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MINISTRY OF HEALTH - ETHIOPIA
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HUMAN RESOURCES FOR HEALTH STRATEGIC AND INVESTMENT PLAN FOR ETHIOPIA

2016-2022 EFY/2024-2030

APRIL 2024

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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

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MINISTRY OF HEALTH

ADDIS ABABA, ETHIOPIA

APRIL 2024

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ACCRONYMS

CHRA-EO	Competency and Human Resources Administration Executive Office
CPD	Continuing Professional Development
CSA	Central Statistical Agency
CSC	Civil Service Commission
CSO	Civil Society Organization (CSO)
DHIS	District Health Information System
ETA	Education and Training Authority
HLMA	Health Labor Market Analysis
HPA	Health Professional Association
HRDA	Human Resources Development and Administration Directorate
HRH	Human Resources for Health
HRHDI-LEO	Human Resources for Health Development and Improvement Lead Executive Office
HRHSIP	Human Resources for Health Strategic and Investment Plan
HRHSP	Human Resources for Health Strategic Plan
HRM	Human Resource Management
HSDIP	Health Sector Medium Term Development and Investment Plan
HSTP II	Health Sector Transformation Plan II
HWIP	Health Workforce Improvement Program
iHRIS	integrated Human Resources Information System
LIP	Leadership Incubation Program
LMG	Leadership, Management, and Governance
M&E	Monitoring and Evaluation
MCC	Motivated Competent and Compassionate
MOE	Ministry of Education
MoF	Ministry of Finance
MoH	Ministry of Health
NHWA	National Health workforce Account
RHB	Regional Health Bureau
SWOT	Strength, Wickless, Opportunity and Traits
THE	Total Health Expenditure
UHC	Universal Health Coverage
USD	United States Dollar
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need
WoHo	Woreda Health Office
ZHD	Zonal Health Department

H.E Dr. Ayele Teshome
State Minister, Ministry of Health
Federal Democratic Republic of Ethiopia

ACKNOWLEDGEMENTS

The National Human Resources for Health Strategic and Investment Plan (HRHSIP) is developed with the aim to ensure availability of an adequate number of well qualified health professionals with an appropriate mix of skills; equitably distributed, motivated, retained and perform well to achieve universal access to quality health care in Ethiopia. The strategy is the result of a collaborative effort between the Federal Ministry of Health, Regional Health Bureaus and relevant sectors of government, academic institutions, professional associations, and development partners among others.

We wish to thank the State Minister Office members, for their outstanding leadership, excellent guidance, close follow up and valuable input to make the strategic document a reality, without their leadership and commitment, it would have been impossible to finalize the strategic plan.

The acknowledgement is extended to members of the Core Technical Advisory Team: Assegid Samuel (MOH), Solomon Woldeamanuel (MOH), Mesfin Kifle (WHO), Mr. Mohammed Hussein, Dr. Tegbar Yigzaw (Jhpiego-HWIP), Dr. Daniel Dejene (Jhpiego-HWIP), Dr. Shelemo Shawula (USAID), Jemal Mohammed (Jhpiego-HWIP), Zeine Abosse (Jhpiego-HWIP), Mohammed Teni (MOH), Abiyu Geta (MOH) and Tegene Arega (MOH) for their tireless engagements and critical technical roles in developing the strategic and investment plan. The appreciation is also extended to the Technical Working Group (TWG) members Melkamu Tamene (MOH), Samuel Abebe (MOH), Alem Edossa (MOH), Birhan Berhe (MOH), Yohanis Mersha (MOH), Samuel Abera, Samuel Bekele and Dr. Firew Ayalew (Jhpiego-HWIP) for their active participation and significant roles in strategic document preparation. We would also like to appreciate Yoseph Belay for crafting the document and particular recognition goes to Solomon Woldeamanuel for his strong leadership commitment and technical support over the course of the development of the strategy including crafting the document.

The Ministry of Health would like to extend its utmost gratitude to World Health Organization-Ethiopia Country Office (WHO) and USAID funded Health Workforce Improvement Program (HWIP/Jhpiego) for their unreserved technical and financial support. Their continued commitment and extensive assistance played a critical role in the preparation of this strategic document.

The Ministry of Health would also like to extend its gratitude to the stakeholders and individuals who have participated in the consultative workshops to review and finalize the Strategic and Investment Plan. The consultation workshops brought together experts from various departments of Ministry of Health, Regional Health Bureaus, Federal Hospitals, Ministry of Education, Ministry of Finance, Education and Training Authority, Universities and Regional Health Science Colleges, Health Professional Associations, and Development Partners. This group of senior health and management experts provided useful feedback and unique views that enhanced and considerably improved the national strategic Plan.

Dr. Ayele Teshome, State Minister

Ministry of Health, Ethiopia

H.E. Dr. Mekdes Daba
Minister, Ministry of Health
Federal Democratic Republic of Ethiopia

FOREWORD

Ethiopia has been implementing National Human Resources Strategic Plan since 2016 and improving human resource for health development and management that has always been one of the priority and transformation agenda for the health sector transformation plans. To improve access to health services, the government has significantly invested on health workforce and witnessed significant achievements.

I am pleased to acknowledge the significant progress we have made in improving the availability, distribution, professional mix, and geographical equity of competent health professionals and the paramount role played by the health workforce in improving the health of our population and increasing access to and utilization of health services. However, there are remaining health workforce challenges including shortage which is lower than the required standard, inadequate competency and skill, low motivation, and high staff turnover. The impact of internal conflicts that resulted in the displacement of communities, dislocation of health workforce, and destruction of health facilities were significant threats to our health system. Though health workforce played a critical role in curving the impact of COVID-19 pandemic and other disease outbreaks, there were multidimensional factors that affected those including infections, deaths, stress, and burnout.

Addressing remaining challenges in health workforce education, development, management, regulation, evidence, and investment requires continuous improvement to achieve the desired health objectives. Building on the existing success and opportunities and in response to the remaining challenges, we found it timely and appropriate to introduce the national Human Resources for Health Strategic and Investment Plan (HRHSIP): 2016-2022 EFY (2024-2030). The plan intends to align with evolving national, regional, and global health development goals and priorities. Moreover, it aims to improve health workforce management, development, regulation, evidence, and financing capacity so that our population's overall health status improved by progressing toward universal health coverage and sustainable development goals.

The HRHSIP builds on the existing Human Resources for Health Strategic Plan (HRHSP): 2016-2025 and aligns with the Health Sector Medium Term Development and Investment Plan (HSDIP):2023/24-2025/26. The HRHSIP outlines 5 strategic focus areas with appropriate outcomes, objectives and interventions that define the health sector's focus areas for the planning period. Key focus areas priorities include HRH Development, Management, Professionals' Regulation, Evidence Generation and data use for Policy Choice and Increase investment on HRH.

In conclusion, I am confident that the Human Resources for Health Strategic and Investment Plan (HRHSIP):2024-2030 will pave the way towards achieving Universal Health Coverage, Sustainable Development Goals and impacting to a healthier and more prosperous society.

Dr. Mekdes Daba, Minister

Ministry of Health, Ethiopia

EXECUTIVE SUMMARY

Health workforce is a vital component of the health system without which it is difficult to deliver and improve access and quality of health care. Ethiopia has been implementing the national human Resources for Health Strategic Plan (HRHSP) since 2016. The strategic plan was guided by the Ministry of Health (MOH) HRH vision, goal, objectives, and guiding principles and was originally developed for the period 2016-2025. However, there is a need to revise it for the period 2016-2022EFY (2024-2030) based on several emerging factors; urging technical and operational reasons; and to align it with national health sector plans and priorities and Regional and Global and HRH strategic directions.

Thus, the revised Human Resources for Health Strategic and Investment Plan (HRHSIP) document is developed with the aim to ensure availability of an adequate number of well qualified health professionals with an appropriate mix of skills; equitably distributed, motivated, retained and perform well to achieve universal access to health care in Ethiopia. The HRHSIP 2016-2022EFY (2024-2030) is being revised to address the impact of the HRH challenges encountered in the past and to align strategies with investments.

The HRHSIP development process followed a participatory approach with active engagement of various stakeholders. The process includes high-level consultation of the Core Technical Advisory Team (CTAT), active engagement Technical Working Group (TWG) and close guidance and collaboration with the State Ministry Office for Health Systems and Capacity Building. It was also informed by an in-depth situational analysis of the HRHSP implementation, findings from the midterm review of HRHSP, the socio-economic situation of the country and aligned with Regional and Global HRH situations and commitments. It builds on the past best experiences and successes and considers the existing challenges and prevailing opportunities.

Strategic focus areas, objectives and directions were updated based on the situational analysis of the HRHSP; and baselines were developed using data from recent studies like Health labor Market Analysis, Workload Indicators and Staffing Need, and routine health workforce data as well as consultation with program experts. Interventions and targets were set based previous years trends, availability of resource, and alignment with national and international commitments. The senior leadership have reviewed and agreed on the major targets of HRHSIP. Health workforce investment costing was developed using the ministry of plan and development's format.

This HRHSIP developed based on five strategic focus areas, effectively linked with the five long term strategic outcomes and objectives that are well aligned with strategic interventions. The five focus areas include: Enhance Human Resources for Health Development, Optimize Human Resources for Health Management, Improve Health Professionals' Regulation, Improve HRH Evidence Generation and data use for Policy Choice and Align Investment with HRH requirements. The strategy is also costed, and appropriate monitoring and evaluation mechanisms and implementation modalities developed.

CHAPTER 1
INTRODUCTION AND BACKGROUND

1.1. Introduction

Ethiopia has been implementing the national human Resources for Health Strategic Plan (HRHSP) since 2016. The strategic plan was guided by the Ministry of Health (MOH) HRH vision, goal, objectives, and guiding principles and was originally developed for the period 2016-2025. However, there is a need to revise it for the period 2024-2030 based on several emerging factors; urging technical and operational reasons and to align with Regional and Global human resources strategies. Thus, this Human Resources for Health Strategic and Investment Plan (HRHSIP) document is developed with the aim to ensure availability of an adequate number of well qualified health professionals with an appropriate mix of skills; equitably distributed, motivated, retained and perform well to achieve universal access to health care in Ethiopia.

Midterm review of the existing strategy was conducted with an independent consultancy firm and situational analysis of the HRHSP was done using targets of the strategic plan and other various documents. The revised HRHSIP is the result of high-level consultation and engagement of the Core Technical Advisory Team (CTAT), Technical Working Group (TWG) comprised of HRH experts from all ministry units, Ministry of Education, Ministry of Finance, Professional Associations, agencies, and development partners, as well as close collaboration with the State Ministry Office for Health Systems and Capacity Building.

The strategic focus areas, objectives and directions were updated based on the situational analysis of the HRHSP; and baselines were developed using data from recent studies like Health labor Market Analysis, Workload Indicators and Staffing Need, and routine health workforce data as well as consultation with program experts. Interventions and targets were set based previous years trends, availability of resource, and alignment with national and international commitments. The senior leadership have reviewed and agreed on the major targets of HRHSIP. Health workforce investment costing was developed using the ministry of plan and development's format.

This HRHSIP developed based on five strategic focus areas, effectively linked with the five long term strategic outcomes and objectives that are well aligned with strategic interventions. The strategy is also costed, and appropriate monitoring and evaluation mechanisms and implementation modalities developed.

1.2. Background: Geographic and Socio-economic

Ethiopia is a country located in the horn of Africa and share border with six countries - Eritrea, Djibouti, Somalia, Kenya, Sudan, and South Sudan. The country has one of the fastest-growing economies in the region, with an estimated 6.4% growth in 2021/22[1]. The health has over the years

[1] *World Bank, 'The World Bank in Ethiopia', updated on 28 February 2023 < https://www.worldbank.org/en/country/ethiopia/overview, [accessed 13 November 2023].*

contributed to, and benefited from, the expanding economy which has translated into massive expansion in health infrastructure, health workforce and other investments[2].

Ethiopia introduced a Federal Government structure composed of twelve Regional States: Tigray, Afar, Amhara, Oromia, Somali, Benishangul-Gumuz, Gambella, Harari, Sidama, Southern West Ethiopia, South Ethiopia, and Central Ethiopia, as well as two City Administrations - Addis Ababa and Dire Dawa. Regions are subdivided into zones and zones are further divided into woredas, which the basic decentralized administrative units are representing 100,000 people governed by an administrative council composed of elected members.

Ethiopia has previously implemented successive Health Sector Development Plans (HSDPs) in four phases since 1997. HSDP-IV, which concluded in June 2015, marked the final phase of HSDPs as part of the country's first Growth and Transformation Plan (GTP-I). After the completion of the four HSDPs, Ethiopia implemented the first health-sector transformation plan (HSTP I) from 2015/16–2019/20, followed by HSTP-II for the period 2020/21–2024/25. During the implementation of these Development Plans, health workforce issue has been among the key priorities and transformation agendas of the health sector. In line with this the country the country has made massive investment in health workforce production and deployment through different initiatives including, flooding strategy, task shifting, task sharing, accelerated programs, and Ethiopia's flagship health extension program. These have contributed to improve the overall health professional population ratio increased from 0.84 per 1000 population in 2010 to 2.22 in 2021[3] and brought about significant improvement in accessibility and quality of health services delivery.

In Ethiopia, health care is mostly provided by the government, and national health policies are implemented through these decentralized structures. The country's healthcare system is structured into three tiers: primary, secondary, and tertiary levels of care[4]. Primary health care units provide essential primary health care, general hospitals offer secondary care, and specialized hospitals provide tertiary care. By the end of 2021/22, 18,200 health posts, 3,579 health canters, and 353 hospitals were providing services to the population. The total health workforce was 342,899 by the end of 2022[5].

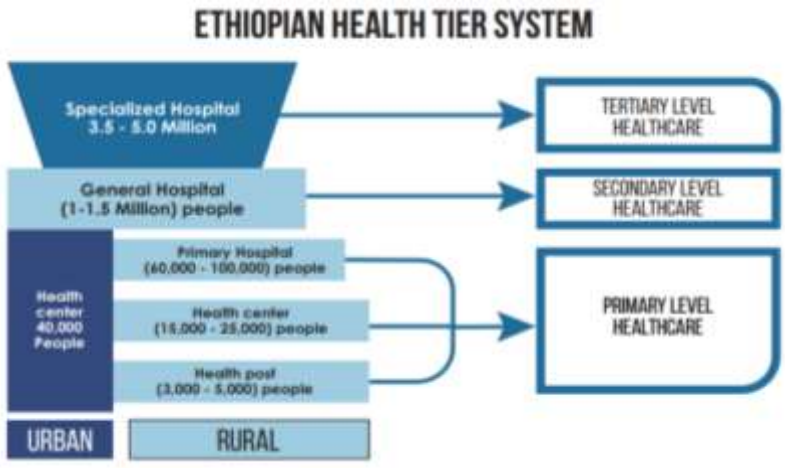

Figure 1 Ethiopian Health Tier System

[2] *World Bank, Ethiopia Public Expenditure Review (Washington D.C: World Bank, 2016).*
[3] *National Health Workforce Update Human Resource Development and Management Directorates Bulletin 5th Edition, September 2022.*
4 Health Sector Transformation Plan [2020/21-2024/25], February 2021, Addis Ababa
[5] *Federal Democratic Republic of Ethiopia Ministry of Health: Health Sector Medium Term Development and Investment Plan (HSDIP): 2016-2018 EFY (2023/24-2025/26)*

1.3. Population and Demographics and health status indicators

Available population data for Ethiopia are mostly estimated from 2007 population census[6] which due to its outdated nature leads to different estimates depending on the source. However, projections from the Central Statistics Agency (CSA) show that Ethiopia's population is about 107,334,000 and is growing at a rate 2.6% annually.

Ethiopia has a high total fertility rate of 4.6 births per woman (2.3 in urban and 5.2 in rural) and an estimated crude birth rate of 27 per 1000. The average household size is 4.6. The population is projected to reach 113.8 million in 2026 and 122.3 million in 2030. Children under age 15 years and individuals in the age group of 15-65 years account for 37.6% and 59.2% of the population, respectively. Only 3% of the population is above the age of 65 years and Life expectancy at birth (years) has reached 63. The sex ratio between males and females is almost equal, and women of reproductive age constitute about *23%* of the population. About 77% of the population lives in rural areas, mainly dependent on agriculture (CSA, July 2013)[7].

Ethiopia's per capita gross national income is $1,020[8]. According to the Ethiopia Health Accounts 2019/2020, the total health expenditure (THE) is about USD 3.62 Billion where the government's share accounts for USD 1.03 Billion (32.3%). Additionally, share of THE contributed to out-of-pocket expenditure has reached 30% and per capita health expenditure is 36.3.

1.4. Health Workforce and Infrastructure

Health workforce is a vital component of the health system without which it is difficult to deliver and improve access and quality of health care. Availability, accessibility, acceptability, and quality of health workforce is critical to improve access and quality of health services to the population.

To improve access to health services, the government has significantly invested in massive expansion in health workforce and health infrastructure. In 2021/22, more than 18,200 health posts, more than 3,800 health centers, and more than 380 public hospitals were providing health service to the population9. The government has invested to improve the number and mix of health workforce over the past decades. However, the health workforce density for core professional categories (physicians, health officer, nurses and midwives) in 2021/22 was only 12.2 per 10000 populations, which is low compared to the required standard. Additionally, according to WHO's Health Workforce Support and Safeguards List 202310, the list identified countries, including Ethiopia, with density of doctors, nurses and midwives below the global threshold and a universal health coverage service coverage index below 55. These countries face the most pressing health workforce challenges related to UHC. Creating a motivated, competent and compassionate (MCC) health workforce is one of the transformation agendas and various activities have been implemented towards it.

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[6] *CSA.*

[7] *World Bank, 'The World Bank in Ethiopia', updated on 28 February 2023 < https://www.worldbank.org/en/country/ethiopia/overview, [accessed 13 November 2023].*

[8] *World Bank, 'The World Bank in Ethiopia', updated on 28 February 2023 < https://www.worldbank.org/en/country/ethiopia/overview, [accessed 13 November 2023].*

[9] *Federal Democratic Republic of Ethiopia Ministry of Health, Health Sector Medium Term Development and Investment Plan, 2016-2018EFY (2023/24-2025/26).*

10 Health Workforce Support and Safeguards List, 2023, https://iris.who.int/bitstream/handle/10665/366398/9789240069787-eng.pdf?sequence=1

1.5. Global and Regional Health Workforce Focus

A health workforce (HWF) of adequate size and skill mix is critical to the attainment of any population health goal. This includes the achievement of universal health coverage (UHC)[11] and the health-related targets of the United Nations Sustainable Development Goals (SDGs). Yet countries globally are affected by multifaceted challenges, such as difficulties in HWF education and training, deployment, performance and retention. Suboptimal allocation of health workers is one of the main challenges that directly influences the availability, accessibility, quality and performance of national health services and may leave populations with inadequate access to the health services they need. The Global Strategy on Human Resources for Health: Workforce 2030 (GSHRH), which sets out the policy agenda to ensure a HWF that is fit for purpose to attain the targets of UHC and the SDGs. To ensure universal accessibility, acceptability, coverage and quality of the HWF within strengthened health systems, adequate investments and the implementation of effective policies at national, regional and global levels are required.

The global health agenda has evolved drastically over the years, with the COVID-19 pandemic, armed conflict, ecological crisis, zoonotic diseases hitting the world like never before[12]. The global impact of COVID-19 between 2020 and 2023 has shown us the central role of the HWF in maintaining the delivery of essential health services as well as simultaneously managing the pandemic response. Through the measurement of HWF data in successive years, there is now a better understanding of the HWF challenges. At the mid-way of the UN SDGs era, although progress was observed, there is still a projected global HWF shortage of 10 million health and care workers (HCWs) by 2030[13]. By the year 2020, there were a total of 65.1 million health workers where the number of medical doctors, nurses and midwives were 12.7, 29.1 and 2.2 million respectively.

To address the new challenges on the global health agenda, a series of programs, directions, tools and guidance were developed. The fourth and fifth Global Forums on HRH enabled identification of key policy priorities to improve the health and care workforce. The World Health Assembly also took actions on protecting, safeguarding, and investing in the health and care workforce with adoption of the Working for Health programs. The WHO developed the Global Strategic Directions on Nursing and Midwifery (SDNM), and through the development of a Global Health and Care Worker Compact.

The HRHSIP has considered the global health workforce environment and produced the national strategy and investment plan in accordance with the anticipated and projected health workforce and financial requirements for 2024-2030.

1.6. Justification: Why We Need to Revise the Human Resources for Health Strategic Plan

There are several justifications for revising the existing National Human Resources for Health Strategic Plan 2016-2025. Strategic plans should be costed, financed, implemented, and continually refined and reviewed to address present changes in countries priorities; current and future anticipations in health workforce policies and strategies; labor market capacity to recruit, deploy and retain health workers; and the capacity to produce sufficient and adequately distributed qualified

[11] *WHO. Universal Health Coverage. Geneva: World Health Organization; 2023 (https://www.who.int/health-topics/universal-health-coverage#tab=tab_1, accessed 27 July 2023).*
[12] *Tangcharoensathien V, Ghebreyesus TA. Ending the pandemic is not a matter of chance; it's a matter of choice. Bull World Health Organ. 2022; 100:90-A. doi: 10.2471/ BLT.22.287849.*
[13] *National health workforce accounts: a handbook, second edition,2023*

workers to meet public health goals and population health needs. Below are major points to explain why we need the revision.

