Ethiopia: Taking forward action on Human Resources for Health (HRH) with DFID/OGAC and other partners.

Jim Campbell & Dykki Settle

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Abbreviations and Acronyms

CoAg  Cooperation Agreement
CAP   Country Assistance Plan (for DFID)
COR   Country Operational Plan (for PEPFAR)
COPRS  Country Operational Plan Reporting System
CDC   Centres for Disease Control and Prevention
DFID  Department for International Development
FMCH  Federal Ministry of Health
GAVI  Global Alliance for Vaccines and Immunisation
GFATM Global Fund for AIDS, TB and Malaria
GHWA  Global Health Workforce Alliance
GoE   Government of Ethiopia
HEP   Health Extension Programme
HEW(s) Health Extension Worker(s)
HPN   Health Population and Nutrition - Donors Group
HRD   Human Resource Development
HRH- AF Human Resources for Health - Action Framework
HRH   Human Resources for Health
HSDDP III Health Sector Development Plan (2005/6 – 2009/10)
HSS   Health Systems Strengthening
IHP+  International Health Partnership (Plus)
INGO  International Non-Governmental Organisation
MoU   Memorandum of Understanding
NGO   Non-Governmental Organisation
OGAC  Office of the US Global Aids Coordinator
PEPFAR President’s Emergency Programme for AIDS Relief
PBS   Protection of Basic Services
PHC   Primary Health Care
RHB   Regional Health Bureau
SBS   Sector Budget Support
TBA   Traditional Birth Attendant
TOR   Terms of Reference
UHEW(s) Urban Health Extension Workers
USAID United States Agency for International Development
WB    World Bank
WHO   World Health Organisation
WHOAs Woreda Health Offices
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For further information please contact:
Jim Campbell, Director, ICS Integrare: jim.campbell@integrare.es
Dyikki Settle, IntraHealth International, Inc: dsettle@intrahealth.org
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1 Executive Summary

1. **Background.** In response to the critical Human Resources for Health (HRH) shortages in Africa, the UK Department for International Development (DFID) and Office of the US Global Aids Coordinator (OGAC) responsible for the President’s Emergency Program for AIDS Relief (PEPFAR) have been in discussion with a number of African countries (Ethiopia, Kenya, Mozambique and Zambia) to develop strategies and country level actions. There is high level political support for this process in the UK and US, highlighted by the joint announcements of President George Bush and Prime Minister Gordon Brown in April and June 2008 and the calls to action at the **UN High Level Event on the MDGs** in September 2008.

2. DFID and OGAC agreed to field a team of two consultants to work with their respective leads in Ethiopia in the period 24 April -09 May, 2009. The main objective of the assignment was to facilitate agreement and document current flexibilities of funding streams for HRH, building on existing work and within national frameworks for priority actions on HRH.

3. **Ethiopia:** is one of 57 countries listed by the World Health Organisation (WHO) as having a health workforce ‘crisis’. The World Health Report 2006 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 utilised to categorise a ‘crisis’.

4. Aside from this stark WHO estimate on density, there is evidence of: poor working conditions; shortages across many other health cadres; geographical mal-distribution of the workforce with a heavy bias in urban centres; a growing non-state sector (comprising non-governmental organisations and private for-profit providers) which reportedly impacts upon attrition, the poor retention of the public sector workforce (especially for physicians) and dual-practice; poor human resource management; inconsistent standards in training and examinations, and; imbalances in gender across the professions. Commentators have described Ethiopia as having an insufficient health workforce ‘to absorb, apply and make efficient use of the interventions being contemplated through the various initiatives related to child survival, safe motherhood, HIV/AIDS [and] malaria’.

5. There are three key documents in respect to HRH plans and strategies. The Third Health Sector Development Plan (HSDP III) 2005/6 – 2009/10 establishes the overall direction and subsequent priorities. A Health Human Resource Development Plan (2006-10) was produced in 2006 and a new 12-year ‘**HR2020 Strategy**’ (2009-2020) has been under development in the last 12-15 months alongside the government’s Business Process Reengineering (BPR) exercise. There is notable leadership and recent success in addressing human resources for health.

6. **A new 12-year ‘HR2020 Strategy’ (2009-2020):** The **HR2020 Strategy** was unfortunately not available to the assignment team during the visit. However, interviews with key FMOH representatives, including Dr. Kebede Worku, the State Minister of Health, did offer considerable insights into the content and ambition of the **HR2020 Strategy**. Of note is the consistency with the existing policy statements and activities originating from HSDP III and the HHRDP.

7. The non-consultative process through which the **HR2020 Strategy** was developed has caused some frustrations within Ethiopia. The principles of the IHP+ Country Compact encourage mutual engagement in policy development. Many partners are especially interested in the strategy since health worker salaries average 70% of recurrent health expenditures across all
regions of Ethiopia and a substantial share is funded through development partner support to pooled funds.

8. The consultation process aside, it is evident from country interviews and documentation that the **HR2020 Strategy** will factor the following areas of development and intervention:

- The ongoing scale-up of the health workforce with corresponding attention to their retention
- The ongoing scale-up of medical education and training infrastructure, equipment, teaching aids/resources;
- The scale-up of teaching faculty, with a focus on recruiting expatriate faculty in the short-term;
- The rapid expansion of student intakes to graduate 10,000 Medical Doctors, with a combination of 4-year and 6-year curricula;
- The expansion of midwifery training to graduate and deploy 3,200 midwives
- The development of a cadre of HEW Supervisors, graduating and deploying 3,000 staff
- The development of a cadre of Health Information Technicians, graduating and deploying 8,000 staff
- Ongoing development of Non-Physician Clinicians
- Ongoing development of Emergency Obstetricians, similar to the accelerated training of Health Officers
- The expansion of management capacities across the health workforce
- Improved accreditation, licensing and re-licensing with enhanced capacity for implementation
- The roll-out of a Human Resources Information System (HRIS)
- Expansion of public-private partnerships in education, training and research
- Improvements in the regulatory and legal frameworks
- Enhancement in monitoring and evaluation methodologies and processes, which appear to relate well with ‘Workforce Surveillance’ principles.

9. The FMOH concedes that there is a need to develop enhanced communication and collaboration and has identified internal capacity within the Ministry and the Department of HR as areas that may require long-term technical assistance. A period of improved engagement is anticipated.

10. **PEPFAR and DFID:** In contrast to PEPFAR’s overall success in meeting Treatment, Prevention and Care (TPC) goals, Ethiopia faced significant challenges. Despite having the fifth highest increase in numbers, this result represents a result far short of Ethiopia’s treatment target of 210,000 (for the period 2004-2008), reaching only 57% of the target number, the lowest of the fifteen focus countries.

11. This may be due in part to significant and unusual volatility in the growth of funding, culminating in a decrease of 2.4% to USD 346 million in FY 2009. This is the second-highest decrease of any African PEPFAR focus country, which decreased on average by 0.8%. Another contributing factor appears to be the low PEPFAR per-capita contribution. Ethiopia is one of Africa’s most populated countries and whilst PEPFAR’s financial contributions are significant it equates to the second lowest contribution per capita of all focus countries at USD 4.06 compared to an average among African focus countries of USD 16.4. Simple analysis demonstrates a strong positive correlation coefficient (0.81) between the per capita investment and attainment of treatment goals.

12. The assessment revealed that collaboration and alignment between PEPFAR, other donors, and the government could be further improved. The new PEPFAR Partnership Framework model introduces a significant opportunity to address this challenge; PEPFAR guidance from May 2009 specifically encourages linkages with broader health systems strengthening and in-country mechanisms such as the IHP+.
13. PEPFAR partners, however, demonstrated clear efforts towards alignment and collaboration with the government of Ethiopia. PEPFAR’s FY09 COP indicates USD 37m specifically for HCD activities (including pre-service and in-service training for health professionals, community health workers and para-professionals), divided among 86 activities and 47 prime partners.

14. Successes in supporting HRH planning are typified by the development of strong human resource information system (HRIS) software, currently being piloted and a comprehensive training information management system (TIMS) for tracking PEPFAR-funded trainings. Both of these extensive investments are at risk of being abandoned without continued support and transition to the GoE. PEPFAR Ethiopia activities demonstrate similar success in retention studies, HR management strengthening, and the development of community health workers, even beyond Ethiopia’s well-publicized Health Extension Worker program.

15. PEPFAR Ethiopia demonstrated typically heavy emphasis on in-service training over the last five years, with available data showing 113,881 trainings supported in all 9 regions and both chartered cities. Training was diverse, with courses covering 25 topic areas from ARV services to Journalism Training. PEPFAR also delivered offsite training to over 84,000 health workers with an average length of 5.75 days, resulting in an average of 410 full-time equivalents (FTE’s) removed from service delivery for each of the last five years.

16. DFID is a champion of and signatory to Ethiopia’s IHP+ Country Compact. A costed, comprehensive HR plan is seen as an integral element of the country health plan. It contributes to three pooled funding mechanisms: the PBS block grants (£135m), the MDG Performance Fund (£35m between 2008/9-2010/11) and to a lesser extent to the HPF-II technical assistance fund. The contribution to HRH is through the application of these pooled funds, and forms part of the UK’s approach to supporting the implementation of the country health plan and broader health systems strengthening.

17. The pooled funding mechanisms strongly support primary health care workers at the woreda level. A percentage of DFID’s financial support to PBS is subsequently allocated to pay salaries. Calculations suggest this is equivalent to the full-time salaries of 7,500 nurses currently employed in Ethiopia (approaching one-half of the 16,311 total) or 2,000 of the 2,085 General Practitioners and specialists.

18. Other Partners: There are a variety of other HRH strengthening activities from global partners as diverse as the World Bank, WHO, UNICEF and UNFPA. At least 12 different country donors join these global initiatives in contributing to HRH through a combination of direct intervention activities and pooled funding support at the woreda level. The three largest donors in Ethiopia are the Global Fund, GAVI and PEPFAR.

19. Recommendations: Section 4 of this report provides the detailed discussion on the findings and recommendations. The table below is a summary of these.

<table>
<thead>
<tr>
<th>Recommendations</th>
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<tr>
<td>Recommendation HRH1: FMOH and HPN Donors Group to revisit arrangements for a Human Resources for Health (HRH) Platform and a national HRH Observatory and agree enhanced mechanisms for coordination, communication and collaboration, potentially utilising GHWA’s Country Coordination Framework (CCF).</td>
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<tr>
<td>Recommendation HRH2: FMOH to develop and articulate the projected resource requirements for</td>
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**Recommendations**

the *HR2020 Strategy*, engaging other line Ministries where appropriate and with consideration given to the offer of technical assistance from the World Bank.

**Recommendation HRH3:** FMOH, working with development partners, to develop and articulate the initial implementation plans, with due consideration to human resource management and technical capacities across government institutions and agencies.

**Recommendation HRH4:** FMOH to develop and articulate the baseline for monitoring and evaluation of the *HR2020 Strategy*, linked to the monitoring and evaluation (M&E) framework of the country health plan and in collaboration with existing work with the Health Metrics Network (HMN).

**Recommendation HRH5:** FMOH to facilitate the review and analysis of the current ‘ABC retention scheme’ in relation to labour market conditions and projections.

**Recommendation HRH6:** FMOH to consider the implementation of an active workforce surveillance culture across all institutions and agencies to support future planning, policy and data-driven decision-making.

**Recommendation HRH7:** FMOH, working with the Ministry of Education, to consider the introduction and ongoing development of the World Federation for Medical Education (WFME) benchmarks and to train faculty with specialist knowledge in Medical Education.

**Recommendation HRH8:** FMOH and partners to agree and implement solutions to improve reproductive health services and address maternal mortality rates, based on Ethiopia’s needs and maximizing the comparative advantages of each of the stakeholders.

**Recommendation CP1:** HPN Donors Group to engage partners to map existing and planned technical activities against the *HR2020 Strategy*.

**Recommendation CP2:** PEPFAR Ethiopia to collaborate with GoE, DFID, and other bilateral agencies on development of Partnership Framework, linking to the Ethiopia IHP+ Compact.

**Recommendation CP3:** PEPFAR Ethiopia to collaborate with Office of the Global Aids Coordinator (OGAC) to address per-capita funding issues and improve predictability of funding.

**Recommendation CP4:** PEPFAR Ethiopia to streamline funding for maximum efficiency gains with implementing partners working to their comparative advantage.

**Recommendation CP5:** Initiate dialogue between GoE and development partners to utilize Human Resource Information System (HRIS) and Training Information Monitoring System (TIMS) as a basis for a central, country-owned system that all partners can report to.

**Recommendation CP6:** Link Human Resource Information System (HRIS) roll-out strategy to Health Management Information System (HMIS) scale-up to maximize economies of scale with little duplication of effort.

**Recommendation CP7:** Recognize and scale-up PEPFAR successes in HR Management training, retention, and community health worker development, realizing the focus provided by new PEPFAR HRH indicators.

**Recommendation CP8:** Review the Training Information Management System (TIMS) data against PEPFAR Ethiopia in-service training (IST) investment and results to address gaps, redundancies and unintended impacts from off-site training.

**Recommendation CP9:** Pooled funding partners review and strengthen impact on government and health systems strengthening.

20. These recommendations are for ongoing dialogue and discussion among partners. Many are complementary and require continuing commitment to working in partnership, applying complementary strengths to take these forward.
2 Background / Introduction

1. In response to the critical Human Resources for Health (HRH) shortages in Africa, the UK Department for International Development (DFID) and Office of the US Global Aids Coordinator (OGAC) responsible for the President’s Emergency Programme for AIDS Relief (PEPFAR) have been in discussion with a number of African countries (Ethiopia, Kenya, Mozambique and Zambia) to develop strategies and country level actions. The aim is to demonstrate the maximum flexibility of disease specific programmes to support broad based primary care in line with countries’ health plans. There is high level political support for this process in the UK and US. This was highlighted by the announcements of President George Bush and Prime Minister Gordon Brown in April and June 2008 committing to actions in the four countries ‘to support partner countries to increase health workforce coverage levels, with a view to work towards the World Health Organization goal of at least 2.3 health workers per 1,000 people’.

2. Further to coordination meetings in Addis Ababa (January 2008) and Kampala (March 2008) DFID and OGAC agreed to field a team of two consultants to work with their respective leads in Ethiopia in the period 24 April – 09 May, 2009. Jim Campbell (INTEGRARE, Spain) was engaged by DFID and Dykki Settle (IntraHealth) was made available under existing arrangements with PEPFAR/United States Agency for International Development (USAID) and the ‘Capacity Project’. The main objective of the assignment was to facilitate agreement and document current flexibilities of funding streams for HRH (building on existing work and within national frameworks for health reform specific priority actions on HRH). The Terms of Reference (TOR) for the assignment is available as Annex 1.

