave their job?

b) What do health managers perceive to be important job satisfaction factors for their employees and what do they think about their organization's success in achieving workforce satisfaction?

METHODOLOGY

A cross sectional study employing both qualitative and quantitative data collection methods was conducted from May 28 to June 14, 2014 in the nine Regional States and 2 City

[12] Job Satisfaction and Its Determinants among Health Workers in Jimma University Specialized Hospital, Southwest Ethiopia - ResearchGate. Available from: http://www.researchgate.net/publication/221878479_Job_Satisfaction_and_Its_Determinants_Among_Health_Workers_in_Jimma_University_Specialized_Hospital_Southwest_Ethiopia [accessed May 4, 2015].

Administrations of Ethiopia. A total of 1,354 health professionals working in 227 health facilities (hospitals and health centers) were included in this study. The study population included nurses (n = 424), medical doctors (n = 374), anaesthetists (n = 252), midwives (n = 177) and health officers (n = 127). Besides, 217 health managers FMoH, Regional Health Bureaus, Zonal Health Departments and the sampled health facilities were included in the study.

Quantitative data were collected from health professionals and health managers using structured interview. In-depth interviews of 63 health managers and senior health workers were also conducted using a separate semi-structured interview guide to gather data on existing promising job satisfaction and retention practices. Quantitative data were analyzed using SPSS 20.0 (IBM Corporation) to generate frequencies, percentages and other descriptive measures. Bivariate analysis was conducted to examine the relationship between the outcomes of interest and several explanatory variables. Recorded qualitative data were transcribed and coded in Atlas to generate query reports which were presented thematically.

GENERAL FINDINGS OF DATA FROM HEALTH WORKERS

The analysis described in the 'Methodology' section above, resulted in two "Outcomes of Interest" or areas of significance in predicting high levels of contentment with current job and retention of staff. These are 1) Job Satisfaction and 2) Intention to leave in one year. In this study, overall motivation and job satisfaction among the target cadres of health workers was low.

- Rates of overall job satisfaction were as follows: 64.4% for midwives, 61.1% for nurses, 48.8% for health officers, 42.5% for anesthetists, and 39.2% for medical doctors.
- 49.4% of all professional health workers were planning to leave their current position in the next one year.
- Satisfaction with salary and benefits was particularly low amongst all the cadres
- Low pay, the high cost of living, and poor access to higher education were the three most important factors in decision to leave their current job.

- Working and living conditions such as workload, work-related risks and hazards, equipment and supplies, water and power supplies at work and home, access to children's school, safe transport from home to work and vice versa were deemed unsatisfactory by all health professionals.
- Limited opportunities for in-service training and career promotion, infrequent supervision, performance support and feedback negatively affected the levels of job satisfaction while recognition and appreciation by co-workers and community have increased the levels of health worker job satisfaction.
- More than 70% of medical doctors, nurses, anesthetists and midwives, and 60% of health officers responded that their job is a good match for their skills.

- More than 85% of each category of health professionals considered themselves part of the local community that they serve.

GENERAL FINDINGS FROM HEALTH CARE MANAGER

In-depth interviews with leaders and managers of selected health facilities and administrative units that were implementing a range of motivation and retention schemes revealed the following observations:

- Functional private wings were a source of extra income except when they were poorly administrated.
- Need-based and fair access to in-service training and merit-based access to professional development opportunities such as further education were reported by both health workers and managers as one of the most successful ways to improve job satisfaction and retention in public health facilities.
- Good governance and conducive working and living conditions increased job satisfaction and retention. This included staff orientation, transportation and internet services, and a functional grievance committee.
- Public recognition of contributions was also found to be successful.
- Rapid implementation of incentive packages allowed by the government was critical.

Study findings indicate that dissatisfaction with salaries and compensation is a key factor in retention, but alone, it is not enough to retain or enhance job satisfaction. The study also showed that job satisfaction is higher among older workers with higher qualifications. This is consistent with other studies, and not specific to Ethiopia. However, the average age of a health care worker in this study was 29 years, unlike other countries in the region. A young workforce can be seen as an opportunity since it can stay in the workforce for longer period of time before retirement. It however can also present challenge it needs more experience, supervision and technical support. In this regard, supervision and professional development are crucial, as are working and living conditions.