- As part of improving HRH planning, the *HRHSP itself proposes a concrete strategic action, to review and regularly update the National HRH strategic plan* (Page 40)[14].
- The HRHSP *Mid-Term Review (MTR) strongly recommended* that the HRH strategy should be aligned with HSDIP with respect to planning, implementation, monitoring, and evaluation in the remaining implementation periods[15].
- The existing strategic plan lacks health workforce data in private sector.
- The national Health Labor Market Analysis (HLMA) for private sector also *recommended to review the HRH strategic plan targets* to reflect the current economic demand and make an investment case to advocate for increased domestic investment in health workforce towards the attainment of financial sustainability for HRH aspirations[16].
- Moreover, the MCC HWF strategy developed strategic directions, which include strengthening ethics and professionalism through pre-service and in-service education/ training; strengthening health systems for compassionate health service; Introduction of person-centered care; and community and stakeholders' engagement[17].
- To incorporate the recent World Health Assembly adopted resolutions, WHA74.14, on Protecting, safeguarding, and investing in the health and care workforce (HCW) on 31 May 2021[18], working for Health Action Plan 2022-2030[19] and Global Health and Care Worker Compact[20].
- There was no health workforce emergency and preparedness plan in response to emerging pandemics and other ongoing and future public health challenges. The COVID-19 pandemic has revealed this reality specially the limitations it has imposed on the health system in general and the challenges it brought about in health workforce readiness.
    - To ensure the alignment of the HRHSIP with the targets and priorities of the HSDIP (2023/24–2025/26).

[14] *National Human Resources for Health HRH Strategic Plan for Ethiopia 2016 – 2025, Addis Ababa, 2016*
[15] *Human Resource for Health Strategic Plan Mid-Term Review (MTR), Final Report, MOH, Addis Ababa, December 2020*
[16] *Federal ministry of Health, Ethiopia, health labor market analysis, June 2020*
[17] *National Motivated, Competent and Compassionate Health Services Implementation Strategy 2020/21-2024/25, Addis Ababa, Ethiopia, December 2020*
[18] *Protecting, Safeguarding and Investing in the Health and Care Workforce, Seventy-Fourth World Health Assembly Wha74.14, Agenda item 15, 31 May 2021*
[19] *Human resources for health Working for Health, draft 2022–2030 action plan, Provision Agenda Item 15: A75/12, 22 April 2022*
[20] *Human resources for health Working for Health Global health and care worker compact, Provision Agenda Item 15: A75/13, 22 April 2022*

CHAPTER 2

SITUATIONAL ANALYSIS OF HRH IN ETHIOPIA

2.1. Situational Analysis

This section describes the existing HRH situation in Ethiopia as one of the components of strategic plan development. Based on published and unpublished reports, guidelines, previous strategic plan documents, mid-terms review reports and other relevant references were used to summarize the situational analysis of the existing HRH situation in Ethiopia for HRH strategic plan revision. In addition, SWOT analysis was done and annexed for further reference.

Accordingly, the situational analysis has been framed using such strategic pillars including Human Resources for Health (HRH) development, HRH Management, Health professionals' regulations, HRH evidence generation and data use for policy option, and HRH investment. The following sub-thematic areas have also been discussed in detail: Pre-service education and training, Continuing Professional Development (CPD), Leadership, Management & Governance

Planning and Administration, Health Workforce Availability and Distribution, Motivation and retention, Performance management and productivity, health ethics practice, scope of practice and health professional licensing and relicensing.

2.2. Structural Reform

The Federal Ministry of Health re-structured Human Resources Development and Improvement Lead Executive Office (HRHDI-LEO) under State Minister for Health Systems and Capacity Building. The lead executive office mainly focuses on improving system of quality of health science education, academic service integration; enhancing Human Resources for Health Information System, HRH Planning, and motivation; and strengthening health workforce continuing professional development (CPD).

Competency and Human Resources Administration Executive Office (CHRA-EO) is also re-structured under the Chief Executive Office where the executive office is dedicated to improving planning, recruitment, deployment, and management of health workforce. The executive office works in line with the Civil Service Commission (CSC) rules and regulations for standardization of job positions, evaluation, and grading, develop and implement national pay scales for the government employees, and provide capacity building to all sectors including health.

Likewise, Health and Health Related Institution and Professionals Regulatory Lead Executive Office (HHRIPR-LEO) is under State Minister for Input, Resource Administration and Regulatory wing which is responsible for provision of national licensure examinations, regulation of human resources through licensing and relicensing, ensuring the implementation of CPD including regulating health and health related facilities using national standards. Heath professionals Licensing Directorate at regional level is established to provide new licenses and relicense based on new guideline developed and endorsed along with federal reform.

Regional level Human Resources Development and Administration Directorate (HRDA) is responsible for HRH planning, recruitment, deployment, and personnel administration functions at Regional Health Bureaus (RHB) level. Similar structures in the regions are assumed to be available at Zonal Health Departments (ZHD), Woreda Health Office (WoHo) and health facility levels.

According to the findings of the mid-term review[21] of the HRH strategic plan (2016-2025), most regions feel that they have been received limited support from MOH. The organizational structure at federal level is not directly like regional and lower levels which does not allow effective communication for implementation of strategic plan. In addition, lack of dedicated HR structures at ZHDs, woreda and health facility levels is among the existing HR governance and leadership challenges. In areas where the organizational structure exists, the number, educational qualification and experience of HR staff is inadequate to effectively lead and govern HRH in the sector. The HR structures at most of WoHos and PHCU levels are integrated into the pool system.

As a result, HRH decisions are subjected to weak governance and leadership practices, inadequate training and education capacity, limited management practice, weak health professionals and institutions regulatory mechanisms, lack of quality of HRH data for use and HRH underinvestment.

2.3. Human Resources for Health Development

2.3.1. Pre-service education

According to the national Health Labor Market Analysis[22] (HLMA) study, Ethiopia has substantially increased its workforce production capacity over the last decade. The number of health workforce in the public sector increased from 114, 362 to 325, 247, representing a health workforce density (doctors, nurses, midwives and health officers) of 10.3 per 10,000 population which represents a significant improvement (about 84%) over the 2015 density of 5.6 per 10,000. According to a World Bank study[23], the Federal Ministry of Health (FMOH) reported a total of 65,554 health personnel in 2008, that translated into a total density of 0.84 per 1,000 population. According to this evidence, there has been an almost fivefold increase in the availability of health workers since 2012.

The overall increase was largely attributed to the implementation of the rapid scale up strategy. There are currently a total of 50 public universities and 90 private higher education institutions in the country. Most of the institutions provide one or more health professionals training programs. In addition, there are 28 public and 7 private medical schools specifically engaged in medical education. Furthermore, there are 22 regional health science colleges. The total number of health professionals' graduation output was 21,071 in EFY 2014 (2021/2022), including 1,556 medical doctors 335 anesthesia professionals, 2,458 midwives, 7,616 nurses,3,212 pharmacists, and 2,149 medical laboratory professionals. Although production has improved markedly, serious gaps remained in educating some healthcare professions indicating limitation in aligning production with needs and demands.

Postgraduate training programs were also scaled up in recent years. Notably, 20 institutions are offering residency training in 22 specialties through the national residency matching program. However, opportunities for advanced training in other healthcare professions are limited. Institutions providing fellowship training for physicians are few where 75.8% of them are general practitioners; 55.3% and 42.8% of midwives are vocational and baccalaureate level, respectively; and 55.5% and

[21] *The Federal Ministry of Health Human Resource for Health Strategic Plan Mid-Term Review (MTR), Addis Ababa, Ethiopia, December 2020*
[22] *Health Labor Market Analysis: Ministry of Health, Ethiopia, Addis Ababa, Ethiopia, 2020*
[23] *A World Bank Study, The Health Workforce in Ethiopia, Addressing The Remaining Challenges, 2012*

40.3% of the nursing workforce was trained at vocational and 40.3% baccalaureate qualification levels, respectively.

Evidence shows that the quality of pre-service education and competence of graduating students is inadequate to meet the healthcare needs of the population. According to HLMA, the cumulative average national licensing examination pass rate at first attempt was less than 60% for nursing, health officer and pharmacy[24]. Clinical competence assessment of medical students in 2022 revealed skills attainment of 72%[25]. There are multiple and interrelated reasons for inadequate quality of pre-service education, including gaps in quality of instructors and preceptors, skills lab and ICT infrastructure, linkage between academic and health systems, and quality assurance.

Program alignment and intersectoral collaboration with other sectors like Education, Public Services and Finance play a significant role in improving HRH education and training. However, re-aligning health workforce production capacity with needs and economic demand are the major challenge.

The COVID-19 pandemic, conflict and political instability in the last few years have also had negative impact on quality of education by disrupting the academic calendar, shifting priorities and resources and affecting motivation of learners and instructors.

2.3.1.1. Innovation and Technology Adoption

The adoption of digital health has increased significantly in the last few years. In 2005 the World Health Assembly through its resolution WHA 58.28 on eHealth urged Member States "to consider drawing up a long-term strategic plan for developing and implementing eHealth services to promote equitable, affordable and universal access to their benefits. The 2030 Agenda for Sustainable Development goal highlights that the spread of information and communications technology and global interconnectedness has great potential to accelerate human progress, to bridge the digital divide and to develop knowledge societies. Digital health should be an integral part of health priorities and benefit people in a way that is ethical, safe, secure, reliable, equitable and sustainable[26].

The ministry of health of Ethiopia has been implementing an electronic health information system nationally in partnership with various development and implementation partners for the past 10 years to improve human resource development, management, and regulation. The software application was developed by a partner organization and revealed various challenges which including not fulfilling all the expected functional requirements, lack of ownership of by the government, the patented nature of the software application, non-interoperability of the software application with other digital health applications in the sector.

The ministry currently developed and implementing the new advanced electronic iHRIS which fulfills both the current and emerging comprehensive requirements and needs aiming to establish resilient system for human resource for health information by fulfilling all the expected functional requirements, enhancing ownership of government, revitalizing interoperability of the application with the existing other digital health applications in the health sector which aspire to improve quality of comprehensive human resource development, management and regulations. Health curricula digitization initiated by medical residence program and will expand in advance in this strategy implementation period.

[24] *Health Labor Market Analysis: Ministry of Health, Ethiopia, Addis Ababa, Ethiopia, 2020*
[25] *Assessment of clinical competence of graduating medical students in Ethiopia, April 4th, 2023*
[26] *Digital health industry –Global Forecasts to 2028), Global strategy on digital health 2020-2025*

2.3.1.2. Continuing Professional Development

Short-term and long-term training of health workers is important to improve competency of health workers. Continuing Professional Development (CPD) has gained momentum in the last few years following the endorsement of the CPD directive and guideline in 2018. The number of CPD providers has increased to 219 and the majority (9 out of the 13 regions) has linked CPD with license renewal. The Ministry of Health in collaboration with stakeholders is playing a critical role in expanding CPD system in the country including training of over 23,100 health workers. However, CPD uptake remains a challenge due to inequitable access by geography and healthcare professions, shortage of accredited CPD courses, limited use of digital learning and financing gap. Moreover, the critical aspect of whether the CPD courses are achieving their aim of equipping the professionals is not yet fully regulated with appropriate triangulation with regulatory LEO.

2.3.2. Human Resources for Health Management

The successful implementation of the various health programs and reform initiatives is dependent on the availability of adequate number of well qualified and equitably distributed health workforce. This requires planning, recruitment and deployment of a health workforce fit for purpose. Human Resource Management (HRM) is the strategic and coherent approach to the effective planning, acquisition and efficient management of health workforce, such that health service demands of the population are properly met. It is the practice of recruiting, hiring, deploying, managing performance with recognition and reward to ensure employees are motivated and properly renumerated so that their performance and productivity are improved.

2.3.2.1 HRH Leadership, Management & Governance

Over the years, MOH has implemented Leadership, Management, and Governance (LMG) strengthening activities at all levels of the health system. The leadership Incubation Program (LIP) also enhanced the leadership, management, and governance practices at the individual, teams, and organizational levels. The LMG capacity building experience has shown that investments in LMG lead to stronger health systems that are responsive and better able to meet ambitious health goals.

However, there exist remaining leadership and governance challenges including lack of clear accountability, transparency, shared vision, evidence-based decision-making, regulation, and coordination. To alleviate these challenges, leadership is among major pillars in strengthening the health system.

The ministry has been working towards improving the capacity of current and future leaders in the health sector through the Leadership Incubation Program (LIP). Since its establishment in 2019, a total of 166 (72 female) LIP candidates were graduated which greatly contributed to improve the overall leadership practice and gender mainstreaming in the health sector.

In addition, training modules on LMG and HRM have also been developed. Trainings were conducted to improve HRH planning, forecasting, budgeting, motivation, retentions, and performance management.

2.3.2.2 HRH Planning and Administration

Under the decentralized system and woreda-based health sector planning approach, the MoH, RHBs and Woreda Health Offices have mandates to plan, identify and fill the gaps within their sphere of management influence. This gives the lower administrative units in each region a sense of ownership, increases efficiency and accountability of the health workforce. Currently, HRDA units at different

levels are relatively better structured and staffed; existence and practice of standard planning and reporting tools; and better performance monitoring, use of data and capacity building exercises are evident at federal and regional levels.

However, in most regions, the lower-level structures are severely understaffed, like at Woreda Health Office (WoHo) level, there is a requirement to have minimum of 20 staff as per the approved structure but the *woreda* health office was able to fill 30-40% of the available positions (MTR 2020)[27]. In some other regions, the HRM structures are managed through pool system rather than being under woreda health offices. Limited HRM capacity is another challenge constrained the HRM functions at all levels. In addition, there is limited opportunities for short-term HRH trainings and CPD for HRH managers and leaders. Furthermore, though most regions, districts and facilities have their annual HR plans, most of them have not been aligned with the national HRH strategic plan. Domestic under investment is another major challenge in areas of HRH planning and budgeting. The other gap is related to the availability and utilization of new technologies to improve HRH planning and administration.

2.3.2.3 Health Workforce Availability and Distribution

The second Health Sector Transformation Plan (HSTP II) has identified the health workforce as a key health sector priority area aims to create motivated, competent, and compassionate health workforce responsive to the population health needs and provide quality health services. The MoH aims to ensure equitable distribution & skills mix of health workers at all levels of the health system by 2030. Effective and equitable health service provision depends to a large degree on the availability, competence, motivation, and distribution of human resources for health. As per the national HRH strategic plan 2016-2025, the projection of health workforce for the upcoming years are far below the World Health Organizations (WHO) threshold to achieve UHC (4.45 per 1000 population). The current gap in health workforce is close to 50,583 and 157,848 shortfalls between what is projected in the strategic plan document in 2025 (353, 454)[28] and what it would be in 2025 (479,082) and (512,333) in 2030 based on national HLMA adjusted staffing norms[29].

In Ethiopia, the number of health professionals per 1000 population is showing a positive trend including improved skills mix in the regions except Afar, Benishangul-Gumuz and Gambella. For instance, from the total health workforce of 273,601 (2020), the administrative and support staffs increased by 32.9% (from 69,021 in 2016 to 91,725 in 2020) and health professionals increased by about 21% (from 150,534 in 2016 to 181,820 in 2020). However, Ethiopia still has acute shortage of health workers in rural areas, where the majority (85%) of the population live, have been particularly chronically under-served. The geographic inequity is still huge as documented through the HRHSP mid-term evaluation. Physician to population is 1 per 7,576 at national level. Physician to population ratio is better than the national average for predominantly urban regions such as Addis Ababa, Dire Dawa and Harari. The distribution is very low for predominantly rural, and developing regions as follows: Southwest Ethiopia (1:32,467), Oromia (1: 14,284), Benishangul-Gumuz (1:13, 389) and Afar regions (1:11,685). The health work force distribution ration per 1000 from 2016-2020 is declining in some regions like Afar 1.5 to 0.9, Benishangul Gumuz 2.7 to 1.79, and Hareri 4.03 to 3.5. Moreover, the comparison of doctors to population ratio among regions indicates high disparity as depicted the two extreme ratios, Addis Ababa and Afar with 1:986 and 1:46,402

[27] *The Federal Ministry of Health Human Resource for Health Strategic Plan Mid-Term Review (MTR), Addis Ababa, Ethiopia, December 2020*
[28] *The Federal Democratic Republic of Ethiopia, Ministry of Health, National Human Resources for Health Strategic Plan for Ethiopia 2016-2023, Addis Ababa, 2026*
[29] *Health Labor Market Analysis: Ministry of Health, Ethiopia, Addis Ababa, Ethiopia, 2020*

respectively. Considering population numbers, in Ethiopia the ratio of health workers to the population shows a heavy urban bias particularly of higher-level health professionals. Especially the problem is worse in agrarian and pastoralist regions[30].

2.3.2.4 Motivation and retention

Enhancing health workforce retention and motivation mechanism is one of the major strategic initiatives stipulated and being implemented during the HSTP II. The Federal Ministry of Health and RHBs has been prioritized, budgeted, and implemented different motivation and retention initiatives to improve performance and productivity of health workforce. The HRH strategic plan 2016-2025 has also proposed the following strategic actions to enhance staff motivation and retention including appropriate financial and non-financial incentives; work climate improvement; increased professional development and promotion opportunities; regular review of career structures; regular motivation and retention studies.

Key findings from job satisfaction, motivation, and retention study conducted by MOH in collaboration with HWIP[31] showed the overall job satisfaction of health professionals has increased to 67.5% from the 41.4%[32]2014 level. On further analysis, health workers' job satisfaction was positively associated with recognition, opportunities for growth, renumeration, supervision and relationships. The health workers reported improvements in several factors including availability of supplies (43.8%), salary (38.9%), duty allowance (35.7%), and supervision (32.7%), access to postgraduate education (13.4%), risk allowance (10.3%), housing allowance (10.9%), and transportation (10.9%) since 2016. The study further showed indicated improvement in salary scale following the job evaluation and grading (JEG) even though the increase was mismatched with the rising cost of living. It was also found that the annual attrition of health workers has declined from 6.2% to 4.1% compared to the 2014 level.

In spite of the fact that, the development of motivation and incentive packages, still there exist a persistent challenge as indicated in the HSTP II in implementation of the packages which resulted in low health workforce motivation and retention due to low salary and benefits, poor facility management, lack of educational opportunity, unfavorable work environment and poor facility infrastructure. The national HRH strategy proposed incentive schemes that include financial and non-financial packages to be implemented for all health professional categories in the nation but does not indicate clear intervention procedures and implementation guidelines. The HSTP II also incorporated health workforce motivation as priority agenda but, there are no clear commitments to implement the priority agenda. The HWF incentive package has been drafted but not endorsed yet. Some of the current motivation mechanisms are housing, training /career development opportunity, certificate, promotion, transfer. The current HWF recognition is being implemented in fragmented ways at different levels.

[30] *Feysia et al. 2012; FMoH 2010*
[31] *USAID Health Workforce Improvement Program/Jhpiego, Assessment of motivation, job satisfaction, and associated factors among health professionals in the public health sector of Ethiopia: a cross-sectional study, Addis Ababa, Ethiopia, 2022*
[32] *Job Satisfaction and Factors Affecting Health Worker Retention in Ethiopia's Public Health Sector, June 2014*

According to job satisfaction, motivation, and retention study[33], doctors have lowest satisfaction level (48%). Health workers in hospitals had lower satisfaction than those in health centers. Payments of the duty allowances are usually delayed in many regions, and the risk allowance is not paid to some professions even though there is perceived risk. Limited housing provision and further educations opportunities; week staff recognition and performance-based reward mechanisms; and subjective and unfair performance evaluation-driven selection are also another challenges.

2.3.2.5 Performance management and productivity

Performance management in the health sector is a collaborative effort between the CSC and MOH. The employee performance appraisal in the sector is one of the most important activities to monitor and evaluate health workforce performance towards improving efficiency and productivity. The Ethiopian CSC has implemented several reform initiatives over the past two decades. These include decentralizing decision making to the woreda level, implementing business process reengineering (BPR), introducing the Balanced Score Card (BSC) and Job Grading and Evaluation (JEG). The focus of all these reforms is to improve performance and create positive practices that are responsive to civil servant needs, improve access to health services, empower communities and create a culture of measuring and rewarding performance. Effective planning and performance management including creating a favorable work environment are critical for long-term health workforce availability, accessibility, and responsiveness, all of which are critical for performance and productivity.

In Ethiopia, modern performance appraisal practice is in its infancy. The existing performance metrics are subjective and not consistently tracked and applied across all the health workforces. There is also a weak mechanism to ensure the skills of the health workforce are being deployed and effectively utilized to meet the needs of the population.