3. This report presents a summary of the main findings from the country visit. Section 2 details the context of HRH in Ethiopia. Section 3 reviews the respective activities of PEPFAR, DFID and other partners and the progress since the January 2008 meeting in Addis Ababa. Opportunities to take forward further action on HRH are presented in Section 4.

4. Method of working:
   - Pre- and on-arrival briefing meetings were held with staff from USAID, CDC and DFID. These generated a list of key informants. A list of people interviewed is appended as Annex 2.
   - A review of relevant documents provided and collected during the assignment. A full list of the documents reviewed is appended as Annex 3.
   - Interviews were conducted by one or both consultants and the results recorded in note form.
   - Representatives of the Federal Ministry of Health (FMOH) and the Health Population and Nutrition (HPN) Donors Group were provided with de-briefings prior to departure
   - Additionally, Jim Campbell participated in the Human Resources for Health Results (HR²) Symposium (11-14 May) hosted by the World Bank, thus facilitating additional discussions and interaction with respective stakeholders.
3 National plans and strategies in Ethiopia

5. The scope of work had particular requests relating to Ethiopia’s national policy and planning frameworks and relation to HRH planning and priorities:

   - Review health sector documentation including those relating to the Health Sector Development Plan and the recently produced HRH strategy and highlight the priority areas identified by the FMOH for action, and possible priority areas for DP support in the short, medium and longer term.
   - Review other public sector strengthening/reform and HR related plans and initiatives and their implications for the health sector, including linkages with the Ministry of Education.

6. It is important to recognise that any assessment of national policy and planning has to account for 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. The principle of mutual respect between Federal and State governments is explicitly stated in the federal constitution.

7. Thus national health policy and planning is subject to the dynamics and ongoing interactions between the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs) and Woreda Health Offices (WHO), where the latter are responsible for managing and delivering primary health care (PHC) services. This report is unable to cover the complexities and intricacies arising from this governance structure, but where relevant does account for the particularities associated with Human Resources for Health (HRH).

8. The Third Health Sector Development Plan (HSDP III) 2005/6 – 2009/10 is well known to partners in Ethiopia and hence is not repeated in detail in this report. Instead and where relevant, footnotes and links are provided to indicate sources of information or further reading for wider interested parties.

9. As an overview, HSDP III concentrates on 8 major objectives to improve the health status of the population and achieve the Health MDGs, with a focus on reducing maternal and child mortality rates and addressing HIV/AIDS, TB, Malaria and other diseases. Universal PHC coverage is one of the eight stated objectives and is being driven by an emphasis on health promotion and prevention within a comprehensive Health Extension Programme (HEP). ¹ ² ³ ⁴ ⁵

10. A tiered system of health service delivery exists and a programme of facility construction and refurbishment is ongoing within the Accelerated Expansion of Primary Health Service Coverage

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¹ FMOH (2005) Health Sector Strategic Plan. p.xiv
Strategy\(^6\). The intention is to create a network of approximately 3,200 Health Centres (1 per 25,000 population) supported by Health Posts (1 per 5,000 population) with referral to district, zonal and specialist hospitals\(^7\). This configuration and the anticipated services partly drive the demand for an indicative number of health workers per facility; including the deployment of 30,000 Health Extension Workers (HEWs) and more recently the engagement and training of 5,000 Urban Health Extension Workers (UHEWs). This is an increase of more than four times the 732 health centres indicated in the 2008 MOH Indicators.

11. Nominal growth in domestic financing for both the new facilities and the increasing health workforce is evident in recent figures released by the GoE via the PBS Secretariat\(^8\). ‘Health’ is one of five priority areas for poverty targeted expenditures alongside Education, Roads, Agriculture and Water. These cumulatively account for a budgeted 63% of GoE spending in 2008/9; up from 43% in 2002/3. Health expenditure has risen to ETB 4,954 million in 2008/9, up from a low of ETB 878 million in 2003/4: a growth of 464% in nominal terms\(^9\).

3.1 **National plans and strategies related to HRH**

12. Ethiopia is one of 57 countries listed by the World Health Organisation (WHO) as having a health workforce ‘crisis’\(^10\). There is an estimated density of 0.247 Doctors, Nurses and Midwives per 1,000 population against the calculated threshold of 2.28/1,000 that was utilised to categorise a ‘crisis’.

13. Aside from this stark WHO estimate on density, there is evidence of: poor working conditions; shortages across many other health cadres; geographical mal-distribution of the workforce with a heavy bias in urban centres; a growing non-state sector (comprising non-governmental organisations and private for-profit providers) which reportedly impacts upon attrition, the poor retention of the public sector workforce (especially for physicians) and dual-practice; poor human resource management; inconsistent standards in training and examinations, and; imbalances in gender across the professions\(^11\)\(^12\). Girma et al (2007) have described Ethiopia as having an insufficient health workforce ‘to absorb, apply and make efficient use of the interventions being contemplated through the various initiatives related to child survival, safe motherhood, HIV/AIDS [and] malaria\(^13\).

14. There are three key documents in respect to HRH plans and strategies. HSDP III, as discussed above, establishes the overall direction and subsequent priorities. A Health Human Resource

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\(^7\) Anticipated infrastructure varies in different documents, but indicatively is: 17 Specialised Hospitals, 83 General Hospitals, 822 Primary Hospitals, 3,286 Health Centres and 15,205 Health Posts.


\(^9\) Government agreed inflation rates for each financial year were not available to calculate growth in real terms.


Development Plan (2006-10)\textsuperscript{14} was produced in 2006 and a new 12-year ‘\textit{HR2020 Strategy}’ (2009-2020) has been under development in the last 12-15 months alongside the government’s Business Process Reengineering (BPR) exercise\textsuperscript{15}\textsuperscript{16}.

15. The BPR has been described as “the fundamental rethinking and radical redesign of business processes to achieve dramatic improvement in critical, contemporary measures of performance, such as cost, quality, service and speed”\textsuperscript{17}. Human Resource Development and Management is one of five cross-cutting support processes that underscore the core outcomes and processes of the BPR in the health sector. This ongoing work has therefore had considerable influence on the development of the \textit{HR2020 Strategy}, with a range of outcomes ranging from the intention to adequately staff all facilities to simplifying systems for salary payments and per diems\textsuperscript{18}. For a number of reasons the new \textit{HR2020 Strategy} has not been developed consultatively and was not available for review (discussed in section 2.1.3). Its publication and dissemination is therefore eagerly anticipated by many stakeholders.

3.1.1 \textbf{HSDP III}

16. \textbf{HSDP III} lists five key themes for Human Resource Development (HRD):

- supply skilled manpower in adequate number to new health facilities
- improve the capacity of the existing health manpower working at various levels
- initiate and strengthen continuing education and in-service training (IST)
- review and improve the curricula of some categories of health workers, and
- rationalise the categories of personnel\textsuperscript{19}

17. The priority areas for HRH have resulted from the above. Specific attention was given to the continuation of initiatives commenced in HSDP II (2002-2005), including the scaling-up of HEWs and the training and appointment of 5,000 Health Officers (HOs) as part of Ethiopia’s “Flooding” strategy (see Figure 1 below).

18. Consistent with the key themes there has been resulting activities in increasing the country capacity to train and retain graduate health professionals and para-professionals.

19. This includes the introduction of mandatory public service after graduation and differentiated terms and conditions for pay and benefits\textsuperscript{20}— referred to as the ‘ABC scheme’. The scheme considers various aspects of employment and training to promote public sector service in rural and remote locations, including:

- Salary

\textsuperscript{14} Referred to as a ‘HRH Development Framework’ and as a ‘National HRH Plan of Action’ in other documents and publications.

\textsuperscript{15} A government-wide re-organisation of roles, responsibilities and activities across the public sector led by the Ministry of Capacity Building.

\textsuperscript{16} FMOH Ethiopia. \url{http://moh.gov.et/index.php?option=com_content&view=article&id=127&Itemid=259}

\textsuperscript{17} FMOH (2008). Report on the Proceedings and Results of the 10\textsuperscript{th} Annual Review Meeting of HSDP. October 8-10, 2008. HSDP Secretariat. p.34

\textsuperscript{18} \textit{ibid.} p.120

\textsuperscript{19} HSDP III p.28.

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- Eligibility for release from public service
- Eligibility for post-graduate training (e.g., to specialist), and
- Eligibility for transfer

20. Urban, rural and remote districts have been classified as A, B or C and terms of compulsory service fluctuate from 2 to 4 years subject to the classification. For those undertaking compulsory service in a remote location the mandatory period is 2 years, whereas urban locations require an engagement of 4 years.

21. A review of terms and conditions for senior level health professionals and enhancements to duty allowance payments have also been developed. However, there is emerging evidence that some Health Bureaus are no longer making payment of the additional incentives due to lack of funding21.

Figure 1: Ethiopia’s “Flooding” strategy – rapidly increasing total N° of Health Workers

![Graph showing the number of health workers per 1000 population deployed in Ethiopia (2000 - 2007). The graph illustrates a steady increase in the number of health workers, with the MDGs attainment threshold set at 2.28 health workers per 1000 population by 2004.

Source: Presentation by the HRD Department, FMOH at the WHO TTR Workshop. 1-2 November 2007, Addis Ababa.

22. Specific activities on reproductive health services have also responded to the overarching strategies in HSDP III. Basic and Comprehensive Emergency Obstetric Care (BEOC and CEOC) programming is being addressed through the scale-up of midwives and anaesthetists in parallel with the scale-up of community services through the Health Extension Programme (HEP). There remain concerns on the skills and competencies and the utilisation of Health Extension Workers to provide services at the community level, including their relationships with Traditional Birth Attendants (TBAs)22.

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21 data provided by the Health Sector Financing Reform (HSFR) programme, Ethiopia
23. This debate appears to be ongoing and will require further engagement and development. The pending distribution (indicated for September 2009) of the National EmONC Baseline Assessment conducted by the Safe Motherhood Working Group will provide an opportunity for further dialogue. Preliminary findings indicate that further effort is required to provide the adequate number of health workers, with the appropriate skills and competencies, to meet targets in HSDP III related to the percentages of delivery attended by a skilled health worker\(^\text{23}\). The policy options will need to be explored and developed accordingly.

**Figure 2: Number of Skilled Birth Attendants by Region (preliminary results)**

![Graph showing number of skilled birth attendants by region](image)

Source: National EmONC Baseline Assessment conducted by the Safe Motherhood Working Group. March 2009

3.1.2 **Health Human Resource Development Plan**

24. The **Health Human Resource Development Plan** (HHRDP) of 2005/6 was linked with the development of HSDP III and precipitated the establishment of an HRH Platform and a national HRH Observatory in April 2006\(^\text{24}\). The Platform was envisaged to provide a coordination forum for relevant national and international stakeholders whilst the Observatory and its internal Secretariat would develop the evidence and policy for future implementation. The first meeting of the National HRH Observatory was held on 13 July, 2006 and the HPN Donor Group was an integral part of initial policy development alongside the FMOH and regional stakeholders. The HRH Action Framework (figure 3 below), jointly developed by the Global Health Workforce Alliance (GHWA) and WHO, was utilised as a tool for the situational analysis and the initial policy considerations\(^\text{25}\).

\(^{23}\) National EmONC Baseline Assessment conducted by the Safe Motherhood Working Group. March 2009

\(^{24}\) Terms of Reference were developed by WHO and approved by FMOH.

\(^{25}\) Communications from WHO and Italian Cooperation who participated in the initial activities.
25. Priority HRH activities resulting and subsequently communicated at a November 2007 workshop\(^\text{26}\) included:

- strengthening of HRH management, with the reorganisation of the Human Resource Directorate in the FMOH and the development of a Human Resource Information System (HRIS)
- reform of staffing patterns and organisation, with associated development on job descriptions, career pathways, expected staffing demand and implementation arrangements to support appointments and deployment
- development of education, training and skills development, with associated activities on curricula development, mentoring, distance learning, accreditation and licensing
- enhanced retention of health workers, with associated activities on financial and non-financial incentives
- review and improve policy, regulatory and financial frameworks, with due attention to costing the HR development plans and implementation arrangements to support resource mobilisation.

**Figure 3: HRH Action Framework**

![HRH Action Framework Diagram](http://www.capacityproject.org/framework/)

Source: [http://www.capacityproject.org/framework/](http://www.capacityproject.org/framework/)

26. Similar information to the bullet points above was presented two months later, in January 2008, to stakeholders at the first meeting of the four African countries (Ethiopia, Kenya, Mozambique and Zambia) and partners participating in the joint US/UK initiative on HRH (see Annex 4 of this report)\(^\text{27}\).

27. The focus on “flooding” was extended to include Medical Doctors - indicative figures suggested the scale-up target was to graduate 12,000 MDs - and mechanisms in support of enhanced retention were to be continuously improved.


28. The new emphasis on training MDs may partly have taken account of work ongoing in 2006 and 2007 to study the deployment and retention of health workers in Ethiopia and the specific impact of the national lottery system for allocating persons to posts\(^{28}\). Feedback from the studies indicated that “there will clearly need to be a sustained long term increase in the net supply of physicians to the Ethiopian market”\(^{29}\).

3.1.3 **HR2020 Strategy (2009-2020)**

29. Whilst the TOR requested a review of the “recently produced HRH strategy”, this document was unfortunately not available to the assignment team during the visit. Requests to the FMOH for sight of the document were declined due to the current internal discussions and debate on elements of the proposed strategy. These debates were specifically considering health workforce retention options, including financial and non-financial incentives and a policy scenario which explored the option to de-link health workers from the civil service terms and conditions.

30. However, interviews with key FMOH representatives, including Dr. Kebede Worku, the State Minister of Health, did offer considerable insights into the content and ambition of the *HR2020 Strategy*. Of note is the consistency in the interviews with FMOH staff and the existing policy statements and activities originating from HSDP III and the HHRDP.

