HUMAN RESOURCES FOR HEALTH REFORMS IN ETHIOPIA

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HRH Efficiency Problems

Major HRH challenges prior to the reform

Low Density:
- Ethiopia ranked in the lowest quintile among African nations in terms of density of health care personnel, with 0.3 physicians and 2 nurses per 10,000 population.
- Ethiopia is one of 57 countries listed by WHO as having a health workforce ‘crisis’

Uneven Distribution:
- uneven distribution of the limited health workforce among and within districts and an inappropriate use of available skills

Poor Skill Mix:
- unavailability of key types of HRH categories who could deliver priority interventions especially in the areas of Maternal and Child Health

Training alignment:
- Curricula not aligned with the health sector need
Reform Elements

Supply Side Interventions Focusing on:

- Creating the new cadre of health extension workers to be deployed in health posts to address the family and community levels of demand.

- The ‘flooding’ strategy to produce the necessary middle level professionals for deployment to the increasing number of health centres.

- Implementing task shifting for specialised tasks that could not be covered through the training programmes of the flooding strategy.

- Expanding the capacity of the country to produce health professionals, especially general practitioners, by introducing innovative pre-service training programmes.
Reform Elements: Step-wise Introduction of Reforms

- **HEWs**
  - Community and Family Level Service Need with the target of achieving universal coverage of 2 HEW for each HP by end of HSDP III
  - Address the huge gap in access to PHC services to the rural population
  - Expand coverage of high impact interventions

- **Mid-level health workers**
  - Meeting minimum staffing requirement for EHSP at PHC Facility (HC and Primary/district hospital)

- **Medical Doctors**
  - Meeting projected medical doctors requirement by 2015
Reform # 3: New Innovative Medical Education....

Current & projected number of medical doctors

- Current
- Projected
Reform # 1: Institutionalization of Community Health Service-HEP….

<table>
<thead>
<tr>
<th>Program Characteristics</th>
<th>Gain inefficiency and effectiveness</th>
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</table>
| Evidence Base Intervention packages to address identified service need at community level | ➢ Relevant to community needs as it focuses on 75% of health burden in the country  
➢ Addition of new interventions as new evidence develops such as ICCM |
| Institutionalization of community level service by deploying salaried HEWs | ➢ Increased PHC at lower cost as HEW require lower fixed cost to train, maintain and motivate as compared to conventional health workers  
➢ Skill mix optimized by using generalist community level workers (HEW) |
| Use of Health Development Army | ➢ Enhance community involvement and empowerment through participating in identifying their need, suggesting solutions, implementation and follow up |
Reform # 1: Institutionalization of Community Health Service-HEP....

<table>
<thead>
<tr>
<th>Program Characteristics</th>
<th>Gain inefficiency and effectiveness</th>
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<tbody>
<tr>
<td>Recruitment from same community</td>
<td>Improved retention and hence reduce inefficiencies related to attrition</td>
</tr>
<tr>
<td></td>
<td>Acceptance by the community</td>
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<tr>
<td>Female Community workers with few exceptions</td>
<td>Effective delivery of maternal and child health interventions through easier communication with mothers</td>
</tr>
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<td></td>
<td>Culturally more acceptable</td>
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<tr>
<td>Contextualization (Training three types of HEWs (agrarian, urban and pastoralist))</td>
<td>Addressed varying levels of development and health needs across various regions</td>
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Major Achievements
Achievement # 1: Improved HRH Availability

Comparison of HRH availability for key HRH Categories before & after the reform

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<thead>
<tr>
<th></th>
<th>1994 (end of HSDP I)</th>
<th>2011/12</th>
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<tbody>
<tr>
<td></td>
<td>Total No</td>
<td>Ratio to Total No</td>
</tr>
<tr>
<td></td>
<td>Population</td>
<td>Population</td>
</tr>
<tr>
<td>Medical Doctors</td>
<td>1,888</td>
<td>1:35,603</td>
</tr>
<tr>
<td>Health Officer</td>
<td>484</td>
<td>1:138,884</td>
</tr>
<tr>
<td>Nurse</td>
<td>11,976</td>
<td>1: 56,13</td>
</tr>
<tr>
<td>HEW</td>
<td>35347</td>
<td>2807</td>
</tr>
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Achievement # 1: Improved HRH Availability…

Improved availability of key HRH Categories for Improving Health outcomes
Achievement # 1: Improved HRH Availability...

Graduates over the year

Students on pipeline
Achievement #2: Improved Health Outcome

- Number of studies have documented the effectiveness of these initiatives in improving access to services and health outcomes.
- Improved service availability and outcome to the main cause of poor child health.
  - 95 percent of health posts were treating severe acute malnutrition.
  - Integrated community case management of pneumonia, malaria, diarrhoeal diseases, and severe acute malnutrition was scaled up and offered in 79 percent of health posts by 2013.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>2004</th>
<th>2011</th>
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<tr>
<td>Contraceptive Acceptance Rate</td>
<td>23%</td>
<td>62%</td>
</tr>
<tr>
<td>Antenatal Care</td>
<td>41%</td>
<td>82%</td>
</tr>
<tr>
<td>Skilled Delivery</td>
<td>10%</td>
<td>17%</td>
</tr>
<tr>
<td>Postnatal Care</td>
<td>16%</td>
<td>42%</td>
</tr>
<tr>
<td>Access to Improved Sanitation</td>
<td>29%</td>
<td>86%</td>
</tr>
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Achievement # 3: Reduced Cost & Improved Distribution

Reform #1 &# 2

- Decreased Training Cost as the duration of training is significantly shorter than conventional health worker training programmes
- Decreased wage bill
- Enhancing allocative efficiency among regions in terms of the distribution of human resources, using the ratio of highest to lowest health worker density as an efficiency indicator.
- Health extension workers are the only cadres for whom the ratio of health workers to population is relatively similar among the regions
Reform # 3: Potential for Improving

Geographic Distribution
- The ‘rural pipeline’ (regional quotas for applicants from disadvantaged regions);
- The location of many of the new medical schools outside regional capitals;
- The emphasis of the curriculum on family and community medicine.

Educational Quality
- The move from the traditional type of medical education to new competency- and problem-based learning approaches is expected to improve educational quality and hence the competency of the graduates.
Conclusion and Lesson Learnt

HRH reforms can improve efficiency through

- Improved Availability of Health Workers along the continuum of care
  - Family and community level Services:
    - Improved Availability of Health Workers for PHC Facility Based services
    - Improved Availability of Medical Doctors
  - Improved Distribution of Health workers
- Decreased cost
- Improved Health Outcome
  - Contribution to reaching MDGs
Conclusion and Lesson Learnt

Enabling/Success Factors
- political and managerial will to implement the reform
- Clear Career Development plan to enhance retention and motivation
- Regulatory Framework that delineates scope of practice for new categories
- Regular follow-up of the reform by top management
- Strong monitoring and coordination mechanisms for training and deployment
- Alignment of funding by government and development partners with agreed priorities

Further Research
- Developing standardized guideline and methodological tools for quantitative measurement of efficiency gain from HRH and other related health reforms