Although health workforce performance measurement and appraisal are being performed bi-annually, there still exist challenges including insufficient technical and managerial skills, poor feedback mechanisms, limited performance measurement system, inconvenient work environment, limited resources, infrastructure, equipment, and medical supplies. Moreover, inadequate supervision, mentoring and coaching, weak plan alignment, and poor integration of performance management with other programmatic areas have weakened the individual and organizational performances.

2.3.3. Health Professionals' Regulation

Health professional regulation safeguards the public from medical malpractices and undue harms. It would also protect and safeguard health professionals. It advances access of the population to quality health care by ensuring the availability of qualified, ethical and experienced health professionals. The MOH, RHBs and Health Professional Associations (HPA) have collaborated to establish health ethics system, strengthen licensing, and developed scope of practices and guidelines. In many regions, the relicensing of health professionals is linked with the CPD requirements through consistent application of regulatory policy. The regulatory structures, standards, and policies were established, and many improvements have been observed so far. Current practices have shown the responsibilities of registration and licensing of health professional graduates has been transferred to the regional regulatory bodies to ensure the oversight and control closer to the service delivery.

[33] *Ibid.*

However, evidence show that significant proportions of health professionals in Ethiopia were not licensed. Not all human resource departments have hired their facility staff based on the federal licensing standards. Based on the national study done[34], out of 365 hiring bodies only 66.3% sought current license from the health professional candidates as basis for hiring process. Out of a total of 4991 health professionals' personnel files reviewed, only 1645 (33%) were found to be working without license while 603 (12%) were found to work with an expired license whereas only 2733 (55%) have a current professional license.

Though there were reports of medical errors and ethical breaches during patient care, the capacity to manage professionals and prevent unethical practices is limited. Many professionals practice beyond their scopes hampering standard medical practice and patient safety. The regulatory bodies in many regions are not independent to execute, monitor and take appropriate measures that improve quality of health service delivery.

Despite enormous efforts in developing and documenting health professionals' scope of practice in recent years, the delay in getting it approved and putting it into effect has remained a challenge. Another remaining challenge is revision, finalization, and approval of health professional's counsel.

2.3.4. HRH Evidence Generation and data use for Policy Option

Accurate and timely HRH information is essential to support HR planning and management. Better HRH data and evidence are required as a critical enabler to enhance advocacy, planning, policymaking, governance, and accountability at national, regional, and global levels.[35] The MOH is introducing new iHRIS software to capture the HR data since 2022. The iHRIS consists of three modules applicable in the current Ethiopian HRH context: HR Development, HRM management and HR License/Regulation. The software development went through a lot of verification processes and is now able to store comprehensive HRH information from all levels to facilitate routine HR data collection and management.

However, the system requires a lot of effort and resources at all levels to have full coverage including private health facilities and related institutions. The required resources include computers, networks, relevant infrastructure, and skilled health workforce to manage and operate the iHRIS at all levels in the health system. Training, mentorship, supervision and related costs are also required recourses to fully implement the iHRIS.

The Human Resources Development Directorate of the MOH has been producing NHWA and Annual HRH update reports since 2021 and 2018 respectively for monitoring health workforce availability and quality of data in the health sector. The Ministry of Health has also conducted Health Labor Market Analysis (HLMA) and Workload Indicators of Staffing Need (WISN) to facilitate equitable staffing and access to qualified health workforce towards achieving UHC and the SDGs. Recent studies were also conducted on HWF such as Health professionals licensing practice, Clinical skill competency, Job satisfaction and motivation, productivity. However, the HRH-focused research is limited in number and not well coordinated. The available HRH data and evidence informed HRH policies and knowledge management which resulted in improved government commitment towards concrete actions in the health system.

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[34] *Health professionals Licensing: The Practice and Its Predictors among health professional hiring bodies in Ethiopia, 19 August 2022 https://doi.org/10.1186/s12960-022-00757-6*

[35] *Global strategy on human resources for health: Workforce 2030, WHO, 2016*

2.3.5. Investment on Health Workforce

The health workforce has vital role in achieving health goals and catalyzing economic recovery and growth is well recognized, though shortage of financing remains to be major challenge. The government has been committed to prioritizing and allocating budget for health workforce development and management activities. This in turn improved health workforce availability, distribution, and performance.

The National HRHSIP is in place to guide the national health workforce agenda and ensure HRH, management, development, and regulatory activities are prioritized, planned, and budgeted. According to the HRHSP Mid-Term Review[36], there is severe limitation in national budgetary allocation to the Health Sector in general and HRH in particular to produce and deploy the required number and mix of health workers. The financial limitation to adequately provide motivation and enabling working environment had negative impact on health worker retention especially in rural areas, emerging regions and some critical cadres. This regrettably has also been noted to contribute to outflow/migration of health professionals that led to loss in investment in health workers training and development. It is also evident that, the country's economy, and the policy to increase health fiscal space is challenged by natural (COVID-19, climate changes and drought) and manmade events (conflicts in various parts of the country) in the last three years, and global economic mishaps.

According to HLMA[37], the need-based requirement with Essential Health Service Package (EHSP) scenario showed that, the country would need a minimum of 610,708 health workers of various occupational categories in 2022, which will increase significantly to 661,239 by 2025 and 751,787 by year 2030. As of 2023, the country has 489,320 health workforces and there is a huge gap between what the country has and what it needs. This projection calls for huge investments in health workforce development, employment, improved working conditions, incentive packages and other related costs.

The HLMA[38] also estimated, the country would need to invest US$2.2 billion, by 2030, to train additional health workforce and fill need-based shortages that was estimated to deliver the essential health package of Ethiopia. This represents an increase of 21% over the current health training investments. The additional investments in the form of employment required to meet the need for health workers under the EHSP is estimated at US $305 million annually. Thus, the total additional HRH investment required for both training and job creation (including currently employed health workers) is about US$ 4 billion over a period of 10 years.

2.4. SWOT Analysis

In the development of HRHSIP:2024-2030, SWOT analysis was conducted to identify best experiences, successes, and strengths; and identified the most determinant factors and challenges encountered during the implementation of HRHSP. Accordingly, these are broadly divided into internal factors (Strengths & Weaknesses) and external factors (Opportunities & Threats). Based on the Mid-term assessment and performance analysis of HRHSP, detailed list of factors are identified in the SWOT analysis that influence implementation and the intended result. See Annex II for detailed information.

[36] *The Federal Ministry of Health Human Resource for Health Strategic Plan Mid-Term Review (MTR), Addis Ababa, Ethiopia, December 2020*
[37] *Health Labor Market Analysis: Ministry of Health, Ethiopia, Addis Ababa, Ethiopia, 2020*
[38] *ibid.*

2.5. Stakeholders Analysis

Stakeholders	Behaviors we desire	Their needs	Resistance issues	Institutional response
Ministry of Health and the Health Agencies	• Overall leadership • Budget allocation • Regulation • Evidence generation	• Quality health services • Adequate number of competent health workforce	• Dissatisfaction • Fail to achieve the health goals and vision	• Establish strong M&E platform • Quality and equitable service
Line Ministries (MoE, Labor and Skill development, Finance, MIT, ETA)	• Workforce education • Job creation and employment • Budget allocation • Evidence generation • Innovation and technology • Accreditation and regulation • Intersectoral collaboration	• Access to quality health service, • Economic development • Healthy and productive workforce	• Dissatisfaction • Loss of interest for active participation and contributions • Fragmentation on joint leadership and coordination practice	• Collaboration • Transparency • Advocacy
Civil Service Commission	• Policy and procedure development • Standardization of job grade and renumeration • HR staffing standard & mix	• High performing, disciple and ethical workforce	• High attrition rate • Low motivation	• Policy and leadership support • Collaboration
Health Sciences Education Institutions and TVET	• Education • Curriculum development	• High quality education • Improved infrastructure and resource	• Poor quality of education • Low passing rate	• Allocate adequate budget and resources
Professional Associations	• Participation and engagement • CPD • Collaboration and partnership • Advocacy • Evidence generation	• High quality health professionals • Professional recognition • Better recognition	• Loss of interest to collaborate and participate • Poor engagement • Workforce grievance	• Policy and leadership • Support
Regional Health Bureaus/Zonal Health Department/ Woreda Health Offices/Health Facilities	• Education • In-service training • CPD • Budget allocation • HRH management	• Access to high quality health service • Adequate number and mix of health workforce • Infrastructure and resource	• Low quality of health service • Inadequate health workforce • Inequity or regional disparities • Public and workforce grievance	• Government leadership • Allocate adequate resource • Collaboration
Private Sector	• Education • Employment • CPD • Advocacy and collaboration	• Enabling environment for their engagement • Fair regulation • Investment opportunities • Recognition	• Dissatisfaction • Grievance • Loss of interest for investment and collaboration	• Ensure enabling environment • Public private dialogue • Strengthen PPP
Development partners and donors	• Financial and technical support	• Access to high quality health service	• Dissatisfaction • High transaction cost • Inefficiencies	• Government leadership • Transparency

Stakeholders	Behaviors we desire	Their needs	Resistance issues	Institutional response
		• Effective & efficient utilization of resource		• Efficient resource use
Health workforce	• Engagement and participation • Quality service provision	• Enabling environment • Incentive • Education and professional development • Recognition	• Dissatisfaction • Attrition • Grievance	• Implement motivation and retention mechanism. • Create educational opportunities
Community	• Engagement and participation • Recognition	• Access to quality health service • Respect and responsive	• Low quality service • Grievance • Underutilization of service	• Community mobilization, • ensure participation. • Quality and equitable service and information

CHAPTER 3

VISION, GOAL AND GUIDING PRINCIPLES

3.1.Vision

To see a competent, responsive, and resilient health workforce capable of meeting the diverse healthcare needs of society.

3.2.Goal

To ensure the health workforce competency, adequacy, skill mix, equitable distribution and capable of delivering and regulating high-quality, culturally sensitive and client centered comprehensive healthcare services to all people in an equitable manner, ultimately leading to the achievement of UHC and SDGs by 2030.

3.3.Guiding Principles

The strategic focus of this plan has been guided by the Ministry of Health HRH vision, goal, objectives and guiding principles outlined below.

- **Country's commitment**: To support actions that contribute to a sustainable health workforce.
- **System linkage**: National HRH strategies should be harmonized with the relevant components of the health system and primary health care principles.
- **Donor alignment**: Donor support should be coordinated and aligned with country HRH plans.
- **Accessibility and accountability:** To ensure that all people, in all places, have access to skilled health workers who are equipped, motivated, accountable and supported.
- **Results-oriented**: HRH strategies and actions aimed at achieving measurable outcomes.
- **Multi-sectoral engagement**: Involve all sectors and stakeholders including the community to build health.
- **Equity and Inclusivity:** Ensuring fair and equitable distribution of healthcare resources and workforce across all regions and communities within Ethiopia.
- **Continuous Learning and Development:** Prioritizing ongoing education and training for healthcare professionals to keep skills and knowledge up to date with best practices.
- **Cultural Sensitivity:** Respecting and integrating diverse cultural beliefs and practices into healthcare delivery to ensure services are sensitive to local customs and traditions.
- **Sustainability:** Building a health workforce system that is sustainable in the long term, considering factors such as retention, motivation, and career development.

3.4. Conceptual Framework for the Development of the HRH Strategic and Investment Plan

The Ethiopian national HRH Strategies are guided by the HRH action framework approved by the World Health Organization. This framework has been designed to guide and ensure that the National HRH Strategy and Investment plan for 2016-2022 (2024-2030) addresses the key components of HRH issues and the relationships between the components are well established for coordination and effective management. The emphasis of the framework as adapted in the development of this strategy is that to improve health workforce in terms of quality, numbers, skills and motivation, there should be coherent links between production, planning, deployment, equitably distribution performance management and continuous professional development. The link is derived from strengthened HRH forecasting and planning that informs investment decisions on production, deployment and management of HRH. This should be aligned with appropriate resourcing as well as building the health sector's execution capacity that contributes to the improvement of equity and quality of health services towards the achievement of National Health Sector Medium Term Development and Investment Plan Goals, UHC and SDGs. The following figure depicts the actions designed to guide the development of the National HRH strategy 2016-2022 (2024-2030).

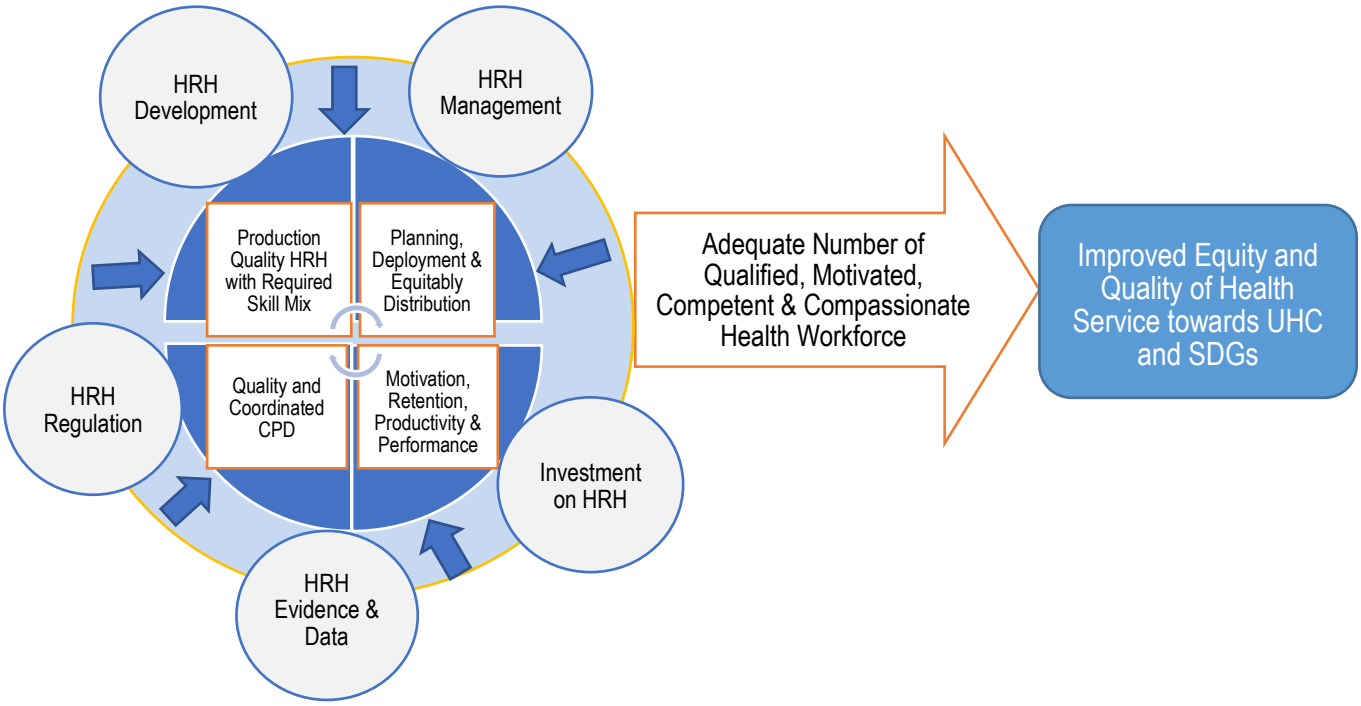

Figure 2 Conceptual Framework for the Development of HRHSIP Strategy

CHAPTER 4

STRATEGIC FOCUS, OUTCOMES, OBJECTIVES, AND INTERVENTIONS

4.1. Strategic Focus, Outcomes, Objectives, and Interventions

4.1.1. Strategic Focus

1. Enhance Human Resources for Health Development
2. Optimize Human Resources for Health Management
3. Improve Health Professionals' Regulation
4. Improve HRH Evidence Generation and data use for Policy Option
5. Align Investment with HRH requirements

4.1.2. Strategic Outcomes

4.1.2.1 Strategic Outcome 1: Strengthened Human resources for health education and training.

This outcome focuses on the production of a competent health workforce to ensure availability of health care workers in right number, and appropriate professional skills mix to meet the HRH needs of health sector through improved capacity of PSE. Moreover, expanding access to quality continuing professional development (CPD) will help to maintain and upgrade the competency of health workers.

This outcome has five strategic objectives with relevant strategic interventions.
SO 1.1 Enhance health professionals production
SO 1.2 Improve quality of education
SO 1.3 Improve Postgraduate education programs.
SO 1 4 Improve post-basic education
SO 1.5 Ensure health workers participation in CPD

SO 1.1 Enhance health professionals' production

This objective will be achieved through the implementation of training needs assessment to determine type, mix and number of healthcare students, promote targeted admission to increase ethnic, gender and geographic diversity of students and Expand healthcare education programs for priority but scarce professionals in collaboration with Ministry of education and higher education institutions.

SO 1.2 Improve quality of education

The quality of Health Professional education will achieve through the implementation of accreditation of healthcare education programs, strengthen faculty development programs for instructors and preceptors, strengthen consortium of health professions schools, and expand use of simulation and digital technology and creating a safe and equitable learning environment for women and men in education of health professionals in higher education institutions.

SO 1.3 Improve postgraduate education programs

This objective will be achieved by expanding demand based medical and other healthcare professions specialty and sub-specialty roadmap align with service expansion in the health system.

SO 1.4 Improve post-basic educations

The post basic education program will be achieved by focusing health system demand based and priority specialty programs in upgrading of selected vocationally trained health workers (Level III, IV and V).

SO 1.5 Ensure health workers participation in CPD activities

This objective will be achieved through the strengthening of service provision based CPD, increase availability and accessibility through different modalities such as face to face, blended and digitization with fair geographic and gender access, and address all professions in need-based approach.

Table 1 Strategic interventions for human resources for health: health science and medical education

Strategic focus	Strategic Outcome	Strategic Objective	Strategic Interventions
SF1. Enhance Human Resources for Health Development	SO 1, Human resources for health education and training strengthened.	SO, 1.1 Enhance health professionals' production	1.1.1. Conduct health workforce education needs assessment to determine type, mix and number of healthcare students
			1.1.2. Conduct targeted admission to increase ethnic, gender and geographic diversity and optimize enrollment of students with disabilities.
			1.1.3. Expand healthcare education programs for priority but scarce professionals
			1.1.4. Strengthen career choice based (passion based) enrollment and placement mechanisms
			1.1.5. Facilitate to increase the number of training institutions, faculties, and clinical training sites to expand the production capacity of prioritized health workforce.
			1.1.6. Develop targeted enrollment strategies to identify, recruit, and support individuals from underserved and rural areas, as well as underrepresented populations, promoting a diverse and representative health workforce.
			1.1.7. Foster partnerships between educational institutions and public or private healthcare providers to create opportunities for practical training and employment for health graduates.
		SO, 1.2 Improve quality of education	1.2.1. Establish rigorous quality assurance mechanisms and accreditation processes.
			1.2.2. Update and align health science and medical education curricula with current evidence-based practices and health system orientation
			1.2.3. Invest in evidence- based faculty development programs for instructors and preceptors.
			1.2.4. Strengthen consortium of health science and medical education.
			1.2.5. Strengthen networking, partnership and collaboration with regional and international health professions education institutions

Strategic focus	Strategic Outcome	Strategic Objective	Strategic Interventions
			1.2.6. Expand use of simulation and digital technology in science and medical education
			1.2.7. Coordinate the use of competency-based education through integrating health system science approaches to students with especial needs
			1.2.8. Design and implement inter-professional education and practice
			1.2.9. Strengthen knowledge and practical examinations (national licensure examination, exit GAT and residency), including implementation of OSCE.
			1.2.10. Develop and implement remediation strategy for health professional who failed national licensure examination and civil service competency assessment.
			1.2.11. Operationalize intersectoral collaboration with MOE, ETA, HSEIs, professional association
			1.2.12. Nurture capacity of academic leaders, including female leaders
			1.2.13. Enhance research and evidence-based education and practice institute a culture of critical inquiry and evidence generation for students and faculty to inform policy and programing
			1.2.14. Optimize academic-service integration, including supporting clinical practice improvement of health science education
			1.2.15. Provide opportunities for students to engage with local communities and gain insights into the socio-economic determinants of health, as well as practical experience in delivering healthcare in diverse settings.
			1.2.16. Revitalize health professions education program and HDP for health science educators
		SO 1.3 Improve Postgraduate education programs	1.3.1. Expand demand based medical specialty and sub-specialty roadmap aligned with service expansion
			1.3.2. Strengthen the nursing/midwife residency program
			1.3.3. Conduct a comprehensive needs assessment to identify the priority areas for specialty and subspecialty development program based on the healthcare needs of the population and the availability of healthcare services.
			1.3.4. Collaborate with medical schools and healthcare institutions to develop new specialty and subspecialty programs in alignment with identified healthcare needs, aspiring to expand the range of available training opportunities.
			1.3.5. Expand the capacity of existing training institutions and create partnerships with national and international bodies to increase the number of available training positions for postgraduate specialty and subspecialty programs.
			1.3.6. Provide financial and logistical support to trainees pursuing postgraduate medical specialty and subspecialty programs, including scholarships, regular payment, and mentorship opportunities.
			1.3.7. Foster partnerships with public and private healthcare providers to create opportunities for practical training,

Strategic focus	Strategic Outcome	Strategic Objective	Strategic Interventions
			exposure to different healthcare settings, and employment opportunities for postgraduate trainees.
			1.3.8. Leverage telemedicine and e-learning platforms to extend the reach of specialty and subspecialty training programs to remote or underserved areas, making them more accessible to a broader range of healthcare professionals.
			1.3.9. Expand demand-based specialty training for other healthcare science programs aligned with service expansion
			1.3.10. Launch and expand Doctor of Public Health programs
		SO 1.4 Improve post-basic education	1.4.1. Accelerate upgrading of vocationally trained health workers (Level III, IV and V)
			1.4.2. Collaborate with and support health education institutions on capacity building, evidence generation, mentorship and supervision.
		SO 1.5 Ensure health workers participate in CPD	1.5.1. Reinforce regulation and management of CPD providers and accreditors.
			1.5.2. Implement service provision based CPD platforms
			1.5.3. Increase availability and accessibility of CPD considering geography, profession, and health needs
			1.5.4. Conduct a thorough needs assessment to identify the specific knowledge and skill gaps among the health workforce and determine the priority areas for CPD.
			1.5.5. Design and develop CPD programs that are tailored to address recent evidence changes and identified skill gaps, with a focus on evidence-based practices, emerging healthcare technologies, and relevant policy updates.
			1.5.6. Implement interactive and participatory learning methods such as case-based learning, simulation exercises, and problem-solving scenarios to engage healthcare professionals effectively during CPD activities.
			1.5.7. Leverage technology to deliver CPD programs through online platforms, webinars, and e-learning modules, making professional development opportunities accessible to a wider audience, including those in remote areas.
			1.5.8. Collaborate with national and international professional organizations, academic institutions, and industry partners to enrich the content and delivery of CPD programs, ensuring that they align with global best practices.
			1.5.9. Establish mechanisms for continuous monitoring, evaluation, and quality assurance of CPD centers and programs to ensure that they meet the highest professional and ethical standards.
			1.5.10. Incorporating service volumes and performance metrics as inputs for continuous professional development (CPD) programs can provide healthcare professionals with valuable insights into their clinical practice and help them identify areas for improvement. This include undertaking Quality Improvement Projects:
			1.5.11. Improve use of digital technology for CPD provision and management

4.1.2.2 Strategic Outcome 2: Optimized Management of Human Resources for Health

This outcome has five strategic objectives with relevant strategic interventions.

