Goals and Objectives

The HRH Project supported the Federal Ministry of Health (FMOH) and Regional Health Bureaus (RHBs) to improve HRM practices. Specific objectives were to:

- Strengthen the knowledge and skills of HR staff and managers, and
- Improve HRM systems and practices.

Need for Action

Weak human resource management (HRM) practices have had a detrimental impact on Ethiopia’s public health sector, undermining organizational effectiveness and the delivery of health services. Human resource (HR) offices have lacked the structure and staffing to handle the volume and scope of work. At the national and regional levels, HR development and administration departments were not fully staffed with qualified professionals, while HR functions at sub-regional levels were pooled with other sectors such as education and agriculture. According to participatory HRM capacity assessments, other challenges included lack of training and supportive supervision for HR staff, a dearth of computers or other mechanisms to collect and track HR data, weak situation assessments and planning, and no job descriptions. These weaknesses have contributed to delayed recruitment, insufficient training, inequitable urban-rural distribution, inadequate incentives, and difficult working conditions. Poor management practices have, in turn, reduced motivation, retention, and performance of health personnel.

To identify and overcome HRM challenges in the public health sector, the Government of Ethiopia sought technical and financial support from the USAID-funded Jhpiego-led Strengthening Human Resources for Health (HRH) Project (2012-2019). The goal of the HRH Project was to improve health outcomes for all Ethiopians by improving human resources for health management; increasing the availability of midwives, anesthetists, health extension workers (HEWs), and other essential health workers; improving the quality of education and training of health workers, and generating evidence to inform HRH policies and programs.
Strategies and Interventions

Improving performance with training, supportive supervision, and performance monitoring. The HRH Project collaborated with the FMOH and RHBs to develop an in-service HRM training package for existing and newly recruited HR staff and to integrate HRM indicators in supportive supervision checklists. In addition, the Project placed an HRH Management Officer in each RHB to transfer knowledge and skills related to planning and budgeting, situation analysis, and performance review. FMOH teams supervise and support HR staff at RHBs, RHB teams offer similar support to zonal and woreda health offices, and zonal and woreda teams supervise HR staff at health care facilities. Supportive supervision findings are shared at regular performance review meetings, and supervisors help develop action plans for performance improvement. Individual staff use job descriptions to develop personal performance plans, which serve as the basis for performance evaluations by managers.

Strengthening implementation of the Balanced Score Card (BSC) performance management system. Although the FMOH and seven RHBs had already adopted the BSC performance management system prior to the HRH Project, understanding of its processes and tools was limited. Therefore, the HRH Project provided technical and financial support to strengthen implementation of the BSC. It conducted BSC training, helped cascade performance planning from the team to the individual level, and organized experience-sharing visits so that RHBs that had not yet implemented the BSC could learn from other regions.

Improving recruitment, selection, motivation, and retention. The HRH Project provided financial and technical support to RHBs to improve recruitment, selection and deployment practices, such as placing health workers where they are most needed. To reduce turnover, the project conducted a study on the factors affecting health workers’ job satisfaction, motivation, and retention and supported consultative workshops to use the findings to design incentives and interventions to improve the work climate.

Strengthening the Human Resources Information System (HRIS). The HRH Project worked with Tulane University and senior FMOH staff to create a fully functional HRIS by helping mobilize resources, install software, and train staff. The Project also provided financial and technical support for data management in eight regions: they collected more comprehensive HR data, entered it into the HRIS, conducted semi-annual data analyses, and used the results for evidence-informed decision making.

Results and Lessons Learned

HR functions have become more visible and better funded. HR planning has been increasingly integrated into the health sector planning cycle and become a routine practice at all levels, including health facilities. Newly developed national and regional HRH strategic plans have been instrumental in convincing regional and district governments to allocate more funds to hire, deploy, and remunerate health workers for improved coverage and quality of health care. In 2016 and 2017, most RHBs received larger HR budget allocations than in previous years (Figure 1). However, most regions do not have a separate cost center for non-salary HR budgets, and budget shortages remain a problem at the zonal, woreda, and facility level.

Figure 1: Trend in Non-Salary Budget Allocations for HR in Five Regions, 2014-2017

Source: HRH Project Progress Report, 2014-2017

The number and distribution of health workers have improved, but regional disparities remain. As the capabilities of HR staff have grown, they are better able to forecast, attract, and distribute the number and types of health workers needed. The number of health workforce in Ethiopia increased from 114,362 in 2012 to 243,602 in 2018, although some regions made greater gains than others. In 2012, the density of health workforce in the region with the highest density was 8.6 times greater than that of the region with lowest density. By 2018, that ratio had dropped to 6.8, suggesting progress in reducing regional disparities. However, the density of health workforce continues to vary widely, from as low as 1.29 per 1,000 population in Somali to as high as 8.83 in Addis Ababa (Table 2).
Performance management and evaluation practices have improved, but motivation and retention schemes need to be developed further. HR offices from the regional to woreda levels of the health system have implemented a variety of interventions to increase motivation and reduce turnover, including overtime pay, hardship allowances, professional risk allowances, transport and housing allowances, salary increases, opportunities for professional development, and linking promotions and transfers with performance. In larger regions, performance management and rewards systems have been institutionalized: semiannual performance appraisals are used as criteria for rewards and recognition, creating healthy competition among staff and improving motivation and retention. However, compensation and rewards systems and work climate improvement schemes are not yet fully developed in much of the country.
HRM practices have improved overall, but some regions lag. Increased access to manuals and handbooks, together with training on how to apply HR policies and procedures, have markedly improved HRM practices in most regions. However, inconsistencies and weak practices persist in certain regions. For example, nine RHBs now provide job descriptions for employees but two do not, and while 13,819 new hires received formal orientations from 2014 to 2017, some RHBs did not follow accepted guidelines for this process.

A fully functional HRIS enables local data analysis and informed decision making in some regions. The HRIS is fully functional in four regions (Addis Ababa, Dire Dawa, Harari, and Tigray), and most other regions have installed and begun using HRIS software. This has enabled RHBs to regularly calculate and report HR indicators, monitor progress against planned targets, document improvements in HRM functions, and engage in evidence-informed decision making. However, implementation of the HRIS has lagged at the woreda, hospital, and health center levels. Only six in ten health facilities nationwide had access to the HRIS database in 2017, and access varied widely between regions.

Next Steps

1. Continue to build HR staff capacity for HR planning, accurate costing, and budgeting.

2. Promote close collaboration among the FMOH, RHBs, and other stakeholders to develop motivation and retention guidelines and strategies that are specific to each region. Use these guidelines to ensure that retention mechanisms are uniform across health offices and facilities within each region.

3. Identify regions that are not making good progress in implementing performance management and rewards system. Help them implement an improved BSC and total quality management approaches.

4. Gain political, financial, and leadership support to fully develop and sustain compensation and reward systems and work climate improvement schemes.

5. Roll out the HRIS to all zonal and woreda health offices and health facilities in Ethiopia, and build capacity to use HR data for decision-making at all levels of the health system.