**Figure 4: HRH Strategy – key directions communicated in October 2008.**

<table>
<thead>
<tr>
<th>The new HRH Strategy addresses both the supply and demand side of the HRH issues. The strategic direction illustrates the FMOH’s intention to follow two mutually reinforcing strategies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Substantial increase in the number of trained health professionals (all types of medical doctors including specialists, midwives and anaesthetists professionals) and;</td>
</tr>
<tr>
<td>- Putting in place systems of financial and non-financial incentive packages to retain health workers in service</td>
</tr>
</tbody>
</table>


31. Whilst the restrictions on the distribution of the *HR2020 Strategy* prevents detailed comparison, the narratives from FMOH staff indicate that the approach taken has been to produce a thorough, reasoned and evidence-based document which supports prior policy directions and implementation arrangements that are already well known to those working in Ethiopia.

32. We are informed that a detailed baseline and situational analysis has been conducted: a requirement of the BPR process to describe the ‘As Is’ situation. A recognised planning tool from WHO has been applied - Workload Indicators of Staffing Need (WISN), and a number of strategic objectives have been defined. The accompanying narratives from FMOH officials are consistent and include:

- “Speed, Volume, Quality” – referencing the continuing scale-up of health workers and the definition in the BPR process
- “Flooding with retention” – reference enhanced production and retention mechanisms

\(^{28}\) Studies supported by the World Bank, AFD, NORAD and Bill & Melinda Gates Foundation

33. Concerns amongst members of the international community in respect to both the non-consultative development process on HR2020 and restricted access to copies of the existent draft are, to an extent, valid. Ethiopia’s participation in the International Health Partnership+ and the completion of the Ethiopia Country Compact in August 2008 signals a joint approach to enabling the GoE and the FMOH to meet their health sector objectives: with an emphasis on both the GoE and partners changing the way they do business.

Figure 5: Extract from Ethiopia Country Compact

III. Government Commitments
40. Recognizing that the Development Partners’ willingness to give assurances of long-term support depends on their confidence in the transparency, predictability and efficiency of Government planning and budget processes and in the public servants in charge of these processes, the Government will:

a) Ensure that the objectives and targets can realistically be achieved taking into account implementation capacity and projections of the available resource envelope.......that they are the outcome of a consultative process involving Development Partners, and that there is a clear framework for monitoring and evaluation.

34. Not engaging IHP+ signatories and other partners in discussions on the future HRH strategy and cost implications, especially when health worker salaries average 70% of recurrent health expenditures across all regions of Ethiopia (see Figure 6 below) and are partly funded through Development Partners (via General Budget Support and the MDG Performance Fund mechanisms for sector programming), is somewhat contradictory to the principles established in the Country Compact.

Figure 6: Health Worker Salaries as a percentage of recurrent health expenditures

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Government</td>
<td>64.18</td>
<td>62.21</td>
<td>69.6</td>
<td>78.28</td>
<td>104.82</td>
<td>n/a</td>
</tr>
<tr>
<td>Tigray</td>
<td>67.49</td>
<td>72.21</td>
<td>88.22</td>
<td>94.5</td>
<td>129</td>
<td>98.34</td>
</tr>
<tr>
<td>Afar</td>
<td>14.46</td>
<td>21.37</td>
<td>18.5</td>
<td>24.3</td>
<td>38.29</td>
<td>27.09</td>
</tr>
<tr>
<td>Amhara</td>
<td>119.85</td>
<td>119.19</td>
<td>139.35</td>
<td>188.44</td>
<td>272.55</td>
<td>201.62</td>
</tr>
<tr>
<td>Oromia</td>
<td>156.95</td>
<td>162.56</td>
<td>196.13</td>
<td>266.27</td>
<td>441.26</td>
<td>292.07</td>
</tr>
<tr>
<td>Somale</td>
<td>15.2</td>
<td>17.85</td>
<td>35.3</td>
<td>42.88</td>
<td>63.84</td>
<td>43.51</td>
</tr>
<tr>
<td>Benshagul Gumuz</td>
<td>13.62</td>
<td>16.52</td>
<td>22.6</td>
<td>24.42</td>
<td>32.05</td>
<td>23.11</td>
</tr>
<tr>
<td>SNNP</td>
<td>60.98</td>
<td>100.39</td>
<td>121.86</td>
<td>155.69</td>
<td>241.29</td>
<td>180.84</td>
</tr>
<tr>
<td>Gambella</td>
<td>9.85</td>
<td>10.43</td>
<td>9.9</td>
<td>9.4</td>
<td>15.12</td>
<td>12.11</td>
</tr>
<tr>
<td>Harari</td>
<td>11.73</td>
<td>13.43</td>
<td>14.95</td>
<td>15.27</td>
<td>18.92</td>
<td>13.59</td>
</tr>
<tr>
<td>Addis Ababa</td>
<td>0.87</td>
<td>68.82</td>
<td>70.64</td>
<td>79.77</td>
<td>105.93</td>
<td>65.2</td>
</tr>
<tr>
<td>Regions Total</td>
<td>480.77</td>
<td>613.75</td>
<td>731.6</td>
<td>914.51</td>
<td>1379.66</td>
<td>970.87</td>
</tr>
<tr>
<td>National Total</td>
<td>544.95</td>
<td>675.96</td>
<td>801.2</td>
<td>992.79</td>
<td>1484.48</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: adapted from data provided by the Health Sector Financing Reform (HSFR) programme, Ethiopia

32 Email correspondence with Leulseged Ageze
35. At the same time, the FMOH is fully entitled to request any technical assistance provider, in this case Tulane University through arrangements with CDC and PEPFAR funding, to keep discussions and documentation confidential. Local frustrations that may have occurred should not therefore hold the staff and representatives of Tulane University culpable when they have only been acting in good faith with the Ministry.

36. Partners have had ample opportunity to reflect on the HRH strategic directions in the Annual Review Mechanism, the Mid Term Review and other forums. The existing bilateral and collective arrangements with the FMOH also offer opportunities for dialogue to resolve concerns.

37. The consultation process aside, it is evident from country interviews and documentation that the HR2020 Strategy will factor the following areas of development and intervention:

- The ongoing scale-up of the health workforce with corresponding attention to their retention
- The ongoing scale-up of medical education and training infrastructure, equipment, teaching aids/resources;
- The scale-up of teaching faculty, with a focus on recruiting expatriate faculty in the short-term;
- The rapid expansion of student intakes to graduate 10,000 Medical Doctors, with a combination of 4-year and 6-year curricula;
- The expansion of midwifery training to graduate and deploy 3,200 midwives
- The development of a cadre of HEW Supervisors, graduating and deploying 3,000 staff
- The development of a cadre of Health Information Technicians, graduating and deploying 8,000 staff
- Ongoing development of Non-Physician Clinicians
- Ongoing development of Emergency Obstetricians, similar to the accelerated training of Health Officers
- The expansion of management capacities across the health workforce
- Improved accreditation, licensing and re-licensing with enhanced capacity for implementation
- The roll-out of a Human Resources Information System (HRIS)
- Expansion of public-private partnerships in education, training and research
- Improvements in the regulatory and legal frameworks
- Enhancement in monitoring and evaluation methodologies and processes, which appear to relate well with ‘Workforce Surveillance’ principles 33

38. Staff at the FMOH indicated that they will be engaging cooperating partners to review the strategy and the arrangements for implementation. This will include discussions on resource mobilisation. The Resource Requirements Tool (RRT), developed by the GHWA Task Force on Financing HRH with inputs from the World Bank and WHO, has been utilised to estimate the anticipated resources. Discussions during the World Bank conference in Addis Ababa - ‘Human Resources for Health Results’ - indicated that the World Bank representative in Ethiopia would be engaging with the FMOH to review and finalise the assumptions in the RRT 34 so that there

33 ‘Workforce Surveillance’ is an emerging and innovative approach within the field of HRH. The concept and science builds on proven methodologies from the field of disease and migration surveillance and is aligned with the platform to strengthen Country Health Systems Surveillance (CHeSS) launched by the World Health Organization (WHO) and partners at the Bellagio Centre, Italy in October 2008 and adopted by the International Health Partnership Plus (IHP+).

34 Author’s discussion with Agnes Soucat, WB.
will be additional confidence in the resource estimates generated by this tool. Previous assumptions and estimates have not yet been exposed to external review by the Bank or the team from Results for Development who produced the costing tool. Without access to the anticipated costs it is not known whether the implementation of the HR2020 Strategy is within the estimates of the projected fiscal space for Ethiopia’s health expenditure.

39. The FMOH has stated that preference is given to using the existing MDG Performance Fund as the conduit to channel additional resources for HRH implementation. This is a new pooled-funding instrument developed by GoE and partners as a result of the IHP+ process. The fund is managed by the GoE, development partners are already contributing and there is great optimism that this new modality will support improvements in aid harmonisation and alignment.

40. The FMOH concedes that there is a need to develop enhanced communication and collaboration and has identified internal capacity within the Ministry and the Department of HR as areas that may require long-term technical assistance. The opportunities for enhanced engagement are therefore imminent.
4  Findings on PEPFAR and DFID supporting activities

41. The TOR requested the assignment consider the following with respect to PEPFAR, DFID and other partner support:

- Review current support for HRH by PEPFAR and DFID and make specific recommendations on how both organisations might increase the impact of their support on HR capacity building.
- Review results of the initial PEPFAR-DFID HRH meeting in Addis Ababa and consider progress made, documenting the extent of current PEPFAR and DFID support to health systems strengthening and areas where the impact of this support could be increased.
- Identify challenges to the predictability of DFID and PEPFAR financing in relation to health systems strengthening and specifically HRH.
- Map any other significant DP support programmes for HRH and highlight where there may be particular future gaps or where the impact of DP support for HRH could be increased.

4.1  ‘PEPFAR’ Ethiopia

42. Overview: Since the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (Public Law 108-25) was enacted, the President’s Emergency Plan for AIDS Relief (PEPFAR) has worked to coordinate the U.S. Government’s response to HIV/AIDS around the world, harmonizing the planning and reporting processes of all USG agencies working in the area of global HIV/AIDS.

43. In 2008, PEPFAR’s success was recognized when the Tom Lantos and Henry J. Hyde United States Global Leadership against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (Public Law H.R. 5501) was signed into law. This legislation expands the U.S. Government commitment to the PEPFAR program for five additional years, from 2009 through 2013.

44. Country activities and the subsequent results contributed to the overall success in attaining the “2-7-10” targets for Treatment, Prevention and Care (TPC) that PEPFAR set itself to achieve by 2010. With the new legislation, these targets have been expanded to “3-12-12” (see figure below).

Figure 7: New PEPFAR Legislative Targets: “3-12-12”

- Treatment for at least 3 million people
- Prevention
  - 12 million new infections averted (measured through modeling)
  - 80% coverage of testing and counseling among pregnant women
  - 80% coverage of ARV prophylaxis for HIV-positive pregnant women
- Care for 12 million people, including 5 million orphans and vulnerable children
- Professional training for 140,000 new health care workers


36 Note that these targets changed from the original “2-7-10” in the PEPFAR Reauthorization in June 2008
37 Next Generation Indicators
45. In the Fifth Annual Report to Congress (January 2009) results through to the end of September 2008 indicate that more than 2 million people are already supported with the lifesaving antiretroviral treatment (ART) in PEPFAR’s 15 focus countries. This achievement, ahead of the original “2-7-10” target date of September 2009 is of particular note. When PEPFAR was first announced, it was estimated that only 50,000 people were receiving treatment for HIV/AIDS in sub-Saharan Africa. 

46. In contrast to the overall success of PEPFAR, the program in Ethiopia has experienced significant challenges. In the latest 2008 figures released by PEPFAR, coverage rates in Ethiopia have increased at a rate twice the average of the other focus countries; from 1% to 39% in the period 2003-2008, an increase of 3838%. 119,600 Ethiopians now benefit from this expanded coverage. Despite having the fifth highest increase, this result represents a result far short of Ethiopia’s treatment target of 210,000, reaching only 57% of the target number, the lowest of the fifteen focus countries. Similar challenges are also noted in the number of individuals receiving care in focus countries, where Ethiopia is reporting 85% attainment against the initial target of 1,050,000, well short of the fifteen country average of 97%.

47. To encourage the expansion of activities and efforts to address the challenges in TPC programmes, there has typically been a year-on-year increase in PEPFAR funding every year prior to FY09 in PEPFAR focus countries. For example, PEPFAR Ethiopia’s field budget has risen from USD 123 million in FY06 to $354.5 million in FY08, experiencing an increase of 105% from FY06 to FY07 and a 45% increase from FY07 to FY08. In contrast, FY09 experienced a decrease of 2.4% to USD 346 million. This is the second-highest decrease of any African PEPFAR focus country, which decreased on average by 0.8%. This year-on-year volatility and decline in funding contributes to the challenges of program implementation and the achievement of targets.

Figure 8 PEPFAR Ethiopia Approved Field Budget
Figure 9 PEPFAR Ethiopia Annual Funding Increases

Figure 8: PEPFAR Ethiopia Approved Funding in COP

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>US (M)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY04</td>
<td>0</td>
</tr>
<tr>
<td>FY05</td>
<td>10</td>
</tr>
<tr>
<td>FY06</td>
<td>30</td>
</tr>
<tr>
<td>FY07</td>
<td>40</td>
</tr>
<tr>
<td>FY08</td>
<td>350</td>
</tr>
<tr>
<td>FY09</td>
<td>400</td>
</tr>
</tbody>
</table>

Figure 9: PEPFAR Ethiopia Annual Funding Increases

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Annual Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY05</td>
<td>80%</td>
</tr>
<tr>
<td>FY06</td>
<td>60%</td>
</tr>
<tr>
<td>FY07</td>
<td>40%</td>
</tr>
<tr>
<td>FY08</td>
<td>20%</td>
</tr>
<tr>
<td>FY09</td>
<td>-20%</td>
</tr>
</tbody>
</table>

40 Ibid, p. 46
41 Ibid, p. 51
42 Previous years had comparable increases (47% in 2006 and 74% in 2005)
48. Another factor in PEPFAR Ethiopia’s challenges is the relative investment per capita. The 2009 funding of USD 346 million represents approximately $4.06 per capita\(^{43}\) in contrast to Namibia’s $51 per capita (338% of treatment goals) or Zambia’s $22.72 per capita (140% of treatment goals), Ethiopia has the second lowest investment per capita. Nigeria has the lowest ($2.96 per capita), at nearly twice the population of Ethiopia, with a comparably low attainment of treatment goals (60%). Simple analysis demonstrates a strong positive correlation coefficient (0.81) between the per capita investment and attainment of treatment goals. Correlation between per capita investment and attainment of PEPFAR’s care goals, while still positive, is not as strong (0.20).