SO 2.1 Enhance human resources for health management, leadership and governance capacity at national, regional, district and facility level

SO 2.2 Improve availability and equitable distribution of health workers

SO 2.3 Re-design and implement HWF performance management system.

SO 2.4 Enhance health workforces' motivation and retention mechanisms

SO 2.5 Develop and implement HRH emergency preparedness, response and recovery plan.

SO 2.1 Enhance human resources for health management, leadership and governance capacity at national, regional, district and facility levels

This strategic objective aims to strengthen institutional capacity for HRH management, leadership, and governance at all levels of the health system including MOH, RHBs district health offices and health facilities. It is required for effective policy stewardship of the national HRH agenda and actions. It also facilitates investments in leadership development programs and succession planning to identify and groom future leaders in the health sector, ensuring continuity and stability in leadership roles.

SO 2.2 Improve availability and equitable distribution of health workers

This objective is aimed to address the health workers shortage and distribution imbalances including geographic, skill mix (staff mix, qualification. experience) and gender considering population health care needs, health system priorities, labor market dynamics and variations of health facility workload. This strategic objective will accelerate the progress towards universal health service coverage.

SO, 2.3 Re-design and implement HWF performance management system.

This strategic objective aims to improve the productivity of the health workforce and maximize service delivery efficiencies to ensure the availability of quality health services, accessible to populations and make further progress toward universal health coverage. This objective is also intended to strengthen performance management systems that include performance-based rewards and accountability.

SO 2.4 Enhance health workforces' motivation and retention mechanisms.

This objective is designed to increase job satisfaction, motivation and retention of the health workforce through enhancing financial and non-financial incentives, and improvement systems to deliver quality and publicly acceptable health care.

SO 2.5 Develop and implement national HRH emergency preparedness, response and recovery plan

The health impacts of recent global infectious disease outbreaks and other disasters highlight the importance of strengthening public health systems including health workforce to protect communities from naturally occurring and human-caused threats. The health system in Ethiopia faces several emergency situations as the result of COVID-19, armed conflicts, and other natural and manmade calamities and disasters.

Table 2 Interventions on Human Resources for Health Management

Strategic focus	Strategic Outcome	Strategic Objective	Strategic Interventions
SF 2. Human Resources for Health Management	**SO 2**. Human Resources for Health Management Optimized	**SO 2.1** Build human resource for health management, leadership and governance capacity at national, regional, district and facility levels	2.1.1. Conduct assessments and identify gaps in leadership, governance and gender for HRH
			2.1.2. Strengthen national capacity to implement and promote the HRH agenda
			2.1.3. Advocate for aligned leadership and governance structures at all levels.
			2.1.4. Establish and implement a national coordinating mechanism among training institutions, private sectors, PAs, regulatory agencies, development partners, civil society organizations, patient groups, and communities.
			2.1.5. Carry out an advocacy and engage political leaders and stakeholders in HRH policy and legislation processes at country, regional and sub-regional levels.
			2.1.6. Improve capacity of adaptive leadership during health emergencies and disasters.
			2.1.7. Professionalize the human resource administration and development staff
			2.1.8. Provide capacity building and HRM training to human resources management staff and supervisors
		SO, 2.2 Improve availability and equitable distribution of health workers.	2.2.1. Build the capacity of regions to improve health workers recruitment and deployment
			2.2.2. Develop tailored incentive packages for hard-to-reach areas and rural community services
			2.2.3. Develop a comprehensive strategy to raise awareness, change attitudes and increase commitment of the health workforce to serve rural communities
			2.2.4. Promote inclusive recruitment procedures and practices to improve the proportion of women health workers
			2.2.5. Develop policies and mechanisms for equitable deployment and distribution of health workers, considering the healthcare needs of different geographic regions and populations, and addressing disparities in access to healthcare services.
			2.2.6. Build local leadership capacity to improve bargaining power to mobilize adequate fund for health workforce recruitment and deployment
		SO. 2.3 Re-design and implement HWF performance management system.	2.3.1. Strengthen regular performance management and appraisal system
			2.3.2. Enhance accountability system for low performance and absenteeism
			2.3.3. Introduce transparent performance-based payment system

Strategic focus	Strategic Outcome	Strategic Objective	Strategic Interventions
		SO 2.4 Enhance health workforces' motivation and retention mechanisms.	2.4.1. Promote locally available innovative financial and non-financial motivation and retention incentive packages
			2.4.2. Ensure conducive work environment and health workforce safeguarding to enhance efficiency and productivity
			2.4.3. Re-design and implement an opportunity for professional career development
			2.4.4. Implement pilot delinking of remuneration at selected hospitals
			2.4.5. Promote mechanisms to measure, and analyze customer and staff satisfactions
		SO, 2.5 Develop and implement national HRH emergency preparedness, response and recovery plan.	2.5.1. Design and implement a risk and Emergency HRM system
			2.5.2. Develop mechanisms to support the physical and mental well-being of health workers during and after emergencies, providing access to counseling, psychosocial support, and resources to address occupational stress and trauma.
			2.5.3. Institutionalize national coordination mechanisms to harmonize HRH readiness in times of emergency situations.
			2.5.4. Strengthen HRH emergency capacity building program to effectively respond to emergencies, including disaster management, infection control, and patient surge capacity.
			2.5.5. Develop mechanism for a surge roster of multi-disciplinary staff to respond for health emergencies.

The health impacts of recent global infectious disease outbreaks and other disasters highlight the importance of strengthening public health systems including health workforce to protect communities from naturally occurring and human-caused threats. The health systems in Ethiopia faces several emergency situations as the result of COVID-19, armed conflicts, and other natural and manmade calamities and disasters. These situations affected the human resources for health planning, management and safety of staff and their families. To enhance the health systems capacity address HRH issues during time of crisis this strategic plan proposes the following strategic actions.

4.1.2.3. Strategic Outcome 3: Improved Health Professionals' Regulation.

This outcome focuses on improving the existing regulatory mechanisms. The outcome targets to protect the public from incompetent and unethical health care practitioners through provision of health professional licensure examination, licensing, relicensing and handling medico-legal cases.

This outcome has four strategic objectives with relevant strategic interventions.

SO 3.1 Strengthen ethical health practice
SO 3.2 Streamline implementation of the scope of practice
SO 3.3 Strengthen health professional licensing and relicensing
SO 3.4 Enhance national licensure examination

SO 3.1: Strengthen ethical health practice

This strategic objective mainly focuses to provide safe health services to the community through protecting both the health professionals as well as the community at large from malpractices. This will be ensured by promoting ethical health practices through increasing the awareness of health professionals at the same time the community and establishing a functional ethical review system to see and manage incidents occurred that result accountability for any malpractice.

SO 3.2: Streamline implementation of the scope of practice

Scope of practice for the health professional's states the level of service health professionals will be allowed to provide in any health care delivery. The regulation of health professionals depends on legislation of professional practice since it establishes criteria for education, ethics, and competent practices as well as the minimal requirements for defining scope of practice.

SO 3.3: Improve health professional licensing and relicensing

This objective aims to ensure the deployment of competent professionals in the health system and helps to prevent forgery and incompetent practice. This will be ensured by issuing license for those who fulfill the requirements and pass the licensure examination, providing appropriate professional title. Monitoring and regulating health facilities and other stakeholders not to deploy unlicensed professionals which will prevent malpractice.

SO 3.4 Enhance national licensure examinations

This objective is intended to enhance the National Licensure Examination process by implementing measures aimed at improving the validity, reliability, fairness and inclusiveness of the assessment to ensure that qualified candidates are licensed effectively in their respective fields. This will involve the refinement of examination content to align with current industry standards, the continual review and updating of examination questions to reflect the latest developments in the field, the utilization of advanced technology to facilitate secure and efficient examination administration, and the provision of comprehensive resources and support for candidates to adequately prepare for the examination. Additionally, a robust feedback mechanism will be established to gather insights from stakeholders, including professionals, educators, and regulatory bodies, to inform ongoing enhancements to the examination process. By strengthening the National Licensure Examination in these ways, the goal is to foster public trust in the licensing system, uphold professional standards, and safeguard the welfare of the general public.

Table 3Intervention on Health Professionals' Regulation

Strategic focus	Strategic Outcome	Strategic Objective (SO)	Strategic interventions
SF 3. Improve Health Professionals' Regulation	**SO 3.** Health Professionals' Regulation Improved	**SO 3.1**Strengthen ethical health practice	3.1.1. Strengthen and expand functional ethics committee at national and subnational level
			3.1.2. Develop and implement health professionals code of conduct and ethics
			3.1.3. Promote and enforce the establishments of preventive ethics platforms/ethics and medicolegal committee at facility level
		SO 3.2 Streamline implementation of the scope of practice	3.2.1. Approve and implement the scope of practice.
			3.2.2. and associated directive for each health profession category
			3.2.3. Increase awareness of health professionals, employers, educators and regulators about scope limits
		SO 3.3 Improve health professional licensing and relicensing	3.3.1. Scale up digitalization of health professional licensing including foreign graduate health professionals through iHRIS.
			3.3.2. Establish semi-autonomous health professions council
			3.3.3. Strengthen national and subnational capacity of regulatory bodies to implement licensing and relicensing including gender and inclusiveness.
			3.3.4. Strengthen integrate of CPD and relicensing
			3.3.5. Enhance multisectoral collaboration on regulation of CPD for relicensing
		SO 3.4 Enhance national licensure examination	3.4.1. Ensure all new graduates of health professions undergone national licensure examination including Initiation and scale up of practical assessment
			3.4.2. Enhance the National Licensure Examination process by implementing measures aimed at improving the validity, reliability, and fairness of the assessment
			3.4.3. Strengthen partnership between health and education sectors to improve quality of education and pass rate on NLE

4.1.2.4 Strategic Outcome 4: Improved HRH Evidence Generation and Data Use for Policy Choice

This outcome has five strategic objectives with relevant strategic interventions.

SO 4.1 Improve credible, comprehensive and quality HRH data
SO 4.2 Enhance and integrate HRH information systems to avail up-to-date HRH data
SO 4.3 Improve HRH evidence utilization practice for policy formation and decision-making
SO 4.4 Enhance HRH data implementation frameworks
SO 4.5 Generate data on HRH investment and requirement for policy choices

SO 4.1 Improve credible, comprehensive and quality HRH data

To prepare standardized data collection tools, formulating a data summary and analysis, improving a data quality assurance system at all levels, using data in an efficient and effective manner.

SO 4.2 Enhance and integrate information systems to ensure up-to-date HRH data

To produce a reliable and quality of data from all data sources helps to identify the main HRH issues and indicators to make need-based data analysis and interpretation so as to produce relevant profile and extracting features and situational trends. Formulate data sharing policy, fulfill data related infrastructure, developing the practice of effective data exchange and evidence-based decision-making along with holistic accountability at all level.

SO 4.3 Improve HRH evidence utilization practice for policy formation and decision-making

To strengthen data driven decision making from all possible data sources complemented by conducting research based on pertinent HRH problems, to produce decision-making tools such as issues, technical and policy briefs.

SO 4.4 Enhance HRH data implementation frameworks

Develop data policy, protocol and standard, data element requirement, design update different data guidelines and directives, establish regular follow up mechanism and ensure transparency at all levels.

SO 4.5 Generate data on HRH investment and requirement for policy choices

Investment and policy option need formative evidences derive from HLMA, WISN, workforce Productivity Analysis, gender and other relevant analysis based on identified gaps.

Table 4 Interventions on Improving HRH Evidence Generation and Data Use for Policy Option

Strategic Focus	Strategic Outcome	Strategic Objective	Strategic Interventions
SF4. Improve HRH Evidence Generation and data use for Policy Option	**SO 4.** Efficient and effective communication and decision-making practice improved	**SO 4.1** Improve credible, comprehensive and quality HRH data	4.1.1. Support implementation and follow up of iHRIS at all levels
			4.1.2. Conduct collaborative HRH research, NHWA, HLMA WISN
			4.1.3. Advocate leaders to allocate adequate finance for HRH research and data collection
			4.1.4. Revise HRH data element and indicator.in the iHRIS software
			4.1.5. Strengthens data quality monitoring mechanisms.
		SO4.2 Enhance and integrate HRH information systems to avail up-to-date HRH data	4.2.1. Avail the HRH data capturing and reporting equipment
			4.2.2. Monitor the interoperability of health information systems
			4.2.3. Conduct maturity assessment of the iHRIS
			4.2.4. Strengthen implementation of NHWA through collaboration with stakeholders
			4.2.5. Improve data sharing and knowledge management platform.
			4.2.6. Conduct regular follow up and support
		SO 4.3 Improve HRH evidence utilization practice for policy formation and decision-making	4.3.1. Encourage different stakeholders to utilize HRH data at all level
			4.3.2. Ensure timely dissemination of HRH information and enable public access to different levels of decision-making.
			4.3.3. Explore, document and disseminate HRH related best practices at global, national and regional level
			4.3.4. Produce HRH policy technical briefs on relevant issues in evidence-based HRH decision making.
		SO 4.4 Enhance HRH data implementation frameworks	4.4.1. Ensure iHRIS implementation as a prerequisite for renewing private facilities licensing.
			4.4.2. Encourage to assign qualified professional and dedicated position for iHRIS at all levels
			4.4.3. Establish a national health workforce registry
			4.4.4. Strengthen national health workforce observatory body/steering committee.
			4.4.5. Harmonize different data analysis tools
			4.4.6. Enacting advocacy on accountability of HRH data and evidence generation and utilization at all level
			4.4.7. Ensure data security and confidentiality
		SO 4.5 Generate data on HRH investment and requirement for policy choices	4.5.1. Assess Health Labor Market dynamics
			4.5.2. Study on Workload Indicators Staffing Needs
			4.5.3. Analyze Efficiency gain on health workers performance
			4.5.4. Conduct Health workforce Productivity Analysis
			4.5.5. Undertake study to determine extent of grants and loans on HRH
			4.5.6. Determine HRH investment needs

4.1.2.5 Strategic Outcome 5: Aligned Investment with HRH requirements

Investing in intersectoral approaches to address the health workforce challenge will yield benefits in various areas such as education, employment, youth empowerment, gender equality, and rural development. Moreover, by actively promoting investment initiatives, countries can enhance their ongoing endeavors to attract and generate increased investments that are of higher quality and greater impact. Investments in the health workforce should focus on access and quality of education and training and improving employment and job creation and overall HRH Management. The attainment of the health related UHC and SDGs are strongly linked with equitable access to health workforce within resilient health systems that are competent, motivated and productive and promptly and effectively respond to all public health emergencies while maintaining the optimal provision of routine health services. The challenges exposed by COVID-19 created new impetus and opportunities to invest in health workforce and has triggered a trend of an investment interest following decades of chronic under-investment.

Investing in health and health workforce is key to achieve national health goals, Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs). The need to invest more in the health workforce is very important to better align health workforce requirement with priorities to the population's health needs. This outcome focuses on increasing domestic and international financing including improved national and subnational sustained political commitment, develop and implement health workforce investment charter.

Strategic Objectives

SO 5.1 Strengthening human resource planning and forecasting
SO 5.2 Increase advocacy for evidence-based HRH investment.
SO 5.3 Enhance the utilization of existing global HRH funding mechanisms to improve HRH financing
SO 5.4 Improve intersectoral collaboration and community engagement to increase HRH financing.
SO 5.5 Develop and implement HRH Investment Charter
SO 5.6 Improve regional domestic health workforce financing.
SO 5.7 Improve Employment and job creation.

SO 5.1 Strengthening human resource planning and forecasting

Even though HRH planning and monitoring units are operational at national and regional level, several challenges were identified during the midterm review of HRH strategic plan (2016-2025). This strategic objective also aimed at developing robust systems for workforce planning and forecasting to align the supply of health workers with current and future healthcare needs, considering demographic changes, disease burden, and epidemiological trends.

SO 5.2. Increase advocacy for evidence-based HRH investment.

This objective is aimed at increasing awareness and commitment to improve investments in health sector human resources development and management. Key approaches and actions include developing the investment cases and strategic policy actions to justify sustaining the current investments and additional flow of resources for HRH.

SO 5.3. Enhance the utilization of the existing global HRH funding mechanisms to improve HRH investment

With this objective the MoH and its partners who will implement the National HRHSIP will identify, access, prioritize and utilize the existing and emerging continental and global opportunities to strengthen HRH for Universal health coverage and achievement of sustainable development goals.

SO 5.4. Improve intersectoral collaboration and community engagement to increase HRH financing

The health sector human resources development and management policies and practices depend on investments in other sectors such as education sector, finance and economic development, innovation and technology, skills development and job creation sectors, foreign policy and diplomacy, private sector, and communities at large. It is imperative to create and / strengthen partnership and collaboration diverse stakeholders to effectively implement the National HRHSIP.

SO 5.5. Develop and implement HRH Investment Charter

According to the World Health Organization (WHO)[39], the HRH Investment charter is evidence-informed investment priorities that are costed and appraised against the expected benefits, with the funding sources for implementation, and clearly identified with the funding parties making formal commitments on the volume, duration, and flow of the funds. It has clear accountability mechanisms in terms of financial management and expected deliverables. During the National HRHSIP period, the Ministry of Health and its partners will conduct high level dialogue to advocate for development of the HRH Investment Charter and ensure key stakeholders buy-in, increase regional domestic health expenditure up to the 15% Abuja target, expand domestic (public and private) investment in health workforce development and administration, develop capacity on efficiency and effectiveness of financial resources utilization for improved sustainable HRH financing, and ensure financial sustainability for HRH in collaboration with other relevant ministries, partners and stakeholders.

SO 5. 6 Improve regional domestic health workforce financing.

Increased regional domestic investment in health workforce played a paramount role towards the attainment of financial sustainability for HRH aspirations. Engaging regional political leadership to prioritise health expenditure in general up to the Abuja target of 15% and especially investing between 50% and 60% of the health is critical to improve health workforce financing.

SO 5.7. Improve Employment and job creation.

Ethiopia has faced with shortage of health workforce and limited job opportunities for new health professional graduates. This situation is among the drivers to develop the current National HRHSIP. Accordingly, the government should mobilize and invest in creation of decent jobs in the health sector to fulfill the health service needs and meet expectations of the communities/citizens for quality healthcare and services. This calls for expanding the existing employment mechanisms such as through implementing newly approved health facility staffing norms, creating new job opportunities including overseas employment, and innovative hiring mechanism including utilization of SDG pool funds to support health workforce employment especially in deprived and hard-to-reach regions and areas.