RECOMMENDATIONS

The study identified three broad priority areas of concern for all health workers:

1. Improve salary and benefits.
2. Increase opportunities for professional development and promotion
3. Improve work environment such as physical settings and amenities; medical equipment and supplies, work place safety, leadership and management practices, performance management and supportive supervision among others.

The details in each of these priority areas are outlined in the full report. (The full report will be disseminated soon.)

It is imperative for the government to use these findings to develop and implement appropriate policy options and strengthen the human resource management systems necessary to support them. Doing so will ensure a return on the investment being made to train new health workers in order for them to improve the health and wellbeing of the people of Ethiopia.

Annex 8: Selected Best Practice 4

Combining Work Climate Improvement with 5S-KAIZEN Total Quality Management Process to Improve Organizational Performance and Quality of Care in Amhara Region, Ethiopia

Work climate is the "weather of the workplace." Just as the weather can affect daily activities, the work climate influences employee behavior and work-group climate influences results. In the health sector a good work-group climate leads to improved service delivery and to better health outcomes.[13]

Health worker job satisfaction surveys and staff exit interviews conducted periodically in the Amhara Region of Ethiopia consistently showed that overall satisfaction with the work place environment was low. This was also corroborated by the findings of a national workforce retention study that was conducted in 2014 by the USAID-funded HRH Strengthening Project. Apart from low salary, health workers cited poor work environment, lack of management support, coupled with inadequate equipment and medical supplies as among the major factors that affected their job satisfaction and motivation in the region. As a result, many staff left or had intentions to leave their positions.

As part of its collaborative effort to improve HR management capacity in the Amhara Regional Health Bureau (ARHB), the Human Resources for Health (HRH) Project assisted the ARHB to improve work environment in order to enhance staff motivation and performance and improve access to quality health services for mothers, newborn and children as well as the general population. ARHB was already planning to implement a government supported quality improvement program using 5S-KAIZEN Total Quality Management (TQM) approach in a few pilot health facilities. The goal of the program is to develop compassionate, caring and respectful health providers – one of the strategic

[13] "Managers Who Lead: A handbook for improving health services". Management Sciences for Health, 2005

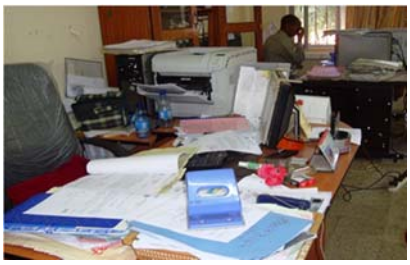
pillars in the National Health Sector Transformation Plan (HSTP). In May 2015, the HRH Project provided technical and financial support to ARHB to conduct training on 5S-KAIZEN Total Quality Management (TQM) approach and initiate pilot implementation of continuous quality improvement. A total of 85 staff drawn from RHB and health facilities received training in principles, approaches and application of 5S- KAIZEN. The training was linked to experience-sharing/benchmarking and participatory planning of interventions to address a specific challenge in the participants' work environment. At facility level, the main focus of 5S-KAIZEN TQM is to reduce wastage and increase efficiency and productivity of health workers and managers by creating organized, clean and safe work spaces, both for health workers and their clients.

Design and implementation of 5S-KAIZEN TQM was combined with MSH's work climate improvement approach and based on the baseline information collected, analyzed and documented through participatory assessment of the work place, and site observations and customer interviews. Key additional interventions included simple, low cost activities that would create a secure, worker-friendly, quality-promoting environment including:

- Uncluttered, comfortable work setting
- Improved signage within the facility
- Well laid out notice boards
- Efficient waste disposal measures

In the HRM department, interventions included: improving office layout, disposal of materials not for immediate use; proper labelling assets/inventory, organizing and shelving of personnel files. This created sufficient space for free and comfortable movement of HR staff and their clients - health workers.

Dramatic improvements observed at the HRM Department of the RHB, encouraged ARHB to scale up work climate improvement and 5S-KAIZEN TQM to other departments in ARHB and 17 hospitals in the region. The overall goal was to increase and sustain staff morale, motivation and performance so that they can provide quality health services in maternal and child health, prevention and treatment of HIV and AIDS, tuberculosis and malaria. Post-interventions' employee satisfaction surveys showed a significant increase in overall satisfaction with work environment.



BEFORE INTERVENTION

POST-INTERVENTION