**Figure 10:** Progress of the twelve African focus countries towards treatment goals shown as a function of PEPFAR investment per capita and population size

![Progress of the twelve African focus countries towards treatment goals](image)

*Notes:* Bubble size indicates total population. Ethiopia is immediately in front of Nigeria in lower left. Outlier to upper left is Uganda. At extreme right are Botswana and Namibia

49. PEPFAR Ethiopia has six major funding streams (see figure 11) USAID and CDC are the government agencies in receipt of the majority of the resources and over 64 Prime Partners are implementing activities, covering all 9 Regions and the 2 chartered cities.

**Figure 11:** PEPFAR financing in Ethiopia

<table>
<thead>
<tr>
<th>Financing Stream</th>
<th>US$ m (rounded)</th>
<th>% of total</th>
<th># Activities</th>
<th>Implemented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID</td>
<td>209.1</td>
<td>58.00%</td>
<td>151</td>
<td>33 partners</td>
</tr>
<tr>
<td>HHS/CDC</td>
<td>117.8</td>
<td>29.65%</td>
<td>154</td>
<td>29 partners</td>
</tr>
<tr>
<td>State</td>
<td>13.9</td>
<td>3.71%</td>
<td>23</td>
<td>3 partners</td>
</tr>
<tr>
<td>DoD</td>
<td>2.7</td>
<td>0.87%</td>
<td>7</td>
<td>1 partner</td>
</tr>
<tr>
<td>Peace Corps</td>
<td>2.5</td>
<td>0.79%</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>346</strong></td>
<td><strong>100%</strong></td>
<td><strong>340</strong></td>
<td><strong>64 unique partners</strong></td>
</tr>
</tbody>
</table>


50. **Partnering, Coordination and Alignment.** Interviews and available documentation revealed that collaboration could be further improved between the government of Ethiopia and PEPFAR as a donor. These are discussed below.

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\(^{43}\) Based on CIA World Factbook (2009) estimate of 85.2 million

\(^{44}\) Available online at: [http://www.pepfar.gov/about/122539.htm](http://www.pepfar.gov/about/122539.htm)
51. The PEPFAR Reauthorization (2009-13) includes new emphasis on ‘Partnership Frameworks’ with national partners and country stakeholders. PEPFAR Ethiopia had not started defining and implementing a Partnership Framework at the time of this assessment. This mechanism represents a significant opportunity to realize greater collaboration and alignment with stakeholders and partners. Recent PEPFAR guidance encourages the use of other partnering mechanisms well established in Ethiopia that can serve as a foundation for establishing a Partnership Framework. The draft Guidance for Partnership Frameworks states:

“Partnership Frameworks should relate to broader development reform efforts (such as the International Health Partnership [IHP+] and the National Strategies Application [NSA] initiative of GFATM) and work within those contexts wherever possible.”

“Where there are effective pre-existing coordinating bodies, for example the GFATM Country Coordinating Mechanism (CCM) or mechanisms through IHP+, consideration should be given to their potential leadership role, perhaps removing the need to create new management bodies for PEPFAR Partnership Frameworks.”

PEPFAR Malawi has recently completed a Partnership Framework Document that can serve as a reference model for the Ethiopia team.

52. PEPFAR’s absence from wider country analysis and planning exercises are conspicuous to country and global partners alike. A GoE report reflecting on the implementation of HSDP III remarks ‘poor predictability of funding and the unwillingness of some development partners to provide financial information’ is seen as a major challenge. This is linked with a recent Wolfensohn Centre for Development case study on aid effectiveness in Ethiopia which shows repeated unavailability of data for PEPFAR in nearly every table comparing donor contributions to Ethiopia’s health sector. The report recommends PEPFAR’s involvement in greater integrated woreda-based planning. It’s worth noting that PEPFAR is not alone in finding alignment challenging in Ethiopia. The report concludes that “Aid (in Ethiopia) is not effectively coordinated. It is fragmented and unpredictable.”

53. **Alignment with government planning.** The Wolfensohn report further highlights: “Most multilateral agencies continue to use their own systems rather than aligning and harmonizing.” While this may be true of PEPFAR financial reporting and planning, there was evidence of PEPFAR achieving the desired government alignment and cooperation through its implementing partners.

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46 Ibid, p. 4
50 Ibid, p. 33
51 Ibid, p. 33
54. Tulane Ethiopia demonstrated strong alignment to the Government of Ethiopia, playing a key support role in the government’s HR2020 Strategy and Business Process Reengineering (BPR) process discussed in section 2, and acting in good faith to the government’s wishes for confidentiality.

55. “Sincere gratitude” is expressed by the Federal HIV/AIDS Prevention and Control Office (HAPCO) to PEPFAR-Ethiopia through CDC and JHPIEGO-Ethiopia “for their enormous technical and financial support throughout the development of” HAPCO’s ‘Guidance for Coordination and Implementation of HIV Training in Ethiopia’.

56. Given the scale of PEPFAR activities, it is not unexpected that there are some harmonization challenges. However, the perception and continuing reference to the non-alignment of PEPFAR as a whole warrants ongoing attention to ensure improvements. The guidance for the PEPFAR Partnership Framework and examples already set by implementation partners will support this effort.

57. **Capacity Development.** The 2009 Country Operational Plan (COP) and Reporting System (COPRS) were reviewed to estimate the volume of resources targeted to Human Capacity Development, resulting in a figure for Ethiopia of 118.79 million for all activities with a human capacity development component. The new COP structure that encourages ‘earmarking’ of the specific funding for the Human Capacity Development components yielded a figure of 34.77 million. This indicates that 11% of all PEPFAR funding in Ethiopia directly contributes to HRH.

**Figure 12: PEPFAR financing for all COP activities with an HCD component**

<table>
<thead>
<tr>
<th>Financing Stream</th>
<th>US$ m (rounded)</th>
<th>% of total (HCD)</th>
<th># Activities (HCD)</th>
<th>Implemented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID</td>
<td>88.72</td>
<td>74.69%</td>
<td>46</td>
<td>17 partners</td>
</tr>
<tr>
<td>HHS/CDC</td>
<td>26.15</td>
<td>22.10%</td>
<td>30</td>
<td>26 partners</td>
</tr>
<tr>
<td>HHS/HRSA</td>
<td>1.50</td>
<td>1.26%</td>
<td>2</td>
<td>3 partners</td>
</tr>
<tr>
<td>Peace Corps</td>
<td>1.50</td>
<td>1.26%</td>
<td>2</td>
<td>N/A</td>
</tr>
<tr>
<td>State</td>
<td>0.92</td>
<td>0.78%</td>
<td>6</td>
<td>2 partners</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>118.79</strong></td>
<td><strong>100%</strong></td>
<td><strong>86</strong></td>
<td><strong>47 unique partners</strong></td>
</tr>
</tbody>
</table>


**Figure 13: PEPFAR financing specifically earmarked for the HCD components**

<table>
<thead>
<tr>
<th>Financing Stream</th>
<th>US$ m (rounded)</th>
<th>% of total (HCD)</th>
<th># Activities (HCD)</th>
<th>Implemented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID</td>
<td>26.04</td>
<td>74.90%</td>
<td>46</td>
<td>17 partners</td>
</tr>
<tr>
<td>HHS/CDC</td>
<td>8.36</td>
<td>24.06%</td>
<td>30</td>
<td>26 partners</td>
</tr>
<tr>
<td>Peace Corps</td>
<td>0.20</td>
<td>0.58%</td>
<td>2</td>
<td>N/A</td>
</tr>
<tr>
<td>State</td>
<td>0.09</td>
<td>0.27%</td>
<td>6</td>
<td>2 partners</td>
</tr>
<tr>
<td>HHS/HRSA</td>
<td>0.07</td>
<td>0.20%</td>
<td>2</td>
<td>3 partners</td>
</tr>
<tr>
<td><strong>total</strong></td>
<td><strong>34.77</strong></td>
<td><strong>100%</strong></td>
<td><strong>86</strong></td>
<td><strong>47 unique partners</strong></td>
</tr>
</tbody>
</table>


58. From a review of the COP and discussions with USG staff and key implementing partners, it is evident that PEPFAR programming is contributing to broader health systems strengthening (HSS) and HRH. Numerous examples of HRH interventions under the categories of planning, development and support are apparent.

59. **Planning.** The Lantos-Hyde Reauthorization Act declares that PEPFAR describe a strategy to:

   (i) strengthen capacity building within the public health sector;
   (ii) improve health care in those countries;
   (iii) help countries to develop and implement national health workforce strategies;
   (iv) strive to achieve goals in training, retaining, and effectively deploying health staff;
   (v) promote the use of codes of conduct for ethical recruiting practices for health care workers; and
   (vi) increase the sustainability of health programs.

PEPFAR has contributed significantly to the Government of Ethiopia’s health workforce strategic planning through its partners and has more resources that have not been fully realized.

60. The greatest single contribution of PEPFAR to the Government of Ethiopia’s workforce planning process has been the extensive support of Tulane Ethiopia for the *HR2020 Strategy*. This strategic plan has been through an intensive development process and is currently undergoing extensive internal review.

61. Tulane has also developed an extensive Human Resource Information System (HRIS) that can become the foundation of a platform for high quality, routine information on the health workforce. This information is essential to support policy, planning and improved service delivery. The Tulane HRIS 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)

62. While the HRIS itself is open source (in that its source code will be made available to the Ministry of Health and presumably, partners) according to interviews with Tulane staff, the underlying technology itself is not open source, but a relatively expensive suite of Microsoft server technologies. These technologies and the application code base are state-of-the-art, however, and will serve well as a country-wide foundation for comprehensive health workforce information. The Tulane system 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. One challenge faced by the Tulane HRIS is recent staff changes among the primary stakeholders. Presentation and consensus-building for the system to the new responsible stakeholders is required in order to recognize full return on this sizable investment.

63. Other than this HRIS system, there appears to be no mechanism for staff returns or other available source of data for a complete picture of the health workforce. This presents challenges for scale-up of the system as there is no routine reporting process in place for information on the health workforce. This means there is not mechanism or capacity in place to regularly

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53 A series of interviews were held on 04 May 2009 with selected PEPFAR partners. Further discussions with implementing partners were held during field visits on 01 and 06 May 2009.

54 Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008 - Section 101(b)(2)(R)
collect, analyze or use health workforce data at any level. A planned exercise to conduct a stock, profile and distribution exercise later in 2009 may provide some baseline data.\(^{55}\)

64. The Tulane HRIS, when put into full operation, will be a powerful tool for understanding the available supply of health workers in Ethiopia. Combining this information with data in the new Health Management Information System (HMIS), which Tulane also contributed to the development of, will provide essential links between supply and demand for health workers and their competencies.

65. A recent assessment by the Health Metrics Network\(^{56}\) of the scale-up progress and challenges for this HMIS estimated a investment and 5 years recurrent cost to be approximately US $112 million. This total is 90% of the government expenditure on capital and recurrent health sector costs in EFY 1999, and does not include the planned additional 2000 health centres within 12-18 months, an additional US$ 24.8 million in recurrent cost. The report also noted that interviews with RHBs identified their lack of involvement and training as major constraints to fulfilling responsibilities, including bearing most recurrent cost and providing technical support to woredas and facilities.

66. The HRIS, as a related routine health information system, will face similar cost and scale-up challenges. As long as the HMIS and HRIS scale-up strategies remain linked, economies of scale can be realized with little duplication of effort.

67. The Training Information Management System (TIMS) managed by JHPIEGO, is another excellent source of data. Mandated to capture and aggregate all PEPFAR trainings from the wide variety of PEPFAR donors and partners, this system was criticized due to lack of effective use by donors and partners. TIMS has captured as many as 114,000 health worker training participants since 2004 from more than 37 training partners. The system is an excellent source of HRH and training information at risk of cancellation at the end of FY09. The TIMS system captures:

- Contact and Demographic information
- Place of work information
- Facility type
- Profession
- Training focus and performance

68. **Management.** While most of PEPFAR’s investment so far has been in workforce training, the reauthorization legislation specifically addresses the importance of retention, deployment, recruitment, and utilization of health care workers. We identified several examples of PEPFAR’s contributions to strengthening Ethiopia’s HRH management systems.

69. A 2007 survey of 20 health facilities providing PPM-DOTS conducted by Abt Associates’ Private Sector Program (PSP Ethiopia) revealed that attrition rates were 80% among doctors, 60% among nurses, and 55% among lab technicians. Considering the sample size, these could be indicative of general concern around the private sector. Based on the results of an Oct. 2008 satisfaction survey and a Jan 2009 workshop, PSP Ethiopia began the following low cost retention interventions for private sector providers:

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\(^{55}\) This was communicated after the assessment and will entail a nationwide sampling of facilities conducted by the FMOH with Tulane University.

\(^{56}\) Church, M. Powerpoint presentation: Health Information System Activities: HMN and HMIS Scale-up. 
*Presented to HPN donor group 28 April, 2009 – Addis Ababa, Ethiopia*
- Partner with the Medical Association of Physicians in Private Practice (MAPPP) to offer HRM training to private-facility owners and managers.
- Provide TA to facilities to develop for each a package of free medical procedures for employees and families, based on their needs and the clinical and financial situation at the facility.
- Partner with MAPPP to advocate for changing the unofficial practice of excluding private-sector employees from specialist training programs.

70. A visit to St. Mary’s Higher Clinic in Addis Ababa saw evidence of the HRM training in action, with simple, high quality guidelines, procedures and tools for stronger HRM practices. The clinic manager expressed a high degree of satisfaction with the training provided and the intent to hire a full-time HR manager based on the training provided.

71. The John Snow International Last 10 Kilometres (JSI/L10K) project has developed an Urban Health Worker Extension Program, working to train more than five thousand under-employed nurses as urban health extension workers to improve hygiene and sanitation, family health, disease prevention and control, and injury prevention and first-aid in Addis Ababa, Bahir Dar and five towns in the Tigray region. This program is an excellent example of increasing health services through appropriate re-engagement of an under-employed workforce.

72. Management Sciences for Health’s HIV/AIDS Care and Support Program (HCSP) has further extended the well-recognized Health Extension Worker (HEW) task-shifting program with Kebele-Oriented Outreach Workers (KOOWs). The KOOWs are low-level community health workers who are trained and deployed by their community to
- Reduce HIV/AIDS stigma
- Teach families and communities to provide care and support for PLWHA and OVCs
- Follow-up with lost clients
- Facilitate delivery of preventive care package at Kebele level
- Promote adherence to TB-DOTS, OI and ART
- Map Kebele Assets
- Make referrals to care and support services

One health extension worker from Awassa noted “Now I have 7 people to do the work. Previously I used to have one.”