[39] *https://www.afro.who.int/sites/default/files/2023-08/Africa%20Health%20Workforce%20Investment%20Charter_v6_ May%202023.pdf*

Table 5 Interventions on Investment with HRH Requirements

Strategic Focus	Strategic Outcome	Strategic Objective	Strategic Interventions
SF 5 Align Investment with HRH Requirements	**SO 5** Increased Health workforces Investment to address health priorities, health security and contribute to inclusive growth.	**SO 5.1** Strengthening human resources forecasting and planning.	5.1.1. Enhance human resources for health management capacity and practices at all levels
			5.1.2. Create a platform that engages healthcare providers, professional associations, educational institutions, and other relevant stakeholders in the planning process to gather diverse perspectives, insights, and expertise for informed decision-making.
			5.1.3. Improve collaborative planning, performance review, and provision of technical supports as aligned with the decentralized structures
			5.1.4. Develop and revise standardized Human resource planning tools and comprehensive plans in line with overall health sector strategy
			5.1.5. Institutionalize and implement a system of modern methods (WISN, HLMA…) for HRH forecasting and planning to consider technology adoption, policy shifts, and other factors that may impact future workforce requirements.
		SO 5.2 Increase evidence-based advocacy on HRH investment	5.2.1. Develop investment case to justify additional HRH investment
			5.2.2. Conduct policy dialogues to engage political leaders for sustained financial commitment and political will.
			5.2.3. Integrate HWF investment strategies into the Health and Education Sector Strategic Plans.
			5.2.4. Conduct national and regional HRH forums to prioritize and increase domestic health investments
			5.2.5. Create a coordination mechanism to involve key National, regional and continental (Africa) stakeholders on Working for health 2022-2030 action plan
		SO 5.3 Enhance the utilization of the existing global HRH funding mechanisms to improve HRH investment	5.3.1. Adopt and implement “working for health 2022-2030 action plan” in Ethiopian context
			5.3.2. Develop and implement evidence-based mechanism to utilize global HRH financing.
			5.3.3. Create and implement a coordination mechanism to engage key stakeholders on Global health and care workers compact
			5.3.4. Collaborate with international donor organizations and philanthropic foundations to secure funding and technical assistance for health workforce training, research, and infrastructure development.
			5.3.5. Coordinate efforts to mobilize resources from diverse national and international sources, directing funding toward health workforce development through strategic planning and coordination.
		SO 5.4 Improve intersectoral collaboration including private sector and community	5.4.1. Bring in HRH investment agenda a priority through HRH Steering Committee.
			5.4.2. Ensure HRH investments are addressed in sectoral strategies, plans and activities
			5.4.3. Conduct continuous dialogue with private sector to increase investment in training and deployment

Strategic Focus	Strategic Outcome	Strategic Objective	Strategic Interventions
		engagement to increase HRH financing	5.4.4. Establish and sustain HRH Observatory/Oversight for Public-Private and Community Partnership
			5.4.5. Launch advocacy campaigns to highlight the importance of health workforce investment for improving healthcare access and outcomes, generating public and political support for increased funding.
			5.4.6. Foster partnerships between public institutions, private healthcare providers, and academic organizations to collectively invest in health workforce development, training, and infrastructure.
			5.4.7. Explore innovative financing models that attract private capital for health workforce development projects with defined social and financial returns.
		SO, 5.5 Develop and implement HRH Investment Charter	5.5.1. Conduct high level dialogue to advocate for HRH Investment Charter and ensure key stakeholders buy-in.
			5.5.2. Develop and implement investment charter
			5.5.3. Establish and implement HRH national investment coordination mechanism
			5.5.4. Introduce performance-based funding mechanisms that link financial support for training institutions to the outcomes and impact of their graduates on healthcare delivery and population health.
		SO 5.6 Improve regional domestic health workforce financing	5.6.1. Support increases regional domestic health expenditure up to the 15% Abuja target.
			5.6.2. Expand domestic (public and private) investment in health workforce development and administration.
			5.6.3. Develop capacity on efficiency and effectiveness of financial resources utilization for improved sustainable HRH financing
			5.6.4. Ensure financial sustainability for HRH in collaboration with other relevant ministries, partners, and stakeholders
			5.6.5. Establish partnerships with healthcare industry stakeholders to invest in specialized training programs, equipment, and technology that align with emerging healthcare needs and advancements.
			5.6.6. Develop and implement incentive programs for private sector investment in health workforce, such as tax credits, grants, or subsidies aimed at supporting educational programs, faculty development, and infrastructure improvement.
		SO 5.7 Improve Employment and Job Creation Strategic Objective	5.7.1. Expand the existing employment mechanisms
			5.7.2. Create new job opportunities including overseas employment
			5.7.3. Conduct needs assessment and develop strategies to utilize the existing HRH pooled funding mechanism
			5.7.4. Utilize the existing pooled funding mechanism to support health workforce employment especially in deprived and hard-to-reach regions and areas.
			5.7.5. Expand Matching Fund initiative in all regions for prioritized health professional categories to enhance job creation and employment.

CHAPTER 5

IMPLEMENTING THE HRH STRATEGIC AND INVESTMENT PLAN

5.1. Implementing the HRH Strategic and Investment Plan

It is critical to strengthen HRH units at the national and subnational levels to effectively implement the HRHSIP. Besides, there is a need to establish coordinating mechanisms such as National HRH Observatory, National Steering Committee, and HRH Forum as well as collaboration with Africa HRH Observatory. Such coordination mechanisms facilitate collaboration, communication, and coordination among stakeholders, including MOH, RHBs, MOE, Education and Training Authority, Ministry of Finance, Civil Service Commission, health science teaching universities and colleges, professional associations, the private health sector and development partners.

The MOH will play an overall leadership role at the national level and support the development of regional and facility level HRH strategic plans. In addition, the implementation approach includes revising and harmonizing health and health-related institutions 'regulatory structure; strengthening integration, collaboration and partnership; good governance; and establishing professional council. Furthermore, detailed annual HRH work plans will be developed, and periodic reviews of the implementation of the HRHSIP will be conducted in order to continuously refine the HRH needs of the health sector.

The leadership, management and governance responsibility for the plan will primarily reside with HRM units at national, regional, district and facility levels. They will coordinate national and regional multi-sectoral HRH forums to align efforts and monitor progress towards improving availability, accessibility, acceptability, and quality of the health workforce. The capacity of those who are in charge of the HRM will be provided with need-based capacity building supports at all levels of the health system. The ongoing capacity building will support the HRH leaders and managers to mobilize and utilize resources, improve work climate, and strengthen the management systems for better HRH planning, forecasting, budgeting, recruiting, deploying, and addressing motivation and retention factors and tracking health workforce performance.

The MOE is primarily responsible for the production of health workers. Therefore, the MOH and MOE shall ensure the education of health professionals is aligned with the need and demand of the health sector with respect to the required HRH number and skills mix by strengthening joint coordination platform (such as the HRH Steering Committee). Both public and private HEIs shall align their education programs with the priorities agreed between MOH and MOE, including their annual enrolment. The MOE shall strengthen pre-service education information system and share relevant data with MOH to facilitate evidence-based workforce planning.

Professional associations have a key role to play in upholding professional standards and ensuring the public receive quality and compassionate healthcare. Therefore, the MOH and RHBs shall collaborate and work with professional associations to provide needs-based continuing professional development activities, promote ethical and safe practice and strengthen registration and regulation.

The MOH and professional associations shall also work together to realize establishment of a semi-autonomous health professional's council. The MOH will also work with ETA and MOE to delegate professional associations or professional council to accredit healthcare education programs.

The private health sector plays an important role in health workforce education and employment. Therefore, private HEIs shall align their education programs and enrolment with priorities set by the MOH and MOE. They also shall improve the quality of their education programs. Furthermore, private health service providers shall increase their participation in clinical placement of health science students. Private health service providers shall also increase their share of health employment. They also shall report health workforce data to relevant public health authorities (MOH, RHBs, zonal health departments). The MOH and RHBs shall strengthen public-private partnership mechanisms and work with other government agencies to create a more enabling environment to increase the capacity and contributions of the private health sector.

Strengthening workforce planning systems is instrumental to enhance data management and use for needs-based planning, and management. Several evidence generation tools like WISN, HLMA, and IHRIS will be widely used to make HRH planning evidence-based that consider workload, diseases burden as well as labor market dynamics.

In an emergency, mobilizing and recruiting staff is an important task for health systems. HRH management is key to ensure that the health sector has enough capacity to prepare and respond. Evidence shows that emergency preparedness and response success largely depend on having the right human resource management staff, skills, policies, and support in place. Based on the available guideline and protocols under Public Health Emergency Management (PHEM) teams, this strategic plan strives to avail practical guidelines for HRH in emergency actions, provide capacity building support for HR managers, officers and create mechanisms to align emergency staff rosters with iHRIS. This strategic plan will facilitate pre-enrollment and pre-deployment orientation and training of future healthcare cadres about being health professionals, the national health policy related directives and the need for their commitment to serve in hard-to-reach areas. The strategic plan encourages implementation of different approaches to address inequality in geographic distribution of health workforce.

This strategic investment plan will apply innovative strategies to enhance motivation and retention of health workforce at all levels. Financial and non-financial incentives models like delinking the remuneration schemes from regular civil services arrangements in pilot facilities. The pilot exercises after careful review will be scaled up at regional and national level. Other incentive models include implementation of non-financial mechanisms that can address the staff need for the residential houses and ownership of fixed assets; these will be achieved by facilitating bank loans and collaboration with housing and land administration entities. Provision of CPD, further professional education and careers promotions are among the incentive schemes. The motivation and retention interventions will also be reviewed and enhanced by research generated evidence. Performance management systems will be reviewed and strengthened in collaboration with civil services commission. Training and orientations on the revised performance management scheme will be held to facilitate its applications. Structured supportive supervision, coaching and mentorship will be implemented to improve staff productivity. Transparent reward and recognition mechanisms will be linked with staff performance and productivity.

Monitoring and evaluation frameworks will be developed and implemented to track the progress of this strategic and investment plan. These frameworks will provide a systematic and structured approach to assess achievements of the focus, outcomes, objectives, and interventions, ensuring that the desired outcomes and any necessary adjustments can be made.

5.1.1. Regulatory Structure Arrangement

Regulatory structure arrangement helps to create stringent and consistent regulatory system across the nation. Health professional regulation shall be delivered through the government administrative regulatory structure which is the Federal (Ministry of Health), regional/city administrations' regulatory bodies and zonal/sub-city regulatory. Health professional regulation structure will be revised and harmonized at all levels of administrative heath system structures to implement this strategic plan and to create semi-autonomous regulatory. At the same time each regulatory body shall fulfill human resource, facility and essential logistics based on the proposed regulatory structure at all levels. Ministry of Health will take the leading role in harmonizing the structure and support in capacity building of regulatory bodies at all levels.

5.1.2. Governance and Leadership

Ensuring governance and leadership is crucial in the realization of the ideas put in the vision and mission of the plan; and in ensuring the outlined activities are executed in an efficient and accountable manner. Governance encompasses the development as well as the organization and management of the strategic plan across different stakeholders involved in its operation. The implementation of the strategic plan will involve stakeholders beyond the health sector. Thus, all citizens, governmental organizations, non-governmental organizations, civil society, professional associations, and other stakeholders with different levels of governance are responsible to ensure responsiveness, inclusiveness, accountability, transparency, and participatory institutional regulatory system. The regulatory system will be strengthening through establishing a health professional council composed of various experts and stakeholders.

5.1.3. Integration, Collaboration and Partnership

Integration, collaboration, and partnership with stakeholders will be made in a harmonized manner to align and mainstream across the regulatory system. Efforts will also be made to integrate and mainstream elements of the health professional regulation in all relevant policies and programs of other sectors in the perspective of multi-sectorial collaboration including the private sector. The realization of health professional regulation will be ensured through active participation of stakeholders and developing partners in planning, implementation, monitoring and evaluation processes.

CHAPTER 6

MONITORING AND EVALUATION

6.1.Monitoring and Evaluation: Indicators and Matrix

6.1.1. Monitoring and Evaluation Indicators for HRHSIP

These general indicators can provide valuable information on the number, placements (urban/rural, primary vs. secondary facilities and management structures), professional qualifications (categories), and levels of specialization and inter-professional proportion of the health workforce. Data on many of these general indicators is available and relatively easy to measure annually by collecting HR data from the regional and sub-regional levels. The indicators can be measured at all levels of the health system. However, for simplicity and to avoid delays in decision-making, they should only be monitored at national and regional levels.

6.1.2. Comprehensive M&E Matrix

Monitoring the progress and evaluating the outcome of this strategic objective is important to know the program's progress. This monitoring and evaluation framework is important for decision making whether activities are performed as per the plan or not. The indicators included input, output, process, and outcome of the activities performed and the means of information exchange within the organization and stakeholders.

6.1.3. Monitoring and Evaluation: Approaches

In addition to identifying suitable M&E indicators, a clear and systematic process should be in place to support the practice. Thus, the MOH will set up mechanisms to continuously monitor the implementation of this SP including the following:

- The MOH will create an appropriate organizational structure, deploy staff, and provide necessary training in M&E of HR development and management in the health sector.
- Conduct quarterly, semi-annual, and annual assessments, supportive supervision, and review meetings at national and sub-national levels.
- Design and conduct a formal mid-term evaluation of the plan in 2018 EFY/2026 and an end term evaluation of the plan will be carried out in 2022 EFY/2030.
- Commission special studies such as the retention study to track outcome and impact level HRH indicators.
- Disseminate the M&E findings to key stakeholders.

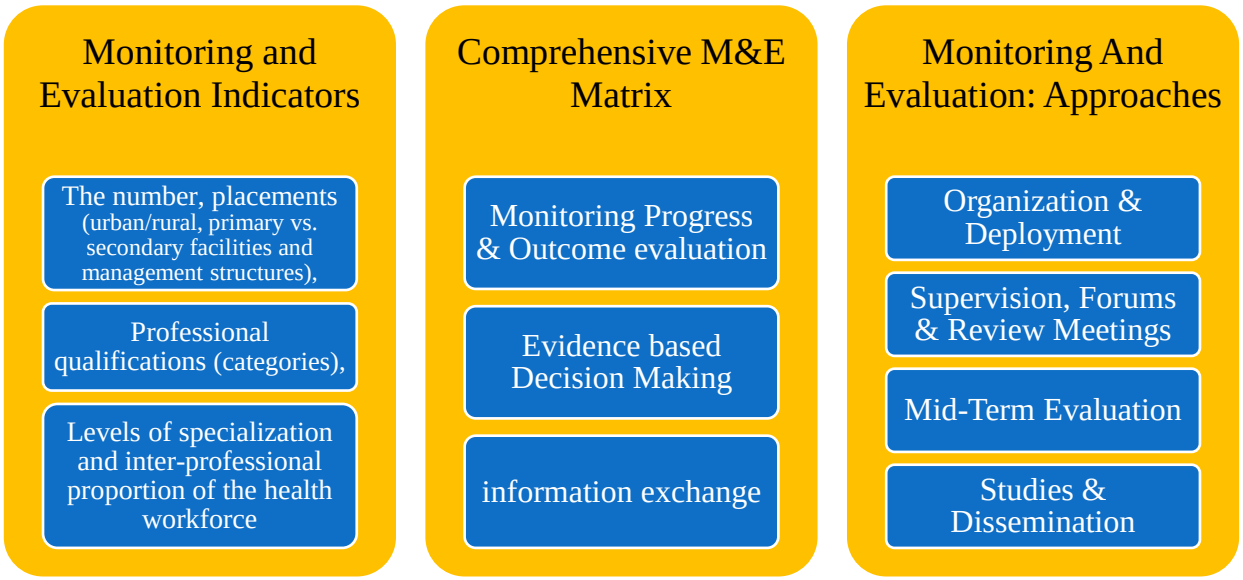

Figure 3 Monitoring and Evaluation Indicators, Metrix and Approaches

6.1.4. Community and Stakeholders Engagement

Ministry of Health is working with different stakeholders to improve access and quality of health services to the wider population. Regional Health Bureaus, line ministries, professional associations, private sectors, universities, health science colleges, TVETs, development partners, communities and many others play a paramount role to wards progressive realizations of UHC and SDGs. Each stakeholder has a role to play in below is list of key stakeholders with roles and responsibilities in the implementation of HRHSIP.

Table 6 Key Stakeholders Engagement and their Roles and Responsibilities

Implementing Sector/Organization	Roles and Responsibilities
Ministry of Health	• Provide overall leadership in the implementation of the strategic and Investment Plan • Support regions in the development of their HRH plans. • Oversee monitoring and evaluation of the plan. • Registration, licensing and regulation of health facilities and professionals • Provide support in HRH Operational planning. • Provide national health professional licensure examination
Ministry of Education (MOE)	• Develop and implement educational and training policies and strategies for health workforce development. • Provide Pre-service education and training through universities and colleges
Education and Training Authority (ETA)	• Regulation of education and training • Accreditation of Health Sciences Education Institutions • Conduct quality audits of Health Training Institutions and recommend improvement interventions. • Include the national health professional licensure examination pass rate for accreditation of health science and education institutions and programs
Civil Service Commission	• Job classification, grading, and salary scale • Regular review, development, and dissemination of HRM legislation, operational guidelines and procedure manuals • Strengthening performance management and reward for staff motivation and productivity • Review and approve HR staffing standards. • Monitor and evaluate implementation of HRH audit
Universities and Regional Health Sciences Colleges	• Provide training for HS students. • Conduct health related research to improve health services and training programs. • Utilize the national health professional licensure examination feedback for program improvement
Regional TVET	• Implement the occupational standard, curriculum, and qualification exam for technical vocational health science training programs

Implementing Sector/Organization	Roles and Responsibilities
Ministry of Labor and skill	• Develop occupational standard, curriculum, and qualification exam for technical vocational health science training programs
Hospital-based training institutions	• Provide training for HS students. • Conduct health related research to improve health services and training programs. • Utilize the national health professional licensure examination feedback for program improvement, as appropriate
Private Sector	• Provide training for health science students. • Recruit and deploy health professions. • Provide practicum sites for health professionals education. • Conduct health related research to improve health services and training programs
Health Facilities	• Support the clinical practice of students. • Assign and motivate preceptors. • Improve the quality of health services. • Support health workers and preceptors to engage in CPD
Health Professional Associations	• Lead the establishment of health professions council. • Accredit CPD providers. • Support the accreditation of health science programs. • Provide accredited CPD courses and in-service training. • Participate in the development of curricula, quality improvement standards; accreditation and quality audit visits; and development and implementation of National Licensing Examinations • Development and enforcement of professional codes of conduct • Promotion of Motivated, competent, and compassionate health workforce • Involve in the registration and licensing of health professions
Ministry of Finance	• Allocate national budget for the health sector. • Audit appropriate utilization of budget
Ministry of Innovation and Technology	• Develop and support data capturing software development
Food and Drug Authority	• Regulate Food and Drug at all levels

Implementing Sector/Organization	Roles and Responsibilities
Regional Health Bureaus/Zonal Health Department/Woreda Health Offices/Health Facilities	• Recruitment, deploy and manage human resources
Ethiopian Public Health Research Institute	• Conduct research in public health issues. • Manage and disaster and public health emergencies. • Provide high level laboratory investigations
Pharmaceutical companies and medical related industries	• Develop new drugs and therapies to address medical needs. • Producing medications in compliance with regulatory standards. • Promoting drugs to healthcare professionals. • Adhering to regulations set by health authorities (e.g., FDA). • Ensuring timely availability of medicines. • Supporting community health initiatives.
Civil Society Organization (CSO)	• Regulate and provide license for Associations
Ethiopian Statistical Service	• Collect statistical data of health and health related events
Development Partners	• Support the relation of Human resource development and management
Ministry of Justice/General Attorney	• Support the development of regulations and guidelines for HR
Private Sector	• Training of health workers • Recruitment and management of health workers
Ministry of Plan and Development	• Evaluate and monitor national strategic plans
Health workers	• Identify a means to participate in continuing professional development activity. • Evaluate the training value of the activity or course and its appropriateness for the learning needs. • Comply with the specified continuing education units of activities in each year
Community	• Support teaching and learning activity. • Support the PSE and community-based practice of health science students.

Table 7 Implementation Matrix of the Human Resources for Health Strategic and Investment Plan

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
SO 1.1: Enhance health professionals' production.	1.1.1. Conduct health workforce education needs assessment to determine type, mix and number of healthcare students	x	x	x	x	x	x	x
	1.1.2. Conduct targeted admission to increase ethnic, gender and geographic diversity and optimize enrollment of students with disabilities.	x	x	x	x	x	x	x
	1.1.3. Expand healthcare education programs for priority but scarce professionals	x	x	x	x	x	x	x
	1.1.4. Strengthen career choice based (passion based) enrollment and placement mechanisms	x	x	x	x	x	x	x
	1.1.5. Facilitate to increase the number of training institutions, faculties, and clinical training sites to expand the production capacity of prioritized health workforce.	x	x	x	x	x	x	x
	1.1.6. Develop targeted enrollment strategies to identify, recruit, and support individuals from underserved and rural areas, as well as underrepresented populations, promoting a diverse and representative health workforce.	x	x	x	x	x	x	x
	1.1.7. Foster partnerships between educational institutions and public or private healthcare providers to create opportunities for practical training and employment for health graduates.	x	x	x	x	x	x	x
SO 1.2: Improve quality of education	1.2.1. Coordinate accreditation of health professions education programs	x	x	x	x	x	x	x
	1.2.2. Promote evidence-based faculty development programs for instructors and preceptors.	x	x	x	x	x	x	x
	1.2.3. Strengthen consortium of health science and medical education	x	x	x	x	x	x	x
	1.2.4. Strengthen networking, partnership and collaboration with regional and international health professions education institutions	x	x	x	x	x	x	x
	1.2.5. Expand use of simulation and digital technology in science and medical education	x	x	x	x	x	x	x
	1.2.6. Coordinate the use of competency-based education through integrating health system science (System Citizenship) approaches in health professions education with safety and support to disadvantaged students	x	x	x	x	x	x	x
	1.2.7. Support clinical practice improvement of health science education	x	x	x	x	x	x	x
	1.2.8. Design and implement inter-professional education and practice	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
	1.2.9. Strengthen knowledge and practical examinations (national licensure examination, exit GAT and residency), including implementation of OSCE.	x	x	x	x	x	x	x
	1.2.10. Develop and implement remediation strategy for health professional who failed national licensure examination and civil service competency assessment.	x	x	x	x	x	x	x
	1.2.11. Operationalize intersectoral collaboration with MOE, ETA, HSEIs, professional association	x	x	x	x	x	x	x
	1.2.12. Nurture capacity of academic leaders, including female leaders	x	x	x	x	x	x	x
	1.2.13. Enhance evidence-based education and institute a culture of critical inquiry and evidence generation to inform policy and programing	x	x	x	x	x	x	x
	1.2.14. Optimize academic-service integration	x	x	x	x	x	x	x
	1.2.15. Enhance rural and community-based learning and practice	x	x	x	x	x	x	x
	1.2.16. Revitalize health professions education program and HDP for health science educators	x	x	x	x	x	x	x
SO 1.3: Improve Postgraduate education programs	1.3.1. Expand demand based medical specialty and sub-specialty roadmap aligned with service expansion	x	x	x	x	x	x	x
	1.3.2. Strengthen the nursing/midwife residency program	x	x	x	x	x	x	x
	1.3.3. Conduct a comprehensive needs assessment to identify the priority areas for specialty and subspecialty development program based on the healthcare needs of the population and the availability of healthcare services.	x	x	x	x	x	x	x
	1.3.4. Collaborate with medical schools and healthcare institutions to develop new specialty and subspecialty programs in alignment with identified healthcare needs, aspiring to expand the range of available training opportunities.	x	x	x	x	x	x	x
	1.3.5. Expand the capacity of existing training institutions and create partnerships with regional, national and international bodies to increase the number of available training positions for postgraduate specialty and subspecialty programs.	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
	1.3.6. Provide financial and logistical support to trainees pursuing postgraduate medical specialty and subspecialty programs, including scholarships, regular payment, and mentorship opportunities.	x	x	x	x	x	x	x
	1.3.7. Foster partnerships with public and private healthcare providers to create opportunities for practical training, exposure to different healthcare settings, and employment opportunities for postgraduate trainees.	x	x	x	x	x	x	x
	1.3.8. Leverage telemedicine and e-learning platforms to extend the reach of specialty and subspecialty training programs to remote or underserved areas, making them more accessible to a broader range of healthcare professionals.	x	x	x	x	x	x	x
	1.3.9. Expand demand-based specialty training for other healthcare science programs aligned with service expansion	x	x	x	x	x	x	x
	1.3.10. Launch and expand Doctor of Public Health programs	x	x	x	x	x	x	x
SO 1.4: Improve post-basic education	1.4.1. Strengthening upgrading of vocationally trained health workers (Level III, IV & V)	x	x	x	x	x	x	x
	1.4.2. Collaborate with and support educational institutions on capacity building, evidence generation, mentorship, and supervision.	x	x	x	x	x	x	x
SO 1.5: Ensure health workers participate in CPD	1.5.1. Reinforce regulation, quality, and management of CPD providers and accreditors	x	x	x	x	x	x	x
	1.5.2. Improve the monitoring and evaluation of CPD implementation	x	x	x	x	x	x	x
	1.5.3. Implement service based CPD platforms	x	x	x	x	x	x	x
	1.5.4. Increase availability and accessibility of CPD considering geography, profession, and health needs	x	x	x	x	x	x	x
	1.5.5. Improve use of digital technology for CPD provision and management	x	x	x	x	x	x	x
SO 2.1: Build human resource for health	2.1.1. Conduct assessments and identify gaps in leadership, governance and gender for HRH	x	x	x	x	x	x	x
	2.1.2. Strengthen national capacity to implement and promote the HRH agenda	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
management, leadership and governance capacity at national, regional, district and facility levels	2.1.3. Advocate for aligned leadership and governance structures at all levels.	x	x	x	x	x	x	x
	2.1.4. Establish and implement a national coordinating mechanism among training institutions, private sectors, PAs, regulatory agencies, development partners, civil society organizations, patient groups, and communities.	x	x	x	x	x	x	x
	2.1.5. Carry out an advocacy and engage political leaders and stakeholders in HRH policy and legislation processes at country, regional and sub-regional levels.	x	x	x	x	x	x	x
	2.1.6. Improve capacity of adaptive leadership during health emergencies and disasters.	x	x	x	x	x	x	x
	2.1.7. Professionalize the human resource administration and development staff	x	x	x	x	x	x	x
	2.1.8. Provide capacity building and HRM training to human resources management staff and supervisors	x	x	x	x	x	x	x
SO 2.2: Improve availability and equitable distribution of health workers.	2.2.1. Build the capacity of regions to improve health workers recruitment and deployment	x	x	x	x	x	x	x
	2.2.2. Develop tailored incentive packages for hard-to-reach areas and rural community services	x	x	x	x	x	x	x
	2.2.3. Develop a comprehensive strategy to raise awareness, change attitudes and increase commitment of the health workforce to serve rural communities	x	x	x	x	x	x	x
	2.2.4. Promote inclusive recruitment procedures and practices to improve the proportion of women health workers	x	x	x	x	x	x	x
	2.2.5. Develop policies and mechanisms for equitable deployment and distribution of health workers, considering the healthcare needs of different geographic regions and populations, and addressing disparities in access to healthcare services.	x	x	x	x	x	x	x
	2.2.6. Build local leadership capacity to improve bargaining power to mobilize adequate fund for health workforce recruitment and deployment	x	x	x	x	x	x	x
SO 2.3: Re-design and implement HWF	2.3.1. Strengthen regular performance management and appraisal system	x	x	x	x	x	x	x
	2.3.2. Enhance accountability system for low performance and absenteeism	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
performance management system.	2.3.3. Introduce transparent performance-based payment system	x	x	x	x	x	x	x
SO 2.4: Enhance health workforces' motivation and retention mechanisms.	2.4.1. Promote locally available innovative financial and non-financial motivation and retention incentive packages	x	x	x	x	x	x	x
	2.4.2. Ensure conducive work environment and health workforce safeguarding to enhance efficiency and productivity	x	x	x	x	x	x	x
	2.4.3. Re-design and implement an opportunity for professional career development	x	x	x	x	x	x	x
	2.4.4. Implement pilot delinking of remuneration at selected hospitals	x	x	x	x	x	x	x
	2.4.5. Promote mechanisms to measure, and analyze customer and staff satisfactions	x	x	x	x	x	x	x
SO 2.5: Develop and implement national HRH emergency preparedness, response and recovery plan.	2.5.1. Design and implement a risk and Emergency HRM system	x	x	x	x	x	x	x
	2.5.2. Develop mechanisms to support the physical and mental well-being of health workers during and after emergencies, providing access to counseling, psychosocial support, and resources to address occupational stress and trauma.	x	x	x	x	x	x	x
	2.5.3. Institutionalize national coordination mechanisms to harmonize HRH readiness in times of emergency situations.	x	x	x	x	x	x	x
	2.5.4. Strengthen HRH emergency capacity building program to effectively respond to emergencies, including disaster management, infection control, and patient surge capacity.	x	x	x	x	x	x	x
	2.5.5. Develop mechanism for a surge roster of multidisciplinary staff to respond for health emergencies.	x	x	x	x	x	x	x
SO 3.1: Strengthen ethical health practice	3.1.1. Strengthened and expand functional ethics committee at national and subnational level	x	x	x	x	x	x	x
	3.1.2. Ensure the use of ethics principles and code of conducts	x	x	x	x	x	x	x
	3.1.3. Promote preventive ethics system	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
SO 3.2: Streamline implementation of the scope of practice	3.2.1. Develop scope of practice and associated directive for each health profession category	x	x	x	x	x	x	x
	3.2.2. Increase awareness of health professionals, employers, educators, and regulators about scope limits	x	x	x	x	x	x	x
	3.2.3. Ensure implementation of scope of practice in collaboration with PAs and relevant stakeholders	x	x	x	x	x	x	x
SO 3.3: Strengthen health professional licensing and relicensing	3.3.1. Scale up digitalization of health professional licensing through iHRIS across all levels	x	x					
	3.3.2. Establish independent and robust regulatory bodies	x						
	3.3.3. Strengthen national and subnational capacity of regulatory bodies to implement licensing and relicensing including gender and inclusiveness.	x	x	x	x	x	x	x
	3.3.4. Strengthen integrate of CPD and relicensing	x	x	x	x	x	x	x
	3.3.5. Enhance multisectoral collaboration on regulation of CPD for relicensing	x	x	x	x	x	x	x
SO 3.4: Enhance national licensure examination	3.4.1. Ensure all new graduates of health professions undergone national licensure examination including initiation and scale up of practical assessment	x	x	x	x	x	x	x
	3.4.2. Enhance the National Licensure Examination process by implementing measures aimed at improving the validity, reliability, and fairness of the assessment	x	x	x	x	x	x	x
	3.4.3. Strengthen partnership between health and education sectors to improve quality of education and pass rate on NLE	x	x	x	x	x	x	x
SO 4.1: Improve credible, comprehensive and quality HRH data	4.1.1. Support implementation and follow up of iHRIS at all levels	x	x	x	x	x	x	x
	4.1.2. Conduct collaborative HRH research, NHWA, HLMA WISN	x	x	x	x	x	x	x
	4.1.3. Advocate leaders to allocate adequate finance for HRH research and data collection	x	x	x	x	x	x	x
	4.1.4. Revise HRH data element and indicator in the iHRIS software.		x			x		
	4.1.5. Strengthens data quality monitoring mechanisms.	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
SO 4.2: Enhance and integrate HRH information systems to avail up-to-date HRH data	4.2.1. Avail the HRH data capturing and reporting equipment	x	x	x				
	4.2.2. Monitor the interoperability of health information systems	x	x	x	x	x	x	x
	4.2.3. Conduct maturity assessment of the iHRIS	x	x	x	x	x	x	x
	4.2.4. Strengthen implementation of NHWA through collaboration with stakeholders	x	x	x	x	x	x	x
	4.2.5. Improve data sharing and knowledge management platforms	x	x	x	x	x	x	x
	4.2.6. Conduct regular follow up and support	x	x	x	x	x	x	x
SO 4.3: Improve HRH evidence utilization practice for policy formation and decision-making	4.3.1. Encourage different stakeholders to utilize HRH data at all levels.	x	x	x	x	x	x	x
	4.3.2. Ensure timely dissemination of HRH information and enable public access to different levels of decision-making.	x	x	x	x	x	x	x
	4.3.3. Explore, document, and disseminate HRH related best practices at global, national and regional level			x		x		x
	4.3.4. Produce HRH policy briefs on relevant issues in evidence-based HRH problem solving.	x	x	x	x	x	x	x
SO 4.4: Enhance HRH data implementation frameworks	4.4.1. Ensure iHRIS implementation as a prerequisite for renewing private facilities licensing.		x	x	x	x	x	x
	4.4.2. Encourage to assign qualified professional and dedicated position for iHRIS at all levels	x	x	x	x	x	x	x
	4.4.3. Establish a national health workforce registry			x				
	4.4.4. Strengthen national health workforce observatory body/steering committee.	x	x	x	x	x	x	x
	4.4.5. Harmonize different data analysis tools	x	x	x	x	x	x	x
	4.4.6. Enacting advocacy on accountability of HRH data and evidence generation and utilization at all levels.	x	x	x	x	x	x	
	4.4.7. Ensure data security and confidentiality	x	x	x	x	x	x	x
SO 4. 5: Generate data on HRH investment and	4.5.1. Assess Health Labor Market dynamics		x					
	4.5.2. Study on Workload Indicators Staffing Needs			x				

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
requirement for policy options.	4.5.3. Analyze Efficiency gain on health workers performance				x			
	4.5.4. Conduct Health workforce Productivity Analysis					x		
	4.5.5. Undertake study to determine extent of grants and loans on HRH						x	
	4.5.6. Determine HRH investment needs.	x						
SO 5.1: Strengthening human resources planning and forecasting	5.1.1. Enhance human resources for health management capacity and practices at all levels	x						
	5.1.2. Create a platform that engages healthcare providers, professional associations, educational institutions, and other relevant stakeholders in the planning process to gather diverse perspectives, insights, and expertise for informed decision-making.	x						
	5.1.3. Improve collaborative planning, performance review, and provision of technical supports as aligned with the decentralized structures	x	x					
	5.1.4. Develop and revise standardized Human resource planning tools and comprehensive plans in line with overall health sector strategy	x	x	x	x	x	x	x
	5.1.5. Institutionalize and implement a system of modern methods (WISN, HLMA…) for HRH forecasting and planning to consider technology adoption, policy shifts, and other factors that may impact future workforce requirements.	x			x	x		
SO 5.2: Increase advocacy for evidence-based HRH investment.	5.2.1. Develop investment case to justify additional HRH investment	x	x					
	5.2.2. Conduct policy dialogues to engage political leaders for sustained financial commitment and political will.	x	x					
	5.2.3. Integrate HWF investment strategies into the Health and Education Sector Strategic Plans.		x	x	x	x	x	x
	5.2.4. Conduct national and regional HRH forums to prioritize and increase domestic health investments	x			x	x		
	5.2.5. Create a coordination mechanism to involve key National, regional, and continental (Africa) stakeholders on Working for health 2022-2030 action plan	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
SO 5.3: Enhance the utilization of the existing global HRH funding mechanisms to improve HRH investment	5.3.1. Adopt and implement "working for health 2022-2030 action plan" in Ethiopian context	x	x	x	x	x	x	x
	5.3.2. Develop and implement evidence-based mechanism to utilize global HRH financing.	x	x					
	5.3.3. Create and implement a coordination mechanism to engage key stakeholders on Global health and care workers compact	x			x			
	5.3.4. Collaborate with international donor organizations and philanthropic foundations to secure funding and technical assistance for health workforce training, research, and infrastructure development.	x	x	x	x	x	x	
	5.3.5. Coordinate efforts to mobilize resources from diverse national and international sources, directing funding toward health workforce development through strategic planning and coordination.	x	x					
SO 5.4: Improve intersectoral collaboration including private sector and community engagement to increase HRH financing	5.4.1. Bring in HRH investment agenda a priority through HRH Steering Committee.	x	x		x	x		
	5.4.2. Ensure HRH investments are addressed in sectoral strategies, plans and activities	x	x					
	5.4.3. Conduct continuous dialogue with private sector to increase investment in training and deployment	x	x					
	5.4.4. Establish and sustain HRH Observatory/Oversight for Public-Private and Community Partnership	x	x					
	5.4.5. Launch advocacy campaigns to highlight the importance of health workforce investment for improving healthcare access and outcomes, generating public and political support for increased funding.	x	x	x	x	x	x	x
	5.4.6. Foster partnerships between public institutions, private healthcare providers, and academic organizations to collectively invest in health workforce development, training, and infrastructure.	x	x	x	x	x	x	x
	5.4.7. Explore innovative financing models that attract private capital for health workforce development projects with defined social and financial returns.	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
SO 5.5: Develop and implement HRH Investment Charter	5.5.1. Conduct high level dialogue to advocate for HRH Investment Charter and ensure key stakeholders buy-in.	x	x	x	x	x	x	x
	5.5.2. Develop and implement investment charter	x	x	x	x	x	x	x
	5.5.3. Establish and implement HRH national investment coordination mechanism	x	x	x	x	x	x	x
	5.5.4. Introduce performance-based funding mechanisms that link financial support for training institutions to the outcomes and impact of their graduates on healthcare delivery and population health.	x	x	x	x	x	x	x
SO 5.6: Improve regional domestic health workforce financing	5.6.1. Support increases regional domestic health expenditure up to the 15% Abuja target.	x	x	x	x	x	x	x
	5.6.2. Expand domestic (public and private) investment in health workforce development and administration.	x	x	x	x	x	x	x
	5.6.3. Develop capacity on efficiency and effectiveness of financial resources utilization for improved sustainable HRH financing	x	x	x	x	x	x	x
	5.6.4. Ensure financial sustainability for HRH in collaboration with other relevant ministries, partners, and stakeholders	x	x	x	x	x	x	x
	5.6.5. Establish partnerships with healthcare industry stakeholders to invest in specialized training programs, equipment, and technology that align with emerging healthcare needs and advancements.	x	x	x	x	x	x	x
	5.6.6. Develop and implement incentive programs for private sector investment in health workforce, such as tax credits, grants, or subsidies aimed at supporting educational programs, faculty development, and infrastructure improvement.	x	x	x	x	x	x	x
	5.7.1. Expand the existing employment mechanisms	x	x	x	x	x	x	x
	5.7.2. Create new job opportunities including overseas employment	x	x	x	x	x	x	x

Strategic Objective (SO)	Strategic interventions	Implementation Timeline						
		2016EFY/2024	2017EFY/2025	2018EFY/2026	2019EFY/2027	2020EFY/2028	2021EFY/2029	2022EFY/2030
SO 5.7: Improve Employment and Job Creation	5.7.3. Conduct needs assessment and develop strategies to utilize the existing HRH pooled funding mechanism	x	x	x	x	x	x	x
	5.7.4. Utilize the existing pooled funding mechanism to support health workforce employment especially in deprived and hard-to-reach regions and areas.	x	x	x	x	x	x	x
	5.7.5. Expand Matching Fund initiative in all regions for prioritized health professional categories to enhance job creation and employment.	x	x	x	x	x	x	x

Table 8 Monitoring and Evaluation Matrix and Timelines

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
SO 1.1. Enhance health professionals' production	Number of health care professionals produced	Health professional production as per health sector demand	Count of health care professional graduated	Output	National level	Annually	47595	57500	62450
SO 1.2. Improve quality of education	Pass rate in national licensing/exit examination.	Total number of health care professionals who passed licensing*[40] considering gender and inclusiveness	**Numerator:** Number of graduates who passed licensing/ **Denominator:** Number of graduates register for licensing	Output	National	Annually	40%	60%	70%
	Proportion of HEIs with accredited program	Total number of programs accredited	**Numerator:** Number of accredited programs **Denominator:** Total number of programs	Outcome	National	Annually	0	7	20
SO 1.3. Improve Postgraduate education programs	Number of health science and medical specialty program endorsed.	Total number of nursing specialty and midwifery specialty program as per the health sector demand	Count of nursing specialty program	Output	National	Bi-Annual	10	12	14
			Count of midwifery specialty program	Output	National	Bi-Annual	3	6	9
		Number of eligible physicians enrolled for medical specialty programs	Number of students enrolled	Output	National	Annually	8500	13,600	20000

[40] Note: r*ecent experiences in Ethiopia we will consider exit exam*

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
SO 1.4. Improve post-basic education	Number of vocationally trained health workers that received upgrading training	Number of HCWs received upgrade training	**Numerator**: Number diploma HCWs who received upgrading training **Denominator:** Total number of diploma/Level IV HCWs	Outcome	National	Annually	5000	20000	40000
SO 1.5. Improve health workers participation in CPD	Proportion of health workers that participated in CPD	Health workers that participated in CPD in the past one year, disaggregated by profession gender and region	**Numerator:** Number of health workers participated in CPD **Denominator:** Number of health workers	Outcome	National	Annually	40%	60%	80%
	Number of regions that linked CPD with license renewal	Regional health bureaus integrating CPD with license renewal	Number of regions that link CPD with license renewal	Output	Nationally	Annually	9	13	13
SO 2.1. Build human resource for health management, leadership and governance capacity at national, regional, district and facility levels	Inclusive institutional HRH coordination mechanisms in place	National and regional Inclusive institutional intersectoral mechanisms to coordinate health workforce agenda	**Numerator**: number of national/regions have functional coordination platform **Denominator**: number of regions/national platform	output	National and regional	Annual	No data	100%	100%
	HRM unit filled with professionals	Human resource administration and development unites filled with BSc and above professionals	**Numerator:** number of organizations that filled HRM positions with BSc and above **Denominator:** Total number of organizations in the country	Output	MOH, RHB, district and health facility	Annual	No data	100%	100%