73. Development. The greatest emphasis of PEPFAR’s reauthorization focuses on training, though the emphasis has now shifted from in-service training to pre-service. The top legislative goals of the reauthorization include:

   a. promote pre-service training for health professionals designed to strengthen the capacity of institutions to develop and implement policies for training health workers to combat HIV/AIDS, tuberculosis, and malaria;57
   b. help partner countries to train and support retention of health care professionals and paraprofessionals, with the target of training and retaining at least 140,000 new health care professionals and paraprofessionals with an emphasis on training and in country deployment of critically needed doctors and nurses and to strengthen capacities in developing countries, especially in sub-Saharan Africa, to deliver primary health care with the objective of helping countries achieve staffing levels of at least 2.3 doctors,

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57 Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act of 2008 - Section 101(a)(4)(F)
nurses, and midwives per 1,000 population, as called for by the World Health Organization;58

74. Noting the equal emphasis placed on ‘paraprofessionals’ in the second bullet above, and recognizing the definition of paraprofessionals in the legislation as “an individual who is trained and employed as a health agent for the provision of basic assistance in the identification, prevention, or treatment of illness or disability.”59 It is evident that PEPFAR Ethiopia programs such as the MSH HCSP KOOWs and the JSI/L10K UHEP noted above are already contributing to the 140,000.

75. The emphasis in in-service training in PEPFAR programs prior to the reauthorization is a direct result of the PEPFAR indicators for reporting and planning. In the most recent final (2007) Indicators Guide60 35% of the 48 program-level indicators concentrated on measuring individual training participation. All of these will now be captured under a single indicator: “Number of health care workers who successfully completed an in-service training program.” According to the guidance, “Only a few priority program areas (the draft guidance only includes two) will be subset for more specific information on people trained.”61 The impact of this change on PEPFAR in-service training programs cannot be underestimated.

76. Two new indicators will have equal impact on the implementation strategies of PEPFAR programs: “Number of new health care workers who graduated from a pre-service training institution” (disaggregated by specific types: Doctor, Nurse) and: “Number of new community health care workers who graduated from a pre-service training institution”. These changes raise pre-service training and community health workers to a much higher priority for PEPFAR programs. Underlying this shift in focus is recognition that new competencies for existing health workers are insufficient to address the needs highlighted by the new PEPFAR reauthorization. The new emphasis on increased numbers of health workers requires a greater emphasis on pre-service vs. in-service training. These changes are in harmony with the HRH priorities articulated by the government of Ethiopia during the course of this assessment.

77. Analysis of the data in the Training Information Management System (TIMS) described in the training section above reveals a broad spectrum of PEPFAR supported-training since FY04. The following tables and charts illustrate the breadth and spectrum of PEPFAR-funded health worker training by year, region, and training focus. (The system does not uniquely identify individuals across trainings - individuals may be counted multiple times for attending multiple trainings.)

58 Ibid. Section 101(a)(4)(J)
59 Ibid. Section 3(9)
61 Ibid, p. 126
Figure 14: Number of PEPFAR Trained Health Workers

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number Trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY05</td>
<td>2549</td>
</tr>
<tr>
<td>FY06</td>
<td>20940</td>
</tr>
<tr>
<td>FY07</td>
<td>31628</td>
</tr>
<tr>
<td>FY08</td>
<td>38644</td>
</tr>
<tr>
<td>FY09*</td>
<td>20120</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>113,881</strong></td>
</tr>
</tbody>
</table>

*through April, 2009

Figure 15: Number of PEPFAR Trained Health Workers by Region
Figure 16: Number and Percentage of Health workers trained by Training Focus

<table>
<thead>
<tr>
<th>Training Focus</th>
<th>Number Trained</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCC/AB</td>
<td>31104</td>
<td>27.62%</td>
</tr>
<tr>
<td>HIV/AIDS Treatment - ARV Services</td>
<td>15879</td>
<td>14.10%</td>
</tr>
<tr>
<td>Counseling &amp; Testing</td>
<td>13318</td>
<td>11.83%</td>
</tr>
<tr>
<td>PMTCT</td>
<td>10118</td>
<td>8.99%</td>
</tr>
<tr>
<td>Medical Transmission - Injection Safety</td>
<td>8282</td>
<td>7.36%</td>
</tr>
<tr>
<td>HIV/AIDS Treatment - ARV Drugs</td>
<td>6171</td>
<td>5.48%</td>
</tr>
<tr>
<td>Laboratory</td>
<td>5236</td>
<td>4.65%</td>
</tr>
<tr>
<td>Other Capacity Building</td>
<td>4071</td>
<td>3.62%</td>
</tr>
<tr>
<td>Other Prevention</td>
<td>3914</td>
<td>3.48%</td>
</tr>
<tr>
<td>Strategic Information (Informatics, M&amp;E, Surveill)</td>
<td>2937</td>
<td>2.61%</td>
</tr>
<tr>
<td>Palliative Care - TB/HIV</td>
<td>2566</td>
<td>2.28%</td>
</tr>
<tr>
<td>OVC</td>
<td>2403</td>
<td>2.13%</td>
</tr>
<tr>
<td>Other/Policy Analysis &amp; System Strengthening</td>
<td>2239</td>
<td>1.99%</td>
</tr>
<tr>
<td>Supplies Management</td>
<td>1126</td>
<td>1.00%</td>
</tr>
<tr>
<td>Palliative Care - Basic Care</td>
<td>987</td>
<td>0.88%</td>
</tr>
<tr>
<td>Community Based Training/Orientation</td>
<td>564</td>
<td>0.50%</td>
</tr>
<tr>
<td>Journalist Training</td>
<td>521</td>
<td>0.46%</td>
</tr>
<tr>
<td>Management</td>
<td>476</td>
<td>0.42%</td>
</tr>
<tr>
<td>Curriculum Development</td>
<td>226</td>
<td>0.20%</td>
</tr>
<tr>
<td>Materials Development, updating/adaptation</td>
<td>184</td>
<td>0.16%</td>
</tr>
<tr>
<td>Guidelines Development</td>
<td>91</td>
<td>0.08%</td>
</tr>
<tr>
<td>Clinical Training Skills</td>
<td>75</td>
<td>0.07%</td>
</tr>
<tr>
<td>Advanced Training Skills</td>
<td>71</td>
<td>0.06%</td>
</tr>
<tr>
<td>Medical Transmission - Blood Safety</td>
<td>22</td>
<td>0.02%</td>
</tr>
<tr>
<td>Presentation/Writing Skills</td>
<td>22</td>
<td>0.02%</td>
</tr>
</tbody>
</table>

78. One important concern with in service training of this magnitude is the amount of time spent away from delivering health care. Over the last five years, 84,285 health workers were trained offsite for an average training length of 5.75 days, yielding a total number of 430,702 person-days of training. Assuming 210 working days a year, this indicates that PEPFAR training has taken 410 FTE's out of the health workforce for a five year period. The level of impact on health services this represents combined with the greater cost of offsite training urges careful consideration of the type and amount of in-service training required.

79. Progress since Addis Ababa. Key issues raised in the GHWA ‘Promoting Synergy Between Partners’ meeting held in Addis in January, 2008 have had mixed success since this seminal workshop. PEPFAR’s funding mechanism is such that country innovation is required for it to contribute to pooled funding and other coordination mechanisms, but it has contributed significantly to the development of a comprehensive HRH strategic plan. In service training has not become increasingly coordinated, but it is clear that emphasis is moving from in-service to pre-service training. Retention activities for private sector staff are underway, but the proposed retention schemes for public sector staff have had little progress. The HRIS system, noted as existing in Jan, 2008 has been piloted, but is far from full-scale deployment. Finally, donor recruitment of public sector leaders and medical professionals appears to continue unabated. The Addis Ababa objectives need to be revisited in the light of current developments. Some guidance and concerns expressed at that time emerged again during this assessment while others demonstrated clear progress.
4.2 DFID

80. DFID operates largely through pooled funding mechanisms. The contribution to HRH is through the application of these pooled funds, and forms part of the UK’s approach to supporting the implementation of the country health plan and broader health systems strengthening. A costed, comprehensive HRH plan is seen as an integral element of the country health plan. The tools and evidence to develop HRH plans are part of ongoing activities nationally and globally.

**Figure 17: DFID support to HRH and HSS**

DFID’s HRH interventions – a ‘big picture’ perspective

![Diagram showing HRH interventions]

- £7 billion - Health (2008-15)
- Bilateral LIC focus
- Multilateral
  - WHO
  - UNFPA
  - WB
  - GFATM
  - GAVI
  - ADB
  - UNICEF
  - UNAIDS
  - EC
- Research Consortiums

**HRH: Tools, Evidence etc**

**Costed HRH Plan**

e.g. UK Global Health; Brown/Bush; EC; GHWA; South Asia; Malawi


81. DFID is a champion of and signatory to Ethiopia’s IHP+ Country Compact. Other signatories to the Compact, notably the first to be signed, include Direzione Generale per la Cooperazione allo Sviluppo (Italy), the European Commission, the governments of Spain and the Netherlands, the African Development Bank, World Bank, UNAIDS; UNICEF; UNFPA; WHO and the Ministries of Health and Finance from the government of Ethiopia. In addition, GAVI, the Global Fund and USAID all sent letters of support for this pioneering document to the Ministry of Health. The Country Compact has the following to say about human resources for health: “The Development Partners recognize that the human resource shortage is one of the main constraints for health sector development: they commit to address the health workforce constraints by contributing to human resource development and to avoid undermining the public sector workforce.”

82. DFID follows the guidance of the Compact in contributing to Protecting Basic Services (PBS) block grants made directly to the woredas. DFID’s contribution of £135m over 3 years demonstrates the commitment to this funding stream. Administered by the World Bank the renewed PBS Program Phase II Project has the support of ten additional partners in addition to the World Bank and DFID: Austria, Ireland, Italy, Japan, Netherlands, Spain, CIDA (Canada), KFW

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62 Federal Ministry of Health, Compact between the Government of the Federal Democratic Republic of Ethiopia and the Development Partners on Scaling Up for Reaching the Health MDGs through the Health Sector Development Programme in the framework of the International Health Partnership (II)(7), p. 4 Available online at: [http://www.internationalhealthpartnership.net/pdf/04_Ethiopia_IHP_Compact_August_2008_FINAL.pdf](http://www.internationalhealthpartnership.net/pdf/04_Ethiopia_IHP_Compact_August_2008_FINAL.pdf)
(Germany), and the European Commission. The Health Extension Program (HEP) particularly benefits from the PBS block grants, and around 6-7% (USD 72-84 million) of the first phase of PBS was used for direct salary support at the woreda level.

83. An external evaluation report published in April 2009 expresses concerns on the first phase of PBS. Whilst noting that it has increased core funding to basic services, the large and disproportionate amount allocated to staff remuneration was questioned. The FMOH position is for partners to support capital and catalytic funding to enable scale-up whilst domestic resources cover all recurrent costs. However, as per the discussion in section 2, the reality is that recurrent costs of staff salaries are heavily subsidised by external financing. DFID’s annual investment is currently greater than the total cost of 971m birr allocated to salaries (see table in section 2).

84. To contextualise this, and using WHO’s conservative estimates from 2008 rather than the external evaluation in 2009, the percentage of DFID’s financial support to PBS which is subsequently allocated to pay salaries is equivalent to the full-time salaries of 7,500 nurses currently employed in Ethiopia (approaching one-half of the 16,311 total) or 2,000 of the 2,085 General Practitioners and specialists.

85. Another pooled funding mechanism is the second iteration of the Health Pooled Fund (HPF-II), a technical assistance fund administered by UNICEF to support the implementation of the HSDP. DFID is joined in support of the HPF by Irish Aid, the Royal Netherlands Embassy, the Swedish International Development Agency (SIDA), Italian Cooperation, and the Austrian Development Cooperation. While HPF-II is largely intended to support high-level technical assistance to the HSDP, it has already supported health worker study trips, telemedicine, surgery training and an evaluation of the Health Extension Program.

86. The Wolfensohn Center for Development’s Case Study on Aid Effectiveness in Ethiopia acknowledges the PBS and HPF-II pooled funding mechanisms as unusual exceptions to the general lack of alignment and coordination among multilateral donors.

87. A third pooled mechanism, the MDG Performance Fund administered by the Ethiopian FMOH using the procedures of the Government of Ethiopia is repeatedly acknowledged as the preferred modality of the GoE for scaling up Development Partners assistance in support of the HSDP. DFID is providing £35 million over 3 years to this scheme.

63 WHO Ethiopia, Human Resources for Health and Aid Effectiveness Study in Ethiopia (June, 2008), p. 32
64 Ibid, p. 25
66 Author’s calculations based on exchange rate of GBP1:ETH Birr 18.8; salary (without allowances) of nurse, MDs and specialists and: number of health workers as available in FMOH Health and Health Related Indicators for 2007/8.
67 The MOU for HPF-II is available online at: http://www.dagethiopia.org/Public/Publications/MOU%20HPF-II%20final%20nov2007.doc
88. **Progress since Addis Ababa**: DFID demonstrates clear commitment to the pooled funding requests and the implementation of broader HRH and HSS activities as encouraged by the GoE: the development and signature of the first IHP+ Country Compact as an example. The use of PBS funding is clearly having a significant impact on the recurrent costs of staff salaries across Ethiopia.

### 4.3 Cooperating Partners

89. As can be seen from the pooled funding mechanisms and collaborations above, many other CPs provide support to HRH and HSS in Ethiopia. We met with a number of agency representatives to appreciate their inputs. A selection of key partners and programs are represented below:

90. **World Bank** The World Bank administered Protection of Basic Services (PBS) program is the major aid instrument supporting improved and more accountable decentralized basic services. On May 14 2009, the World Bank’s Board of Executive Directors approved USD 540 million in International (IDA) funding for Phase II of the Protection of Basic Services (PBS) block grant program over the next three years. The Government of Ethiopia is expected to contribute USD 700 million a year to the PBS, and the 12 donor partners (including the IDA) will contribute about USD 400 million a year. This direct support to the woredas is expected to continue to strengthen the Health Extension Program, and will provide additional support to primary and community health workers. The PBS is a strong example of donor coordination and pooled funding.