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
SO 2.2. Strengthening human resource planning and forecasting	Comprehensive HRH plan in place	Percent of regions, districts and health facilities with HRH forecasting and planning capacity using modern evidence generation methods (WISN&HLMA)	**Numerator:** Number of regions, districts and health facilities have comprehensive HRH plan in the country **Denominator:** total number of regions, districts, and health facilities in the country	Output	Region, district, health facility	Annual	No data	100%	100%
SO 2.3. Improve availability and equitable distribution of health workers.	Density of health workers	Number of health professionals per 10,000 populations	**Numerator:** Total number of health Professionals in the country **Denominator:** Total population of the country X 10,000	Impact	National and regional	Annual	31	36	44
			Numerator: Total number of medical doctors, nurses, midwives, and health officers in the country **Denominator:** Total population of the country X 10,000	Impact	National and regional	Annually	18	23	33
	Proportion of women health workers	Number of women health workers from the total health workers	**Numerator:** Total female health workers **Denominator**= #total health workers	Outcome	National and regional	Annually	52%	53%	54%
SO 2.4. Re-design and implement HWF performance management system	Provider productivity	Relative number of specific tasks performed among health workers	**Numerator**: Specific tasks performed over a given period (e.g. ambulatory visits, immunizations, surgeries) by a given health service provider	Output	National, regional, and health facility	Annual survey or study	No data	Study for 3 professions (MD, Nurse, Midwifes	4 professions

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
			Denominator: Total number of specific tasks performed over the same period among all health services providers						
	% Client satisfaction	Proportion of surveyed population expressing satisfaction with the health services	**Numerator**: Total number of clients satisfied **Denominator**: Total number of respondents	Outcome	National Regional Health Facility	Quarterly	46%	60%	80%
	Staff satisfaction	Proportion of surveyed health care worker expressing job satisfaction	**Numerator**: Total number of health workers satisfied **Denominator**: Total number of health workers	Outcome	National Regional Health Facility	Bi-annually	67.5%	75%	80%
SO 2.5. Improve health workforce motivation and retention mechanism	Financial and non-financial incentive package in place	% of health facilities implementing at least two innovative non-financial schemes for the health workforce	**Numerator**: Number of health facilities implementing innovative non-financial schemes **Denominator**: total number of health facilities in the country	Outcome	MoH, regions and health facilities	Annual survey	No data	80%	100%
	Health workforce attrition rate	Proportion of health workers form the public health sector	**Numerator**= #health workers left **Denominator**= total #health workers	Output	National and regional	Annual	3.2	3	2.6
	Performance and productivity research	Conduct survey or research to document health workers performance and productivity	**Numerator**: Number of research conducted nationally **Denominator**: total number of research planned	Output	National	Annual	No data	3	4

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
	Hospitals with full autonomy to set grade of remuneration	hospitals implementing health workforce remuneration with their own autonomy	**Numerator**: number of hospitals performing delinking of HWF remuneration **Denominator:** total proposed hospitals for delinking of remuneration	Outcome	National and regional	Three years	0	1	2
SO 2.6. Develop and implement national HRH emergency preparedness, response and recovery plan	Emergency HRH roster system in place	Functional national and regional HRH roster system for emergency preparedness, response, and recovery	**Numerator:** number of organizations (MOH & RHBs) with functional roster system **Denominator:** total number of organizations (MOH and RHBs) in the country	output	National and regional	Annual	0	100%	100%
SO 3.1. Strengthen ethical health practice	Number of ethics committees established	Total number of health professionals' ethics committee established disaggregated by region	**Numerator:** Total number of ethics committee established **Denominator:** Total number regions	Output	Regional	Annually	5	7	14
	Proportion of medico-legal cases managed,	Proportion of health professional's medico-legal cases managed disaggregated by regions, professions	**Numerator:** Total number of medico legal cases managed **Denominator:** Total number of medico-legal cases reported	Outcome	National Regional	Annually	0	75%	85%
	Number of health facilities with preventive ethics committees	Total number of health institutions with preventive ethics committee disaggregated by type	**Numerator:** Total number of health institutions with preventive ethics committee **Denominator:** Total number of comprehensive specialized, general and primary hospitals	Output	Facility	Annually	1	20	172

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
SO 3.2. Streamline implementation of the scope of practice	Scope of practice guides endorsed	Scope of practice prepared and endorsed	Endorsed scope of practice	Output	National	Annually	0	50	120
	Proportion of health facilities implementing scope of practice	Total number of health institutions implementing scope of practice, disaggregated by regions and type of HF	**Numerator:** Number of health facilities implementing scope of practice **Denominator:** Total number of health facilities	Outcome	Federal Regional Health facility	Annually	0	2000	4269
SO 3.3. Strengthen health professional licensing and relicensing	Proportion of eligible health professionals relicensed using iHRIS	Relicensed health professionals using iHRIS	**Numerator:** Total Number of health professional relicensed **Denominator:** Total number of eligible health professionals for relicense	outcome	National Regional	Annually	0	60%	100%
	Number of regions with full implementation licensing directive	Regions implementing licensing directive	**Numerator:** Number of regions with full implementation licensing directive **Denominator**: total number of regions	Output	Regional	Annually	1	9	14
SO 4.1. Improve credible, comprehensive and quality HRH data	Percentage of organization submitted complete and timely report using iHRIS	It considers the coverage of all reporting organization with full information of data elements using iHRIS with indicated period	**Numerator:** Number of reported organization **Denominator:** Total number of organizations	Outcome	Percentage National/ Regional/ Institutional, disaggregated by public and privet facilities	Quarterly	<10%	40	100

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
	# of HRH research report produced	This indicator counts the number of HRH research reports	Count of research reports	Output	National	annual	0	3	7
SO 4.2. Strengthen the integration of information systems to ensure comprehensive and up-to-date HRH data	Percent of stakeholders organizations integrated their system with MoH	The level of interoperability of information system	**Numerator:** Number of organizations strengthen /integrated application **Denominator:** number of organizations expecting to integrate information system	Output	National/ Regional/ Institutional	annual	0	50	100
SO 4.3. Improve HRH evidence utilization practice for, policy formation and decision-making.	Number of studies used for policymaking.	Advocate program leaders to utilize the HRH evidence findings for policy development and decision making	**Numerator:** Number of study used for policy development and decision making,	Process	National/ Regional/ Institutional	Annual	0	03	03
SO 4.4. Develop HRH data implementation framework	Number of HRH data implementation guidelines/tools developed	Implementation guidelines/protocols will be developed to standardized HRH data capturing, analyzing, and reporting.	Count number of guidelines/protocols developed	Output	National	Annual	01	03	02
SO 4.5. Generate data on HRH investment and requirement for policy options.	Number of investment related briefs production	Selection of investment related concerns	**Numerator:** Number of investment related policy, issue, and technical briefs production **Denominator:** the number of expected briefs	Process	Percentage	Quarterly	0	25	100
SO 5.1 Strengthening human resource planning	Comprehensive HRH plan in place	Percent of regions, districts and health facilities with HRH	Numerator: Number of regions, districts and health facilities have	Output	Region, district, health facility	Annual	No data	100%	100%

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
and forecasting (moved from strategic objective 2		forecasting and planning capacity using modern evidence generation methods (WISN&HLMA)	comprehensive HRH plan in the country Denominator: total number of regions, districts, and health facilities in the country						
SO 5.2. Increase evidence-based advocacy on HRH investment	# of investment case developed	Developing HRH investment mechanisms to justify additional HRH investment	**Numerator:** number of HRH investment cases developed **Denominators:** number of planned HRH investment cases planned	Output	National	Annual	0	1	2
	# of national and regional investment focused HRH forums	Conducting investment focused national HRH forum with the objective of increasing domestic health financing	**Numerator:** number of HRH forums conducted **Denominators:** number of HRH forums planned	Output	All levels	Semi annual	0	6	8
SO 5.2. Enhance the utilization of the existing global HRH funding mechanisms to improve HRH investment	# of existing global HRH funding mechanisms used	Tapping the available global HRH funding mechanisms to increase HRH investment	**Numerator:** number of global HRH funding mechanisms used **Denominators:** Number of global HRH funding mechanisms available	Output	National	Annual	0	3	5
SO 5.3. Improve intersectoral collaboration and community engagement to increase HRH financing	# of stakeholders actively engaged	Intersectoral collaboration and community participation is one of the mechanisms to enhance HRH financing	**Numerator:** number of stakeholders engaged **Denominators:** Total numerator of stakeholders		Number	Semi annual	0	6	4

Strategic Objectives	Indicator	Descriptions	Calculations	Type of indicator	Measurement level	Frequency	Baseline (2023)	Target	
								2026	2030
SO 5.4. Develop and implement HRH Investment Charter	# of key stakeholders engaged in the high level intersectoral dialogue	A formal commitment to adhere to agreed principles in investment and to pursue a common purpose through investment actions.	**Numerator:** Total numerator of high level intersectoral dialogues conducted **Denominators:** number of high levels intersectoral dialogue planned		Number	Annual	0	1	1
	# of key stakeholders engaged in the high level intersectoral dialogue		**Numerator:** number of high levels intersectoral dialogue planned **Denominators:** Total numerator of high level intersectoral dialogues conducted		Number	Semi annual	0	6	8
SO 5.5. Support increase regional domestic health expenditure up to the 15% Abuja target.	# of regions increased domestic health expenditure up to the 15% Abuja target	Enhance the allocation of regional budget on health	**Numerators:** of regions increased domestic health expenditure up to the 15% **Denominators:** Total number of regions increased domestic health expenditure up to the 15%		Percentage	Annual	11.1%	12.4%	15%
SO 5.6. Improve Employment and Job Creation	Reduce health workforce unemployment rate	Improving employment opportunities and new jobs creation to enhance access and quality of service provision.	Improve health workforce employment status	Output	Rate	Survey	Unemployment rate 20%	18.5%	17%

CHAPTER 7

HRH PROJECTION AND COSTING

7.1. Costing of the HRH strategy

Estimating the costs of implementing the national human resource for health (HRH) strategy (2024-2030) is important to policymakers for several reasons including the fact that the cost estimates can be used to inform decision-making, advocate for increased investment in HRH, and to monitor and evaluate the implementations of HRH initiatives and activities indicated in the strategy. In the strategy, there are four cost elements to be considered: staff salary and benefits, program costs, in-service, and pre-service costs. However, the costing of in-service and pre-service training are not attempted here as the magnate lies under the ministry of education.

7.2. Staff salary and benefits

For staff salaries and benefits, estimates were taken from the recently conducted health labor market analysis where the health workforce projection was developed under adjusted health facilities staffing norms (HLMA, 2022). The study indicated that because of acknowledged limitations in the current staffing norms, some adjustments were made based on international experience and benchmarking with other countries that developed staffing norms using WISN. Based on this scenario, the total heal workforce requirement is 368,812 which will be projected to 512,333 by 2030. The projected number of workforces under different staff categories is shown in the annex (Table 5). As shown in the table below, the total cost for staff salary and benefits is estimated to be 15 billion ETB in 2024 to 23 billion ETB in 2030.

Table 9: Estimated staff salary and benefits

CATEGORY OF STAFF	2024	2025	2026	2027	2028	2029	2030	Total
Administrative and Support Professionals (Degree and Masters)	871	945	1,025	1,113	1,208	1,311	1,424	219,273
Administrative and Support Staff (Diploma and Below)	2,438	2,645	2,870	3,114	3,380	3,670	3,984	397,880
Anesthesia (all categories)	220	236	254	273	293	315	338	27,015
Biomedical Engineering/ Technology	28	30	33	35	38	41	44	4,333
Dentist	28	30	33	35	38	42	45	2,474

CATEGORY OF STAFF	2024	2025	2026	2027	2028	2029	2030	Total
Emergency Medical Technicians	156	168	181	195	210	226	243	27,243
Environmental Health, and Occupational Health and safety Professionals	15	16	17	19	20	22	24	2,224
General Practitioners (Non-Specialist)	493	530	569	611	656	705	758	54,495
Health Extension Workers (rural)	1,758	1,930	2,119	2,326	2,554	2,804	3,078	261,619
Health Informatics/Information technician	142	152	163	175	188	202	217	21,972
Health Related/Health science Professionals	144	154	166	178	191	205	220	22,290
Medical Laboratory	449	482	518	556	597	641	689	69,605
Medical Radiographers	41	45	48	53	57	62	68	6,203
Medical Specialist	144	155	166	179	193	208	223	17,572
Mental Health Professionals	238	255	273	293	314	337	361	21,710
Midwives	1,102	1,182	1,269	1,362	1,462	1,569	1,684	135,448
Non-physician Clinicians (Health Officer)	513	551	592	636	683	734	789	63,019
Nurses (all categories)	3,681	3,993	4,333	4,702	5,103	5,540	6,014	426,604
Ophthalmic and optometry	26	29	31	34	37	40	44	3,978
Other Dental Professionals	157	168	180	194	208	223	240	21,455
Pharmacists	82	89	96	104	113	123	133	12,455
Pharmacy Technicians (Druggists)	375	402	432	463	497	534	573	46,100
Physiotherapists	4	5	5	5	6	6	7	782
Rehabilitation professionals	32	35	38	41	44	48	52	4,880
Total	**15,161**	**16,253**	**17,437**	**18,723**	**20,119**	**21,635**	**23,281**	**1,884,825**

7.3. Program cost

The program cost of implementing the strategy primarily involves identifying and quantifying the cost drivers for the different activities, determining, and quantifying the type of specific inputs for implementing the activities and gathering unit costs from different sources. After gathering the necessary information, a costing tool was developed to produce estimates of the investment needed.

The HRH strategy is organized under five strategic focuses under which there are twenty-four strategic objectives and activities that needs to be accomplished in order to achieve the objectives. The activities were used as cost item or the costing units for the costing exercise of the strategy. For the activities identified as costing units, the type and number of inputs required were then determined by the task force considering the realization of the strategic objectives through the execution of the activities. According to the nature of the inputs and methodological advantage, the inputs were categorized into the following groups: 1) Training and workshop; 2) Supervision; 3) Document preparation and printing; 4) Research and development; 5) Capital expenditure; 6) Data and information system; and 7) Media and other costs. Unit costs for the different inputs were gathered from various sources, which include unit cost database available from Strategic Affairs Executive Office. In addition, we have used a discounting rate of 7 percent and USD to ETB exchange rate of 55. Once the identification and quantifications on activities and inputs are done, an appropriate costing template was developed in MS-Excel which facilitates the computation of the each of the activities and adjusting as needed. The template was then filled based on the available information from the quantification of inputs, assumptions and unit costs set as above.

Based on the approach stated above, the total cost of implementing the national HRH strategy over the seven years is estimated to be ETB 1.4 billion ETB or about 25 million USD using the current period exchange rate. On average, this is equivalent to an average annual investment need of ETB 200 million or 3.6 million USD. The total cost of each year as well as the investment needs under each focus area is given in the table below. Among the five focus areas, improve the HRH evidence generation and data use for policy (28%) and improve health professionals' regulation (26%) constitute the first and second highest costs while optimize HRH management constitute the lowest share (12%) of the total program cost. In addition, the program costs by strategic objective are also given below (Table 3).

Table 10: Total estimated program cost under each focus area (million ETB)

Strategic Focus	2024	2025	2026	2027	2028	2029	2030	Total cost
SF1: Enhance HRH Development	29.02	31.05	33.22	35.55	38.04	40.70	43.55	**251.11**
SF2: Optimize HRH Management	19.26	20.61	22.05	23.60	25.25	27.01	28.91	**166.69**
SF3: Improve Health Professionals' Regulation	42.53	45.51	48.69	52.10	55.75	59.65	63.83	**368.06**
SF4: Improve HRH Evidence Generation and data use for Policy Option	45.29	48.46	51.85	55.48	59.37	63.52	67.97	**391.96**
SF5: Increase HRH investment	24.48	26.19	28.02	29.99	32.09	34.33	36.73	**211.83**
Total Cost	**160.58**	**171.82**	**183.85**	**196.72**	**210.49**	**225.22**	**240.98**	**1,389.65**

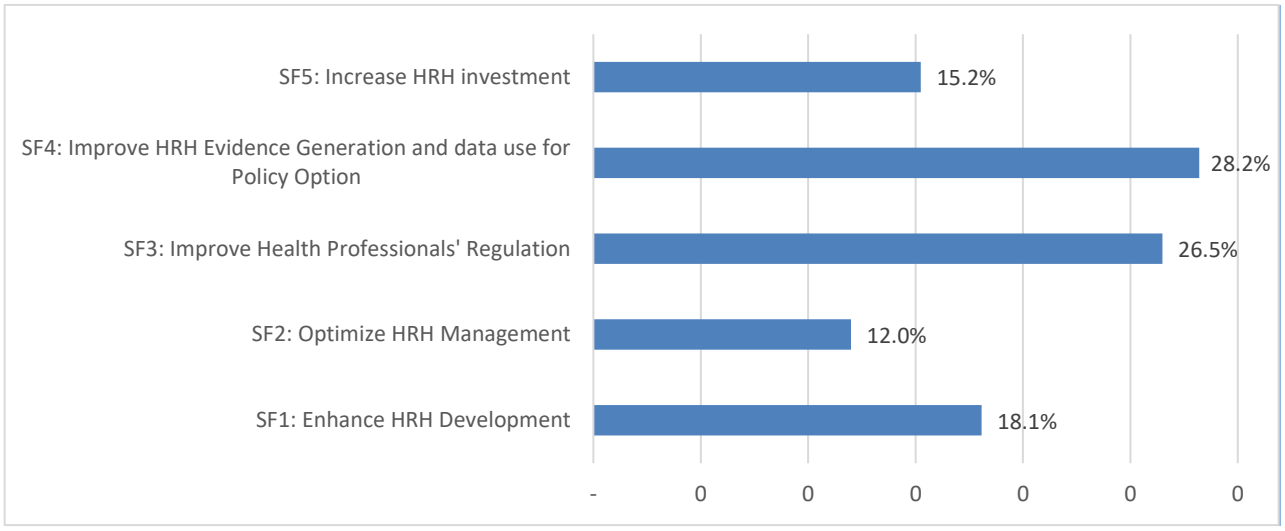

Figure 4: Distribution of total cost across strategic focus

Table 11: Program cost by strategic objectives (Million ETB)

	Objective	2024	2025	2026	2027	2028	2029	2030	Total
SF1	Enhance health professionals production	1.22	1.30	1.39	1.49	1.60	1.71	1.83	10.53
	Improve quality of education	10.94	11.70	12.52	13.40	14.34	15.34	16.41	94.65
	Improve Postgraduate education programs	2.99	3.19	3.42	3.66	3.91	4.19	4.48	25.84
	Improve post-basic education	2.04	2.18	2.33	2.49	2.67	2.86	3.06	17.62
	Ensure health workers participate in CPD	11.84	12.67	13.56	14.50	15.52	16.61	17.77	102.46
SF2	Build leadership and governance capacity for HRH management	4.78	5.12	5.47	5.86	6.27	6.71	7.17	41.37
	Strengthening human resources forecasting and planning	4.00	4.28	4.58	4.90	5.24	5.60	6.00	34.58
	Consolidate human Resources for health Management system	3.78	4.05	4.33	4.64	4.96	5.31	5.68	32.75
	Develop and implement national HRH emergency preparedness, response and recovery plan.	1.54	1.65	1.76	0.89	2.02	2.16	2.31	13.34
	Ensure equitable availability, distribution and skills mix of health workers	4.14	4.43	4.74	5.07	5.42	5.80	6.21	35.80
	Improve health workforce motivation and retention	1.02	1.09	1.17	1.25	1.34	1.43	1.53	8.84
SF3	Streamline implementation of the scope of practice	20.34	21.77	23.29	24.92	26.66	28.53	30.53	176.04
	Strengthen ethical health practice	11.33	12.12	12.97	13.88	14.85	15.89	17.00	98.04
	Strengthen health professional licensing and relicensing	10.86	11.62	12.43	13.30	14.23	15.23	16.30	93.98
SF4	Generate credible, comprehensive and quality data	24.89	26.63	28.50	30.49	32.63	34.91	37.35	215.40
	Strengthen and integrate information systems to ensure up-to-date HRH data.	5.51	5.90	6.31	6.75	7.22	7.73	8.27	47.69
	Improve data utilization and management used for research, policy formation and decision-making.	6.32	6.76	7.24	7.74	8.28	8.86	9.48	54.69
	Develop HRH data implementation frameworks	1.71	1.83	1.96	2.10	2.25	2.40	2.57	14.83
	Generate data on HRH investment and requirement for policy options	9.04	9.67	10.35	11.07	11.85	12.67	13.56	78.20

	Objective	2024	2025	2026	2027	2028	2029	2030	Total
SF5	Develop and implement HRH Investment Charter	2.99	3.20	3.43	3.67	3.92	4.20	4.49	25.91
	Improve governance mechanisms on HRH investment grants and loans.	3.78	4.05	4.33	4.64	4.96	5.31	5.68	32.75
	Improve Employment and Job Creation	4.57	4.89	5.23	5.59	5.99	6.41	6.85	39.52
	Utilize the existing global HRH funding mechanisms to improve HRH investment	8.80	9.41	10.07	10.78	11.53	12.34	13.20	76.12
	Improve intersectoral collaboration and community engagement to increase HRH financing	2.16	2.31	2.47	2.64	2.83	3.03	3.24	18.67
	Total cost	**160.58**	**171.82**	**183.85**	**196.72**	**210.49**	**225.22**	**240.98**	**1,389.65**

The estimated program costs for each type of activity category are also computed and presented as shown below in the table and graph (Table 3 and Figure 2). The cost for training and workshop constitutes the highest share (33%) followed by supportive supervision (32%), and capital expenditure (17%). On the other hand, document preparation and printing and other costs including media take the lowest cost share, 5% and 0.7% respectively.