91. **WHO**. The WHO Country Office plays a leading role in the health sector coordination, especially for Health Systems Strengthening. Recent work by WHO has identified and framed support for health systems around ‘six pillars’: Service Delivery, HRH, Leadership and Management, Health Financing, Pharmaceutical and Logistics, and Information. Support identified for Ethiopia in the HRH ‘pillar’ includes:
   a. Support development of evidence based comprehensive health workforce planning
   b. Support integrated PSE
   c. Support capacity development on HRH management
   d. Support, develop and implement retention of strategies, including better management of migration
   e. Support development of country and local level HRIS

92. **UNFPA**. UNFPA has increased its funding to USD 22.8 million in its sixth round of support to its Ethiopia country program action plan (2007-2011). The initial workplan indicates USD 2.2 million will be allocated to regions specifically for basic social services and human resources. UNFPA has played and will continue to play a significant role in reducing Ethiopia’s high maternal mortality rate. (It was estimated during the interview that fifty Ethiopian women per day die of preventable RH causes.) Specific activities observed included:
   a. Support and training for emergency obstetric surgery (EmOC) teams through the Integrated Emergency Obstetrics and Surgery (IEOS) and the Health Systems Strengthening for Equity (HSSE) programs

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69 Press release available online at:


71 WHO Ethiopia, Human Resources for Health and Aid Effectiveness Study in Ethiopia (June, 2008), p. 32
b. Working with the International Council of Midwives (ICM) to revitalize midwifery in Ethiopia through tutors, capacity-building (supplies and teaching aids), strengthening of midwifery associations, and quality of care interventions.

93. **UNICEF.** Beyond the lauded administration of the HPF pooled funding mechanism, UNICEF has invested significantly in integrated refresher trainings (IRT) for health extension workers (HEWs). Funding for these programs have been decentralized to the regions to benefit more than 32,000 HEWs. The programs have been particularly useful for on the job training, skill upgrading and supervisor training at various levels.\(^{72}\)

94. **JICA.** The 2008 announcement at the TICAD IV Conference ‘to train 100,000 people as health workers [in Africa] over the coming five years’ was to be factored into the next round of JICA planning. JICA staff indicated that this process was ongoing and a senior delegation from Japan was in the process of discussions with the GoE. This was responding to a request to support the HR2020 Strategy and in particular the scale-up of MDs, where a request for $105 million had been tabled by the GoE. At the time of the assessment, JICA staff indicated that these discussions were complicated by an absence of the **HR2020 Strategy** and a firm accord between partners on its implementation.

95. **Global Fund.** The available Round 8 proposal for malaria cites as its sixth objective: “To strengthen the overall health system, including decentralized HR capacity development; improved HIS; and enhanced service delivery.”\(^ {73}\) The specific Service Delivery Area (SDA) 7 emphasizes the specific training on malaria for technical staff at regional and district level, as well as extensive training of HEWs. This last is particularly important, as malaria is the only disease that allocates diagnosis and treatment responsibility to HEWs. The proposal also includes a malaria control workload analysis to develop a HR malaria planning tool and guide to support evidence-based information for program managers to advocate for improvements in staffing levels. The assessment team also met with the consultant supporting the country coordinating mechanism for round 9, who communicated that a continued emphasis on HRH support will be included in the Round 9 application.

96. Funders and partners not interviewed (due to time, availability and/or assessment scope include: GAVI, the EU, Austria, Ireland, Netherlands, Spain, CIDA (Canada), KFW (Germany), and the European Commission. We do note that a number of these donors have significant funding and contribute to HRH activities. The GAVI Health Systems Strengthening program, for example has allocated $14.2 M from 2006-2010 for Human Resource Development and Performance Management. Activities include refresher courses for 25,050 HEW’s, apprenticeship for 12,600 HEW students, capacity strengthening for health management teams, and training of health workers in IMNCH.\(^ {74}\)

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\(^{72}\) *Ibid*, p. 36

\(^{73}\) *Ethiopia Country Coordinating Mechanism Proposal for Round 8 Malaria*, p. 29. Available online at: [http://www.theglobalfund.org/grantdocuments/8ETHM_1672_0_full.pdf](http://www.theglobalfund.org/grantdocuments/8ETHM_1672_0_full.pdf)

\(^{74}\) GAVI Ethiopia Health System’s Strengthening Proposal. Available online at: [http://www.gavialliance.org/resources/HSS_Ethiopia.pdf](http://www.gavialliance.org/resources/HSS_Ethiopia.pdf)
5 Discussion and recommendations

97. Two presentations of initial findings were held on Friday 8th May. The first to FMOH staff and the second to the HPN Donors Group. Copies of the presentations are available as Annexes 5 and 6 respectively.

98. The feedback to both groups reflected the request in the assignment TOR to ‘highlight the risks and challenges to strengthening of HRH going forward and recommend how best DP support to the HRH strategy can be improved in terms of coordination and communications’. The principle concern addressed to both groups was the need for enhanced modes of communication, coordination and commitment on HRH. The IHP Country Compact and its coordination mechanism (offering scope for PEPFAR’s Partnership Framework development) could support a more consultative process and offers many opportunities to recover from the current position and add considerable value to the next steps.

99. It is suggested that the HR2020 Strategy, over a period of 12 years, can be considered a visionary document that guides partnerships to mutually achieve the GoE objectives. The intended, or unintended, pun on ’20-20‘ and vision/sight highlights the analogy of a visionary document. Implementation will require considerable engagement, on an annual basis, between the Federal Ministry of Health (FMOH), Regional Health Bureaus (RHBs), Woreda Health Offices (WHO) and wider line Ministries from the GoE. Development partners and their implementing agencies are thus likely to be called upon at regular intervals to support reflection, review and implementation modalities.

100. The review and pending implementation process thus presents an opportunity for all partners to collectively contribute to the objectives outlined by the GoE. Preparation for this engagement, by both the FMOH and the HPN Donors Group, is therefore essential.

5.1 HRH

101. As above, enhanced HRH engagement to translate the HR2020 Strategy into clear implementation plans is forthcoming and the coordination and communication mechanisms will need to respond. This relates to a recommendation from the Mid Term Review (July 2008) calling for strengthened coordination between the FMOH and Development Partners75. The former arrangements for a HRH Platform and a national HRH Observatory could be revisited with due attention to staffing and national human resource management capacity to take these forward. This could be structured around the guidance from the Global Health Workforce Alliance and the introduction of a Country Coordination Framework (CCF)76.

Recommendation HRH1: FMOH and HPN Donors Group to revisit arrangements for a HRH Platform and a national HRH Observatory and agree enhanced mechanisms for coordination, communication and collaboration, potentially utilising GHWA’s Country Coordination Framework (CCF).

76 The framework sets out opportunities whereby partners, members, regional bodies and all other stakeholders in countries can work together in a collaborative and participatory manner to develop specific actions to address country specific HRH workforce crisis.
102. Of keen interest to all partners will be how they can support the GoE in the implementation of the HR2020 Strategy. The FMOH, working with appropriate line ministries, is therefore encouraged to develop and communicate the anticipated resource requirements for its implementation and to relate these calculations to the available and projected fiscal space in the next 3-5 years. The offer of technical assistance from the World Bank could be engaged to support this. Whilst the FMOH has indicated that they are seeking capital and catalytic investment for the initial costs of implementation, the findings in section 2 and 3, demonstrate that cooperating partners are currently subsidising the recurrent costs of health worker salaries and allowances. Scaling-up the workforce by the volume indicated in the ‘flooding’ strategy will require due consideration to the projected resources available to the GoE to cover recurrent costs, consistent with the country compact of August 2008.

Recommendation HRH2: FMOH to develop and articulate the projected resource requirements for the HR2020 Strategy, engaging other line Ministries where appropriate and with consideration given to the offer of technical assistance from the World Bank.

103. Moving from the development of the HR2020 Strategy to its implementation will require due consideration to the human resource management and technical capacities of government institutions and agencies. The BPR exercise has evaluated the core competencies and sets out revised structures going forward so much of this work exists. There will however be further development work required with RHBs and WHOs to cascade the evaluation, planning and implementation competencies to the decentralised levels. The FMOH has indicated that development partners’ support to provide long-term technical assistance in HRH management and planning will be appreciated. Defining the scope of the implementation needs and the added value role of technical assistance will enable further discussion and agreement.

Recommendation HRH3: FMOH, working with development partners, to develop and articulate the initial implementation plans, with due consideration to human resource management and technical capacities across government institutions and agencies.

104. With all HRH reforms it is essential to develop and affirm the baseline against which the anticipated (or unexpected) results can be measured. It is assumed that the HR2020 Strategy has collated and acted upon much of the country evidence and hence a relatively robust and recent baseline may be available. On review of this evidence and in collaboration with existing work with the Health Metrics Network, careful consideration should be given to identifying any gaps and acting upon these. Particular attention should be given to the review of metrics and indicators which may have been included in the HR2020 Strategy. An assessment of how these relate to the IHP+ Compact and the concept of one monitoring and evaluation framework at the country level, their availability from current information sources and the required actions to generate additional data should be considered.

105. A potential gap identified during this assignment is the strengths and weaknesses of the current ‘ABC retention scheme’. Given the ongoing discussions on the optimum terms and conditions for health workers to improve public sector retention, and the internal sensitivities that were being discussed during the visit (i.e. delinking health workers from the civil service), it would be of added value to determine the effectiveness and efficiency of the scheme currently in operation. There were a number of concerns expressed during the assignment on the disincentives within the current system (i.e. withholding diplomas, barriers to post-graduate specialisation). The existing work by a WHO-led expert group on Increasing Access to Health
Workers in Remote and Rural Areas through Improved Retention offers considerable evidence that financial and non-financial packages should be developed and revised based on regular and rigorous analysis of labour markets and current interventions. This evidence may factor in the HR2020 Strategy, but if not the FMOH is advised to facilitate this in the coming months.

106. From this initial review, there will be an opportunity to determine the priorities and enhancements that may be required in the country M&E frameworks, linked to the ongoing roll-out of the health information system (HIS) and the human resource information system (HRIS). A move towards active Workforce Surveillance, engaging wider ministries, the National HRH Observatory, parastatal agencies and partners in an active, dynamic role to capture, collate and analyse student and workforce data across the public and private sectors is advised. This extends to the role of training institutions, accreditation and licensing bodies and the array of professional associations in Ethiopia as well as line Ministries responsible for payroll and secondary/tertiary education. Developing the collective capacity of all data providers to produce live workforce surveillance indicators, supported by appropriate technology will enable considerable benefits to future planning, policy and data-driven decision-making.

**Recommendation HRH4:** FMOH to develop and articulate the baseline for monitoring and evaluation of the HR2020 Strategy, linked to the M&E framework of the country health plan and in collaboration with existing work with the Health Metrics Network.

**Recommendation HRH5:** FMOH to facilitate the review and analysis of the current ‘ABC retention scheme’ in relation to labour market conditions and projections.

**Recommendation HRH6:** FMOH to consider the implementation of an active workforce surveillance culture across all institutions and agencies to support future planning, policy and data-driven decision-making.

107. The ambition of the HR2020 Strategy to rapidly scale-up particular cadres of health professionals, with a parallel investment in training facilities and faculty is notable. The ‘flooding’ and “Speed, Volume, Quality” strategies raise implementation challenges that will need to be addressed. Maintaining quality and standards in both the public and private sector training institutions and linking recruitment to graduation dates to rapidly deploy newly qualified health workers are some of the challenges. This is a topical issue. The Minister of Health, responding to the findings of the MTR and the conclusion that the ambitious targets may compromise quality responded that “an ambitious/big target does not necessarily compromise quality. What needs to be done is to identify in advance the conditions where quality can be compromised and deal with them effectively”.

108. A comprehensive approach to Medical Education is one area which will support future quality. The absence of specialist medical educationalists and the stated intention to import expatriate faculty from differing backgrounds are elements which will confound the introduction of international benchmarks. The World Federation for Medical Education (WFME) proposes international benchmarks for under-graduate, post-graduate and continuous professional development. These and the introduction of post-graduate training in Medical Education may be appropriate investments to ensure quality is delivered. Such standards can then be applied to

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77 Further information is available from the WHO website at: [http://www.who.int/hrh/migration/expert_meeting/en/index.html](http://www.who.int/hrh/migration/expert_meeting/en/index.html)

both public and private sector training institutions, with the capacity of the latter harnessed to provide greater impetus to the scale-up ambitions.

Recommendation HRH7: FMOH, working with the Ministry of Education, to consider the introduction and ongoing development of World Federation for Medical Education (WFME) benchmarks and to train faculty with specialist knowledge in Medical Education.

109. The debate on the role and competencies of health workers to improve reproductive health services and address maternal mortality rates is ongoing. This extends to the interactions between HEWs and TBAs as discussed in section 2. It is already agreed that further effort is required to meet targets in HSDP III related to the percentages of delivery attended by a skilled health worker. Policy options will need to be explored and developed accordingly, but the critical element is to include the many stakeholders in this debate and fashion responses which maximize the comparative advantages of each of the stakeholders.

110. A comprehensive approach to training midwives and anesthetists is positive. In parallel, extending community based services, through the appropriate health cadres and community representatives should also be part of an integrated strategy. Existing forums for reproductive health, family services and maternal, neonatal and child health should come together to agree and implement multiple approaches based on Ethiopia’s needs. The benefits of task-shifting in community health services, as evident in Ethiopia, could form part of the solution.

Recommendation HRH8: FMOH and partners to agree and implement solutions to improve reproductive health services and address maternal mortality rates, based on Ethiopia’s needs and maximizing the comparative advantages of each of the stakeholders.

5.2 Cooperating Partners – supporting actions

111. Harmonisation and alignment to government priorities is an agreed process within Ethiopia. In preparation for the engagement on the HR2020 Strategy, partners are encouraged to collectively document their current and anticipated technical support. Whilst this report captures an overview of some of the interventions, more detailed mapping is required. An internal assessment by WHO may provide an example of this mapping approach. Ideally the key headings and sub-headings within the HR2020 Strategy can provide a structure for the mapping.

Recommendation CP1: HPN Donors Group to engage partners to map existing and planned technical activities against the HR2020 Strategy.

112. The importance of harmonization with government, donor partners and implementation partners cannot be over-emphasized. The PEPFAR Partnership Framework provides an excellent vehicle for proactive alignment, using existing partnership mechanisms (such as Ethiopia’s pioneering IHP+ Compact) as a starting point. Greater alignment and collaboration will help leverage limited per-capita funding and harmonize related activities, with greater success in achieving TPC and systems strengthening goals.

Recommendation CP2: PEPFAR Ethiopia to collaborate with GoE, DFID, and other bilateral agencies on development of Partnership Framework, linking to the Ethiopia IHP+ Compact.

113. The link between Ethiopia’s shortfall on care/treatment goals and the low per-capita aid investment is evident. By proactively discussing this specific funding challenge with
Washington, along with a conversation about the challenges created by highly volatile funding on a year-by-year basis may yield productive results. It is very difficult to plan, achieve long-term goals and align with partners with unpredictable resource availability.

**Recommendation CP3:** PEPFAR Ethiopia to collaborate with Office of the Global Aids Coordinator (OGAC) to address per-capita funding issues and improve predictability of funding

114. Some of the challenges observed stem from the wide variety of activities and partners. Consolidation of HRH activities, focused support of the GoE’s **HRH2020 Strategy** and HIV goals, consolidation of activities around that effort, and reduction in the number of partners delivering smaller HRH interventions will strengthen the ability of PEPFAR to achieve goals and high-quality results.

**Recommendation CP4:** PEPFAR Ethiopia to streamline funding for maximum efficiency gains with implementing partners working to their comparative advantage

115. PEPFAR Ethiopia has invested in the development of two strong strategic information resources for improved health workforce surveillance. The Tulane HRIS is a solid system, tailored to address Ethiopia’s unique challenges. Supporting the GoE’s uptake of this system, will help strengthen the quality and availability of health workforce information for policy, planning and decision-making for improved service-delivery. While the Tulane HRIS is a solid central system, it can be supported at the regional and district levels with a wide variety of paper and low-cost technology solutions. Start low-tech. Any system that works with paper will lay the foundation for a technology-based system. We were encouraged to learn that USAID is already developing new programming which will support a culture of workforce surveillance, data collection and analysis using low-tech, reporting systems linked to existing engagements with primary health care facilities. We were further encouraged that conversations have already started around aligning the MOH HRH job classifications around the International Labor Organizations current International Standard Classification of Occupations (ISCO-08)79. This is a key standard for accurately comparing HRH jobs across organizations, sectors and countries. Our review of the Tulane HRIS indicated the potential for easy implementation of this important standard.

116. Similarly, the JHPIEGO TIMS system provides an excellent resource of initial workforce data, as well as a wealth of historical training information. A 2008 study of the value of the TIMS data found “...that the information in the Training Information Monitoring System can be used to track the working status of trained providers ... Further study on reasons why providers leave sites and why providers are not working on HIV at the sites where they were trained, in addition to our project findings, can provide valuable data for development of national and regional strategies and retention schemes.”80 Upgrading this system to a web-based architecture (integration with Tulane HRIS should be considered) and transitioning it to GoE support and use will facilitate the tracking and understanding of training interventions. Concurrent capacity building in required eHealth, ICT, and data quality and use will ensure sustainability and

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effective application of these valuable tools. Once these systems are enhanced there is an opportunity for all partners to report their training programmes into this country-owned system.

**Recommendation CP5:** Initiate dialogue between GoE and development partners to utilize HRIS and TIMS as a basis for a central, country-owned system that all partners can report to.

**Recommendation CP6:** Link HRIS roll-out strategy to HMIS scale-up to maximize economies of scale with little duplication of effort.

117. The new indicators move the focus from a wide variety of in-service training to a greater emphasis on pre-service and paraprofessional training. PEPFAR Ethiopia is already projecting over the next five years pre-service trainings of 17,338 clinical, social and community health workers, and further trainings (in-service) of an additional 23,978 case managers, data clerks, counsellors, IMAI, and kebele outreach workers for a total of 41,316 health workers. PEPFAR Ethiopia already has demonstrated success in paraprofessional training and has the opportunity to pro-actively identify and scale up pre-service strengthening opportunities.

**Recommendation CP7:** Recognize and scale-up PEPFAR successes in HR Management training, retention, and community health worker development, realizing the focus provided by new PEPFAR HR indicators

118. Similar to the increased emphasis on pre-service and paraprofessionals, the new PEPFAR indicators’ decrease in IST emphasis creates an opportunity for an in-depth review of PEPFAR Ethiopia’s IST activities. A comprehensive analysis of the TIMS data will reveal unexpected patterns and results. Key areas to address include training priorities, costs, and impacts on service delivery (such as extended off-site training removing providers from care provision).

**Recommendation CP8:** Review the Training Information Management System (TIMS) data against PEPFAR Ethiopia in-service training (IST) investment and results to address gaps, redundancies and unintended impacts from off-site training.

119. Partners in the pooled funds should work with the GoE to specifically document the presence and effectiveness of systems strengthening activities of the pooled funding mechanisms, particularly contributions to HRH. Any identified gaps and opportunities may then be proactively addressed. This work is partly ongoing within the independent evaluation of the IHP+, conducted by the North-South Observatory (with an Ethiopian partner in the consortium). The external evaluation will be reporting to the IHP+ later this year. The HPN Donors Group is encouraged to act in advance of the external evaluation.

**Recommendation CP9:** Pooled funding partners review and strengthen impact on government and health systems strengthening.

120. These recommendations are for ongoing dialogue and discussion between partners. Many are complementary to each other and require continuing commitment to working in partnership, applying complementary strengths to take these forward. Once the FMOH provides its responses, further discussion between USG, DFID and other partners in HPN Donors Group will be required to agree where respective programming can support the implementation.

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81 Projections provided via email 6 May, 2009
Annexes

Annex 1 – Terms of Reference

TORs for joint DFID/PEPFAR work on Human Resources for Health (HRH) in Ethiopia

Background:
1. In response to the critical HRH shortages in Africa, DFID and Office of the US Global Aids Coordinator (OGAC) responsible for PEPFAR have been in discussion with a number of African countries to develop strategies and country level actions. The aim is to demonstrate the maximum flexibility of disease specific programmes to support broad based primary care in line with countries’ health plans.

2. An initial operational meeting was held in Ethiopia in January 2008 with US, UK and country representatives from Ethiopia, Zambia, Mozambique and Kenya (PEPFAR, DFID overlap countries). Some initial progress was made and a matrix was produced for each country highlighting key short to mid term priorities that could be potentially funded. However, these required further work and details on priority areas for each country.

3. There is high level political support for this process in the UK and US, provided that the efforts result in specific actions and commitments in each country. There are risks that this activity runs counter to existing country processes and every effort should be made to ensure that this work does not bypass country systems and HRH working groups. This should be undertaken in low key manner, with support from DFID and US country teams and the Ministry of Health and focus on operational level activities. Discussions should include appropriate Government of Ethiopia staff and key Development Partners from the Health, Population and Nutrition (HPN) donor group with involvement in HR support including WHO.

4. The Ministry of Health in Ethiopia has completed the design of its Business Reengineering Process including HR as a key support process. A new HRH strategy has also recently been finalised. This is an opportune time to identify how DP support for HRH could be strengthened.

Purpose:
5. To document the current priority actions on HRH in Ethiopia and current flexibilities for funding streams to support the emerging Human Resource Development strategy from DPs including the United States Government (USG) and DFID. This will build on existing work and within national frameworks including the Health Sector Development Plan, and the Business Process Reengineering processes.

Scope of Work
6. The consultant(s) will:
   - Review health sector documentation including those relating to the Health Sector Development Plan and the recently produced HRH strategy and highlight the priority areas identified by the MOH for action, and possible priority areas for DP support in the short, medium and longer term.
   - Review other public sector strengthening/reform and HR related plans and initiatives and their implications for the health sector, including linkages with the Ministry of Education.
Review current support for HRH by PEPFAR and DFID and make specific recommendations on how both organisations might increase the impact of their support on HR capacity building.

Map any other significant DP support programmes for HRH and highlight where there may be particular future gaps or where the impact of DP support for HRH could be increased.

Highlight the risks and challenges to strengthening of HRH going forward and recommend how best DP support to the HRH strategy can be improved in terms of coordination and communications.

Review results of the initial PEPFAR-DFID HRH meeting in Addis Ababa and consider progress made, documenting the extent of current PEPFAR and DFID support to health systems strengthening and areas where the impact of this support could be increased.

Identify challenges to the predictability of DFID and PEPFAR financing in relation to health systems strengthening and specifically HRH.

Consult with and present outputs to stakeholders including the MOH, US, UK and other key HPN group DPs.

**Timeframe:**

7. The consultancy is expected to start in April 2009.

**Output:**

8. A draft report the responds to the above scope of work, highlighting current investments, challenges, flexibilities and opportunities for strengthening DP support for HRH in Ethiopia including by DFID and PEPFAR. The report will be submitted within 10 days of departing from Ethiopia. The draft will then be amended within 10 days of receiving comments.

**Inputs:**

9. Up to xx days shared between two consultants (UK/US) with a background in health systems and human resources for health, with strong facilitation skills and experience of working in Africa.
Annex 2 – Itinerary and persons met

Draft Itinerary 25 April – 09 May, 2009

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<th>Jim Campbell</th>
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<td>Mon 27th</td>
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<td>Briefing Meeting(s) with DFID / USG personnel: Ahmed Attieg (CDC), Ali Forder (DFID), Dr. Girma Azene (Tulane), Dr. Oluma Bushen (Tulane), Brad Comer (USAID), Petros Faltamo (USAID), Garoma Kena (USAID)</td>
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<td>Health Promotion, Disease Prevention and Control Directorate, FMOH: Dr. Kesetebirhan (Director General, HPDPCD), Brad Comer (USAID), Dr. Girma Azene (Tulane) Ethiopia</td>
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<td>Tues 28th</td>
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<td>Clinical Services Directorate, FMOH: Dr. Yibeltal Assefa (Director, Clinical Services), Dr. Girma Azene (Tulane)</td>
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<td>National AIDS Council NAC/HAPCO: Ato Meskele Lera (Deputy Director General, HAPCO), Dr. Girma Azene (Tulane)</td>
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<td>MTEF Office, Ministry of Finance (MOFED): Ato Johnssie (MTEF), Ato Desta Lambebo (MTEF), Dr. Girma Azene (Tulane)</td>
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<td>Drug Authority and Control Administration (DACA): Ato Mengistab Aregay (Deputy Director General, DACA), Ato Abebe Asmelash (Director of HRD, DACA, former Director, HRD, FMOH), Dr. Girma Azene (Tulane)</td>
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<td>Dinner with Ali Forder, Senior Health Advisor, DFID</td>
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<td>Weds 29th</td>
<td>am</td>
<td>Millennium Medical School, St. Paul’s Hospital: Dr. Mesfin Araya, Dean of Medicine</td>
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<td>Lunch with Mimi Church, Health Metrics Network (HMN)</td>
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<td>Office of the State Minister of FMOH: H.E. Dr. Kebede Worku, (State Minister of FMOH), Dr. Girma Azene (Tulane)</td>
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<td>Meet with Anne Martin Staple, Health Strategies International</td>
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<td>Thurs 30th</td>
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<td>CDC Ethiopia, EHRNI: Dr. Abubaker, Dr. Girma Azene (Tulane)</td>
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<td>DFID Ethiopia: Ali Forder (Senior Health Advisor), Paul Walters (Senior Economic Advisor)</td>
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<td>Capacity Project, Ethiopia: Jeanne Rideout (COP), Solomon Hagos (M&amp;E Manager), Annette Bennett (Dean, Hamlin College of Midwives)</td>
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<td>USAID Ethiopia: Meri Sinnitt (Office Chief – Health, AIDS, Population, Nutrition Office), Dr. Abebe Zegeye (HIV/AIDS care &amp; Support Advisor), Dr. Richard Reithinger (Malaria Advisor/Team Leader – PMI), Brad Comer</td>
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<td>Fri 1st</td>
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<td>Addis Ababa Fistula Hospital: Dr. Gordon Williams</td>
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<td>UNFPA Ethiopia: Dr. Monique Rakotomalala (Country Director), Dr. Kidone Ghebrekidan (RH Program) WHO Ethiopia: Dr. Akram Eltom (HIV/AIDS Country Team Leader), Dr. Gebrekidane Mesfin (National</td>
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<td>Sat 2nd</td>
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<td>Bethesaida Higher Clinic: Dr. Melaku Mulatu (Clinic Director), Dr. Tekele-Ab Zaid (Policy Advisor, PSP)</td>
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<td>St. Mary's High Clinic: Habtorm Tsefaye (Executive Director), Dr. Lidoj (Clinic Manager), Dr. Million Seid (Internist), Dr. Tesfamarien G/Amlek (Internist)</td>
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<td>Sun 3rd</td>
<td>AM/PM</td>
<td>MSH/HCSP (Training, Task Shifting, Case Managers): Haile Wubneh (Deputy Chief of Party, MSH/HCSP), Nelia Matinhure (Senior Specialist &amp; Team Leader, Same the Children/HCSP), Petros Faltamos (USAID), Faris Hussein (USAID/HAPN)</td>
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<td>Abt Associates/PSP (Human Resources Management Training): Abenet Leykun (Deputy Chief of Party), Petros Faltamos (USAID), Faris Hussein (USAID/HAPN)</td>
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<td>JSI/L10K (Pre-service Health Extension Worker Training): Wuleta Belemarian (Director), Samuel Yalen (Deputy Director), Petros Faltamos (USAID), Faris Hussein (USAID/HAPN)</td>
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<td>Carter Center/AHOTP (Pre-service Health Officer Training): Hailu Yeneneh (Resident Technical Adviser), Petros Faltamos (USAID), Faris Hussein (USAID/HAPN)</td>
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<td>JHPIEGO: Hannah Gibson (Country Director-Ethiopia), Yassir Abduljewad (Deputy Country Director-Ethiopia), Ahmed Attieg (CDC)</td>
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<td>Tulane Ethiopia: Dr. Oluma Bushen, Dr. Girma Azene, Ahmed Attieg (CDC)</td>
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<td>HRD Directorate, FMOH: Dr. Birhanu Feyisa (Director of HR Development, FMOH)</td>
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<td>Tues 5th</td>
<td>AM</td>
<td>Italian Cooperation: Marina Madeo (Health &amp; HIV/AIDS Adviser, Embassy of Italy Development Cooperation Office)</td>
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<td>UNFPA/ICM Midwifery Program Launch (Ghion Hotel): Ted Chaiban (Representative UNICEF Ethiopia), Sister Aster Berhe (President, Ethiopian Nurse Midwives Association), Monique Rakatomalala (UNFPA), Annette Bennett (Hamlin College of Midwives)</td>
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<td>Weds 6th</td>
<td>AM</td>
<td>JHPIEGO/TIMS Visit: Hannah Gibson, Yassir Abduljewad</td>
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<td>JICA: Mr. Futami (Health, JICA)</td>
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Annex 3 - Documents consulted / referenced materials.