Table 12: Cost breakdown by type of activity (ETB in Millions)

	Cost Breakdown	2024	2025	2026	2027	2028	2029	2030	Total
1	Training and Workshop	52.67	56.36	60.31	64.53	69.04	73.88	79.05	455.84
2	Supportive supervision	52.02	55.67	59.56	63.73	68.19	72.97	78.07	450.22
3	Document preparation and printing	8.16	8.73	9.35	10.00	10.70	11.45	12.25	70.65
4	Research and development	12.69	13.57	14.52	15.54	16.63	17.79	19.04	109.78
5	Capital expenditure	27.27	29.18	31.22	33.41	35.75	38.25	40.93	236.01
6	Data and information system	6.60	7.06	7.56	8.08	8.65	9.26	9.90	57.11
7	Media and other costs	1.16	1.24	1.33	1.42	1.52	1.63	1.74	10.04
	Total Cost	**160.58**	**171.82**	**183.85**	**196.72**	**210.49**	**225.22**	**240.98**	**1,389.65**

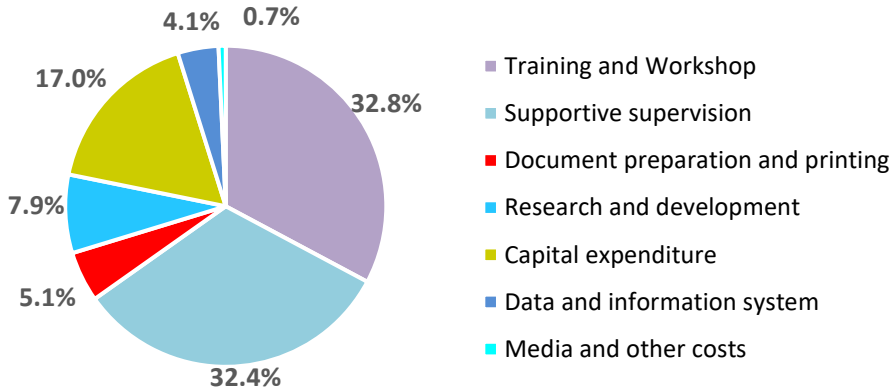

Figure 5: Percent distribution of under each cost driver

7.4. Summary cost

The total cost for implementing the national HRH strategy excluding the cost for pre-service trainings is about 518 billion ETB or on average, 74 billion ETB per annum. This includes all costs related with salary and benefit of all health workforce and program cost to implement the strategic plan, most of the costs are for salary (74%) and benefits (25%), which include current available stack and future employment and deployment, while program cost constitutes less than 1 percent of the total cost. The average yearly cost per staff grows from 58 thousand birr in 2024 to 92 thousand birr in 2030.

Table 13 Summary of cost required

Cost Category	2024	2025	2026	2027	2028	2029	2030	Total
Salary	43,077	46,486	50,186	54,202	58,563	63,298	68,440	384,253
Benefit	15,161	16,253	17,437	18,723	20,119	21,635	23,281	132,609
Program cost	161	172	184	197	210	225	241	1,390
Total cost	**58,398**	**62,910**	**67,807**	**73,122**	**78,893**	**85,159**	**91,963**	**518,251**

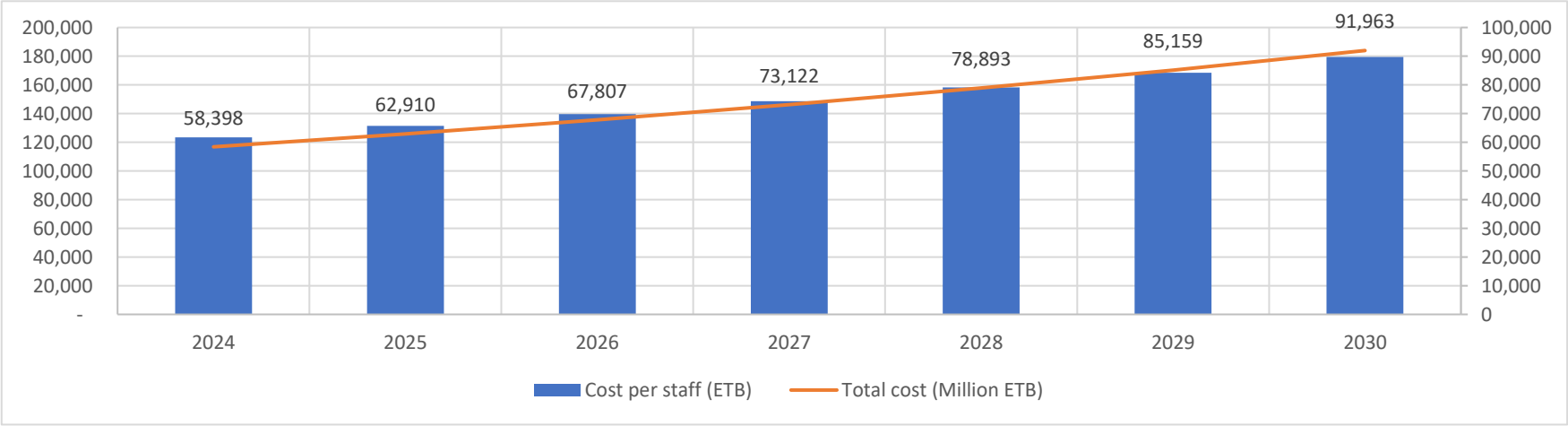

Figure 6: trends of total cost and cost per staff

CHAPTER 8

ASSUMPTIONS AND RISK MANAGEMENT

8.1.Assumptions and Risk Management

Effectiveness implementation of HRHSIP in achieving the expected results is based on the following assumptions and enabling factors:

- **Improved production capacity of health science institutions**. The implementation of the plan can be translated into action with the assumption that the number and capacity of the existing and new health science institutions to produce adequate number of competent and quality health professionals.
- **Availability of adequate funding:** There is an assumption that the economy of Ethiopia continues to grow with the current trend or more and the government of Ethiopia allocates adequate resources to the health and health related sectors. Similar assumption was made that RHBs improve health workforce budgets as per the Abuja Declaration, 15%. Development partners and agencies will also improve investment on HRH.
- **Improved engagement of the private sector:** The private health sector is playing a critical role both in producing as well as employing health professionals in improving access to and quality of health services is essential to strengthen the health system. The recent health labor market study showed that, the overall contribution of the private sector to health workforce employment is estimated to be 22%[41]. The HRHSIP assumes public-private partnership (PPP) will be enhanced.
- **Strong political will, commitment and capacity building**. The implementation assumes robust commitment of political leaders and lower-level structure in executing the strategic plan. Capacity building should also be considered to enhance proper and timely implementation of the HRHSIP.
- **Improved Employment Opportunities.** This also assumes adequate employment opportunities for the newly graduate health workforce and improved deployment and geographical mix.
- **Effective multi-sectoral Collaboration**: A strong multi-sectoral collaboration is essential to address social determinants of health. A strong collaboration with all sectors and implementation of health in all policies will enable the effective implementation of the strategic plan. collaborative partnership and engagement among relevant stakeholders is essential for the effective implementation of the strategic plan.
- **Capacity building**: Strengthening the capacity of the health workforce, institutions and communities that are involved in the implementation process is essential for success. Capacity building measures should include enhancement of technical knowledge and skills along with strengthening organizational capacity, access to information and decision-making at different levels involved in the strategic plan's implementation.

[41] *Health Labor Market Analysis: Ministry of Health, Ethiopia, Addis Ababa, Ethiopia, 2020*

8.2.Risks and mitigation strategies

Below is summary of mitigation strategies in response to the unforeseen circumstances that night be encountered during HRHSIP implementation.

Table 14: Risks and mitigation strategies

S. No	Risks	Mitigation Strategy
1	Domestic and External Financing and Budgetary Deficits	• **Prioritization**: The cost of human resource development and management is the second largest cost item identified in HSTP II[42]. It is critical that HRH financing should be prioritized in allocating adequate budget to ensure proper implementation. This will involve analyzing the existing resources and setting appropriate spending plans. • **Cost reduction**: MOH, RHBs and other key stakeholders should consider cost reduction strategies and practices with the anticipation of reductions in funding. To mitigate such incidents, reallocating budgetary funds, cost reduction measures, encouraging private sectors and mobilize donors support could be part of the strategy. • **Collaboration**: Another mitigating strategy could be partnering with other organizations working on HRH and related objectives. This can facilitate better resource management practice. • **Mechanisms**: Develop domestic financing strategy and mechanisms to address any unforeseen financial gaps and strengthen public-private partnership. • **Initiate and Implement**: Social Insurance as an internal mechanism to increase financing to the health sector
2	Peace and Security	• Put functional mechanisms in place to enhance national peace and security through active engagement of all concerned stakeholders
3	Pandemic	• Develop and implement national emergency preparedness and response plan including health workforce requirement
4	Education system	• Put in place collaborative partnership mechanism to improved production capacity to produce adequate number of competent and quality health professionals.

[42] *Ministry of Health, Health Sector Transformation Plan II, 2020/21-2024/25 (2013 EFY - 2017 EFY), Addis Ababa, Ethiopia*

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ANNEXES

Annex 1: Projected number of health workforce for the planning period

CATEGORY OF STAFF	2024	2025	2026	2027	2028	2029	2030
Administrative and Support Professionals (Degree and Masters)	57,665	58,466	59,288	60,132	60,997	61,885	62,797
Administrative and Support Staff (Diploma and Below)	102,515	103,940	105,401	106,901	108,440	110,019	111,638
Anesthesia (all categories)	6,327	6,351	6,375	6,399	6,424	6,450	6,477
Biomedical Engineering /Technology	1,039	1,047	1,055	1,063	1,072	1,080	1,089
Dentist	574	582	590	598	607	615	624
Emergency Medical Technicians	6,559	6,598	6,638	6,679	6,721	6,764	6,809
Environmental Health, and Occupational Health and safety Professionals	541	549	557	565	574	582	591
General Practitioners (Non-Specialist)	12,654	12,701	12,749	12,798	12,849	12,901	12,954
Health Extension Workers (rural)	73,931	75,854	77,826	79,849	81,925	84,056	86,241
Health Informatics/Information technician	5,220	5,236	5,252	5,268	5,285	5,303	5,320
Health Related/Health science Professionals	5,295	5,311	5,327	5,343	5,360	5,378	5,395
Medical Laboratory	16,548	16,602	16,658	16,716	16,774	16,835	16,897
Medical Radiographers	1,513	1,536	1,560	1,585	1,610	1,636	1,662
Medical Specialist	4,132	4,155	4,179	4,204	4,229	4,255	4,281
Mental Health Professionals	4,928	4,936	4,944	4,952	4,961	4,969	4,978
Midwives	31,677	31,770	31,866	31,965	32,066	32,169	32,276

CATEGORY OF STAFF	2024	2025	2026	2027	2028	2029	2030
Non-physician Clinicians (Health Officer)	14,760	14,814	14,870	14,928	14,986	15,047	15,109
Nurses (all categories)	105,847	107,315	108,820	110,365	111,950	113,576	115,245
Ophthalmic and optometry	971	987	1,003	1,019	1,036	1,054	1,071
Other Dental Professionals	5,058	5,074	5,090	5,106	5,123	5,141	5,158
Pharmacists	3,021	3,060	3,100	3,141	3,183	3,226	3,271
Pharmacy Technicians (Druggists)	10,780	10,811	10,843	10,876	10,910	10,944	10,980
Physiotherapists	186	186	186	186	186	186	186
Rehabilitation professionals	1,184	1,200	1,216	1,232	1,249	1,267	1,284
Total	**472,928**	**479,082**	**485,395**	**491,872**	**498,518**	**505,337**	**512,333**

Annex II: Human Resources for Health Strategic Plan Revision SWOT Analysis

Strength	Weakness
• Expanded number of tertiary education institutions, health professional programs, and increased enrollment and graduation capacity. • Introduced competency-based curricula, occupational standards, staff, infrastructure and skills lab facilities, and faculty development. • Availability of multiple health facilities (private and public) for better student practice • Introduction of regulatory mechanisms licensure exam, COC, and push for accreditation. • Supportive national strategies and policies (academic program standards, and accreditation, clinical practice, and simulation guidelines) • Existence of the CPD directive and guideline and implementation manual, National CPD committee and commitment of MOH to implement CPD. • Increasing number of CPD accreditors, and accredited providers in the country. • Availability of CPD courses & online training for health professionals • Progress on integration of CPD with license renewal • Availability of licensure examination manuals, guideline and following evidence-based approach for licensing. • Progressively increasing number of health professions included in licensure examination. • Improved stakeholders' collaboration for licensing examination and ensured exams security throughout exam process)	• In adequate community engagement in pre-service education (PSE), weak utilization of PSE evidence and student data to improving PSE. • Underdeveloped academic- health service integration, and weak academic – industry linkage. • Inequitable distribution, low motivation, performance, and high turnover of the faculty. • Rapid changes in structures of education system: MoE, MoSHE, MoE; HERQA ETA resulting in the lost momentum for educational quality reform implementation Low awareness of CPD among health professionals, limited access to CPD activities for health professionals in both public and private in terms of location, premises, budget, time, • Inadequate digital learning facility and courses, tendency to use unstandardized training courses, and low provision of accredited IST trainings. • Unsatisfactory stakeholder alignment for CPD implementation. • Lack of functional monitoring and evaluations system • Lower capacity of CPD providers in designing and delivery of the CPD courses. • Delay in iHRIS implementation to monitor HRD and CPD • Underutilization of the exam result feedback by HEIs • Not all licensure examination includes practical assessments such as OSCE. • Inadequate budget to incorporate all health professions of health workforce for licensure exam and for quality assurance activities. • Unable to administer computer-based testing. • Lack of payment system by candidate to sit for licensure examination.

Strength	Weakness
• Piloted OSCE and CBT Examination • Feedback given to stakeholder. • Good grievance handling mechanism • Availability of decentralized licensing system • Licensing activities are prioritized, planned, and budgeted. • Presence of approved legal documents and directive. • Institutional commitment to start iHRIS. • Availability of draft Scope of Practices • Availability of ethics committee at federal and regional level • Availability of federal level ethical misconduct directive • Progress on integration of CPD with license renewal • Accreditation of CPD accreditors by ministry of health • Availability of well-established governing board (AGP) including accreditation council. • Strong collaboration between ETA, MOH, MOE and professional associations. • Availability of endorsed binding documents like accreditation guideline, operational standards and supporting documents. • Regulation regarding career development for health professional developed and endorsed. • Establishment of trained team of assessors' pool. • Application for accreditation, conducting and submission of SED by HEIs • All schools have started self-review for accreditation purpose.	• Absence of legal enforcement to decide the number of exam repeats allowed for re-examinees • Weak system to detect of fake license, and no system and control over the professionals revoked the health professional license. • Poor HRIS implementation • Poor stakeholder collaboration to implement enforcement strategies. • There is no uniform implementation in all regions. • Low relicensing rate • Delayed ratification of the scope of practices, and the standard operating procedures are not based on the scope of practice. • Delayed ratification of qualification standard • Unavailability of functional ethics committee in some regions • There was no structure to lead ethics activity at ministry of health. • Limited awareness on professional code of conduct and limited enforcement of code of ethics • Weak or lack of mechanisms to report malpractices, and weak investigation and management of health mal practices. • Lack of clear legal background and structure for ethics committee coordination, poor leadership commitment and high professional burnout rate • Weak quality assurance structure in higher education institution. Shallow institutional self-review overstated self-scoring and becoming defensive for feedback. • Lack of institutional memory or repository • Weak monitoring and guidance of accreditation procedure AGP • Absence of clearly delineated roles and responsibilities among stakeholders (ETA, MOH, MOE, PAs) during implementation.

Strength	Weakness
• HIS established- Availability of systems- iHRIS, DHIS 2, Master HF registry (MFR) • Skilled/Training HIT professionals and education • NHWA implementation with multi-stakeholder participation • Availability of annually updated HRH report (until 5th edition) • Available evidence on HLMA, WISN and other studies (motivation and retention study) • Establishment/Presence of HRIS case team at ministry level HRH Strategic Plan is in place to guide the national health workforce agenda. • Human resources management, development and licensure activities are prioritized, planned, and budgeted. • Government commitment to allocate budget for health professional training and employment (including matching funds). • Assessments completed on health workforce labor market dynamics and workload conditions (HLMA & WISN) resulted in HRH and financial requirement projections, financing and revising staffing standards. • Progressively improved investment in health workforce (education, deployment, motivation and performance improvement)	• The accreditation practices were not periodically evaluated. • ETA didn't delegate its accreditation authorities partly or fully to professional associations during implementation. • Quality audit is not linked with accreditation. • Licensure exam is not linked with accreditation. Incomplete data from HSCs • Lack of interoperability between relevant systems needs intersectoral approach (e.g. MOH, MOE, FDA, etc.) • NHWA lacks Private health sector data. • Poor utilization of data • Limited availability of evidence to guide concrete actions/ inform rational health workforce policy and planning – e.g., productivity. • Use of multiple formats for similar data request in the health sector • Fragmented information system at Health science training institutions • Weak accountability for the HRH data reporting Inadequate HRH projected budget and investment • Weak capacity and advocacy for improved budget allocation and expand fiscal space. • Increasing unemployment rate resulting in wastage of training expenses • Weak partnership system in place to enhance stakeholders' engagement (Sectorial, developmental partners and private sectors) • Challenges in financial utilization and liquidation in the health science colleges • Weak public Private Partnership

Opportunities	Threats
• Global efforts, advocacy, and collaboration for health workforce strengthening. • Positive government attention and political will are being paid to global commitments to quality education and stronger HRH. • The national education roadmap, HSTP II, EHSP, specialty subspecialty service road map, • Increased private sector engagement. • Increased societal demand for better quality healthcare. • Increased ICT policy, infrastructure, and equipment • National and international donors are available to assist the education sector. • Development of health service standards • Engagement of professional associations and stakeholders to improve the quality of education. • Supportive health policy in place • Increased professionals' association engagement in implementation of CPD • Expanded use of smartphones by health care workers • CPD is linked to license renewal. • Increasing public demand for high quality health care • Emphasis given for digital technology. • Improved attitude towards digital based learning • Availability of potential partners supporting CPD program • Availability of online courses from abroad and Licensure examination • Government Priority intervention related to exit and qualification examination. • Global initiative	• .Conflict and natural disasters • Enrollment decisions are not based on industry need and capacity. • Low economic status of the population (poverty, high unemployment) • Lack of consistency in the implementation of gender mainstreaming • Weak enforcement of regulatory mechanisms • Emergence and re-emergence of disease epidemics • Low digital skill in health professionals • Low access and high cost of the internet • Weak International Collaborations • Unable to endorse remediation guideline. • Unstandardized learning, teaching and assessment practice by HEIs. • Presence of forgery • Unresolved conflicts among scopes of practice. • Weak enforcement of regulatory mechanisms • Resistance of health professionals and employers to CPD system • Political instability • Forgery of training certificates • Malpractice among few CPD providers ETA is not internationally accredited. • Low accreditation rate • Slow progress of overall accreditation practice • Lack of institutional readiness • Lack of political commitment/ engagement • Fragmented system • The civil service reform is weakening existence of HR unit at lower level- pool system. • Limited resource/budget

Opportunities	Threats
• ICT advancement and availability of infrastructure at HEIs for computer-based exam • Availability of skill development labs in HEIs for OSCE examination • Working with AAU and Educational Assessment and Examination services • Government commitment on quality service/ regulation relevant professional associations are well engaged. • Government commitment to establish accreditation system on WHO's HRH 2030 • Restructuring of ETA: as a result, ETNQF, Ethiopian National Qualification Framework established • Increased donor interest and partner support • Improved collaboration among stakeholders (USAID, WHO, other) • HR unit available at all levels • Increased interest/demand to use data for decision-making. • Align with the global HRH strategy. Availability of domestic, private, NGOs, and global funding mechanisms • Existence of partnership platform for HRH stakeholders (steering committee and HRH forum) • New Global and Regional HRH investment initiatives • Economic growth and presence of strong government structure • Global efforts, advocacy, and collaboration for health workforce strengthening.	• Poor infrastructure including internet connection, power, etc. • Increasing trends in unemployment • Natural, and man-made disasters • High staff turnover and loss of institutional memory. • Slow economic growth, Inflation, and high cost of living • Increasing gaps in geographic mismatch in public and private sectors • Donor fatigue and priority shift • Limited capacity to generate evidence-based HRH funding and budget allocation.


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