Church M. Health information systems activities: HMN and HMIS scale-up. Presentation presented to HPN donor group; 28 April 2009; Addis Ababa, Ethiopia.


Concept note: Scale-up strengthening health workers pre-service education on health-related MDGs. Draft paper. 13 April 2009.


Ethiopian Public Health Institute. BPR. Presentation. n.d.

Ethiopia public health training initiative network: MOE-MOH; 7 universities, 7 regions, 21 hospitals. USAID. n.d.


FHAPCO. FHAPCO integrated supportive supervision. Final draft. 13 June 2008.


Five year projection of training health workers. PEPFAR. April 2009.


Hawassa University College of Health Sciences Faculty of Medicine. Curriculum for master of science course in integrated emergency surgery (obstetrics, gynecology and general surgery). [Hawassa, Ethiopia], November 2008

Health and health related services and products quality regulation core process. Redesign overview. n.d.


HIV/AIDS monitoring and evaluation in Ethiopia. n.d.


HRD Department FMOH. The human resources for health (HRH) situation in Ethiopia. Presentation presented at the WHO TTR workshop; 1-2 November 2007; Addis Ababa, Ethiopia.


Interest group analysis on task shifting to NPCs. Presentation. 15 April 2009.

Kassa A. Overview of FHAPCO’s BPR process and key results. Presentation presented at the HPN group BPR orientation forum; March 2009; Addis Ababa, Ethiopia.

Kebele oriented outreach workers (KOOWs) – roles, responsibilities, linkages and selection process. USAID. n.d.


Lera M. Ethiopian multisectoral response against HIV/AIDS. Presentation presented to delegation from PEPFAR and DFID; 28 April 2009; Addis Ababa, Ethiopia.


MOH business process re-engineering (BPR) March 2009.

MOH policy, planning and monitoring & evaluation core process presentation. n.d.

Federal Ministry of Health of Ethiopia. MSc course in integrated emergency surgery (obstetrics, gynaecology and general surgery), Project proposal. 2007.


Overview of public health emergency management core process presentation March 2009.


PEPFAR procurement integrity, conflict, of interest and non-disclosure statement for all U.S. government emergency plan for aids relief confidentiality agreement April 2009.

PEPFAR procurement integrity, conflict, of interest and non-disclosure statement for all U.S. government emergency plan for aids relief confidentiality agreement. December 2008.

PEPFAR sponsored training course event information form. PEPFAR, Ethiopia. n.d.


 Provisional agenda. Agenda for the Fourth session of the African Union conference of ministers of health; 4-6 May 2009; Addis Ababa, Ethiopia.


Ethiopia: Taking forward action on Human Resources for Health (HRH) with DFID/OGAC and other partners.


UNFPA. Health systems strengthening for equity: the power and potential of mid-level providers. UNFPA. n.d.


WHO’s contribution to universal access to HIV/AIDS prevention, care and treatment. [Geneva, Switzerland]; World Health Organization.


Annex 4: HRH in Ethiopia – discussion and presentation from Jan 2008 meeting

The HRH plan
Work on Ethiopia’s HRH plan is still in progress. The main strategies are flooding (i.e. stepping up production of health workers) and improving retention.

Progress toward the target of deploying 30,000 health extension workers (HEW) is on track and over 17,500 are now at work in health posts. Accelerated training of nurses to become Health Officers (HOs) is also proceeding as planned, and a new two-year MSc in emergency obstetric and surgery for HOs will begin soon. Capacity for health worker training has been expanded with the establishment of 13 new universities, where 12,000 new doctors will need to be trained in the next 10 years to meet the country’s goals for universal access to primary health care services including HIV/AIDS.

Measures to improve retention include pay increases, provision of allowances and enforcement of minimum periods of service prior to release from the public sector. Career ladders for all cadres are being improved and provision of housing for health workers is also planned. An HR information system is being developed to improve health workforce planning.

Programmes of Integrated Refresher Training for HEWs and for Woreda (district) and Health Centre Management Teams are in place.

Donor funding behaviour
Ethiopia’s health system is grossly under-funded and FMOH plans are rightly ambitious. Support from partners for HRH is not yet commensurate with FMOH ambitions as it is mainly for in-service training, is sometimes provided in a fragmented manner (which does not enable health workers to achieve additional qualifications), and is often held in hotels rather than proper training facilities.

Ethiopia’s International Health Partnership (IHP) roadmap urges donors to channel more of their support through pooled funding mechanisms including the FMOH Millennium Development Goal (MDG) Fund. The MDG Fund is designed to support strengthening of several generic elements of the health system including pre-service training. The MOH wants partner support to change to a training model focused on the development and use of national centers of excellence and regional training centers as regular venues for training, stronger and more accessible pre-service training, and an on-site approach for in-service training.

Health workers can only be effective if they have appropriately-equipped facilities to work in, steady supplies of essential commodities, regular supportive supervision, and a health management information system that feeds into decision-making at all levels. Hence FMOH urges partners to make unearmarked contributions to the MDG Fund.

In order to improve its management of gaps created by movement of public sector health professionals to employment with development partners, FMOH asks partners to provide information in advance of recruitment on their plans for recruitment of such staff, emphasizing the importance of following the Code of Conduct developed as part of the harmonization process launched last year.
Priorities for financing
- Training for some lower and intermediate cadres is covered but additional support is needed for to train 12,000 new doctors over the next 10 years, and additional cadres may need substantial support to achieve universal access and MDGs; expatriate service providers may be needed to fill some gaps until pre-service capacity is expanded to increase the supply of physicians and some other critical cadres
- Funding for the MSc in Emergency Obstetrics and Surgery is also sought
- Funding is required for bicycles for HEWs and for motorcycles to facilitate supervision of HEWs
- Rather than fragmented IST there is a need for training as part of strategic continuing medical education (CME) and continuing professional development (CPD)
- National centres of excellence and regional training centres exist and if supported appropriately can be used for CME and CPD training (instead of hotels)
- On-site training approach to minimize personnel absence from facilities
- External support for trainers/professors, service delivery, facility upgrades
- Analysis of incentives to prevent attrition

<table>
<thead>
<tr>
<th>Key Actions Resulting</th>
<th>Responsibilities</th>
<th>Outputs/indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and financing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully costed strategic plan for HR expansion</td>
<td>Government, partners can provide TA to develop plan</td>
<td># personnel trained (pre service) # in public sector service</td>
</tr>
<tr>
<td>Pooled fund with longer term, flexible resources</td>
<td>Partners</td>
<td>- Resources in pooled fund - Duration of partner commitments</td>
</tr>
<tr>
<td>Implementation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthening/expanding pre-service training</td>
<td>Government with partner financial and technical support</td>
<td>These were not specified at the workshop, but could include: # of new medical students # of medical graduates (and in other cadres)</td>
</tr>
<tr>
<td>Coordination of in service training</td>
<td>Government and partners</td>
<td>Timing of in service training sessions # staff attending</td>
</tr>
<tr>
<td>HR information system built and functioning</td>
<td>Government with partner TA support</td>
<td>HRIS exists</td>
</tr>
<tr>
<td>Development and costing of distance learning approach</td>
<td>Government and partners</td>
<td># personnel trained through distance learning</td>
</tr>
<tr>
<td>Reduction of hiring of government staff</td>
<td>Partners</td>
<td># of staff recruited from public sector</td>
</tr>
<tr>
<td>Hiring of training/teaching, service delivery and development staff from overseas</td>
<td>Government and partners</td>
<td># training posts in institutions filled with foreign staff # service delivery positions filled with foreign staff</td>
</tr>
<tr>
<td>Incentives for retention of public sector staff, e.g. housing in rural areas</td>
<td>Government</td>
<td># housing units for rural staff</td>
</tr>
</tbody>
</table>

Notes prepared by Marion Kelly (DFID) & Jamie Browder (PEPFAR)
Ethiopia: Taking forward action on Human Resources for Health (HRH) with DFID/OGAC and other partners.

Annex 5: Presentation to the FMOH

Ethiopia: Taking Forward Action on Human Resources for Health

Presentation to the FMOH, Addis Ababa, Ethiopia
08 May, 2000

Jim Campbell & Dykki Setle

Background to PEPFAR/IHP collaboration

Jan 08: Addis Ababa workshop at launch of Task Shifting Guidelines
Mar 08: Kampala, setting of Global Forum on HRH (SHAWA - Kampala Declaration + Addis)
Apr 08: Mozambique - joint review
Apr 08: Bush / Brown statements (Washington)
Jun 08: Brown / Bush statements (London)
Jul 08: US Communicate
Jul 08: PEPFAR Reauthorization - 140,000 new HCWs
Sep 08: Kenya - joint review
Sep 08: Brown - USAID MOH - statements (New York)
Jan 09: Zambia visit
May 09: Ethiopia visit

Ethiopia HRH Context

FMOH - Consistent messages on HRH
- HSDP III
- GHWA Meeting (Jan 2008)
- HSDP Mid-Term Review (June 2008)
- SFP processes

HR 2020
- FMOH feedback suggests the new 12 – year strategy further develop these messages with additional detail, implementation arrangements and costing.

What we’re hearing

The accompanying narrative
- "Scope, Volume, Quality"
- "Funding with retention"
- "Resource mobilization for a paradigm shift"

- Scale-up of Medical Schools - associated faculty, equipment, teaching aids/resources
- Scale-up of various clinical and support cadres
- Retention initiatives
- HRIS - shortly available
- Registration, Licensing, re-licensing (DACA)
- Minimum staffing norms for facilities

Opportunities

FMOH
- short-term partner engagement
- identifying TA requirements
- reviewing implementation arrangements
- preparing for resource mobilization
- keen to link to pooled funding mechanisms (i.e. MDG RF)

Cooperating Partners
- anticipating communication and discussion
- IHP+ & PEPFAR Partnership Framework exist / in development

Dialogue can start now...
Annex 6: Presentation to the HPN Donors Group

Background (1)

- Jun ’08: Addis Ababa side meeting at launch of Task Shifting Guidelines
- Mar ’08: Kampala side meeting at Global Forum on HRH
  (GHWA - Kampala Declaration + A4/S4)
- Apr ’08: Mozambique - country visit
- Bush / Brown statements (Washington)
- Jun ’08: Brown / Bush statements (London)
- Jul ’08: G8 Communicates
- Sep ’08: PEFFAR Reauthorization - 140,000 new HCWs
- Sep ’08: Kenya - country visit
- Brown - HLF MOGs - statements (New York)
- Jun ’09: Zambia - country visit
- May ’09: Ethiopia - country visit

Background (2)

<table>
<thead>
<tr>
<th>Country</th>
<th>Density</th>
<th>Cost of Health</th>
<th>Estimated Savings</th>
<th>Cost of Training</th>
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<tbody>
<tr>
<td>Ethiopia</td>
<td>0.247</td>
<td>99.97</td>
<td>192.03RPE</td>
<td>99.97</td>
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<tr>
<td>Kenya</td>
<td>1.204</td>
<td>160.07</td>
<td>32,000</td>
<td>140.07</td>
</tr>
<tr>
<td>Malawi</td>
<td>0.345</td>
<td>120.07</td>
<td>38,000</td>
<td>130.07</td>
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<tr>
<td>Zambia</td>
<td>2.121</td>
<td>99.97</td>
<td>192.03RPE</td>
<td>99.97</td>
</tr>
</tbody>
</table>

Mixed circumstances:
- Ethiopia: low density, high shortage
- Kenya: medium density, medium shortage
- Malawi: low density, medium shortage
- Zambia: high density, low shortage

Background (3)

<table>
<thead>
<tr>
<th></th>
<th>Plan</th>
<th>Period</th>
<th>Costed?</th>
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</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>Short</td>
<td>2005-2020</td>
<td>Yes</td>
</tr>
<tr>
<td>Kenya</td>
<td>Yes</td>
<td>2007-2010</td>
<td>Yes</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Yes</td>
<td>2008-2015</td>
<td>Yes</td>
</tr>
<tr>
<td>Zambia</td>
<td>Yes</td>
<td>2006-2010</td>
<td>Yes</td>
</tr>
</tbody>
</table>

What we’ve heard from FMOH (1)

- “Speed, Volume, Quality”
- “Focusing with retention”
- “Resource mobilization for a paradigm shift”
- Scale-up of Medical Schools - associated faculty, equipment, teaching aids/resources
- Scale-up of various clinical and support cadres
- Retention initiatives
- HRIS - shortage available
- Registration, Licensing, Re-licensing (DACA)
- Minimum staffing norms for facilities

Ethiopia HRH Context

- FMOH - Consistent messages on HRH
  - GHWA
  - GHWA Meeting (Jan 2003)
  - GHWA Mid-Term Review (June 2008)
  - BPR processes

- HR 2020
  - FMOH feedback suggests the new 12-year strategy further develops these messages with additional detail, implementation arrangements and costings.

August 2009.
Ethiopia: Taking forward action on Human Resources for Health (HRH) with DFID/OGAC and other partners.

What we’ve heard from FMOH (2)

- Will shortly be inviting partner engagement
- Will be reviewing implementation arrangements
- Are preparing for resource mobilization
- Are keen to link to pooled-funding mechanisms (i.e. MDG FF)
- Recognize that recent process has not been participatory
- Recognize internal capacity needs strengthening
- Are indicating long-term TA needs in HR Department

Some thoughts

- New opportunity for communication, cooperation and collaboration
  - agree to park any previous frustrations
- Prepare for pending HRH discussions
  - Mobilization of HMO - HRH Technical Group (or similar)
  - Current/expected partner activity to be shared
- Link to HSDP IV planning process
- Speed, Volume, Quality offers entry point
  - i.e. quality in pre-service education
  - i.e. quality in information management

Quality Information Management

Building a culture of data use...
... for Workforce Surveillance

- Dynamic model
- Proactive analysis of available workforce data
- Based on established disease surveillance methodologies
- Comparing current situation against predictive models
- Enhancing monitoring and evaluation frameworks

Questions?

For further information please contact:

- Jim Campbell: jim.campbell@intelcrare.es
- Dykki Settle: dsettle@capacityproject.org