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BJS

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Journal:	*BJS*
Manuscript ID	BJS-1447-Jul-25.R1
Manuscript Type:	Research Letter
Date Submitted by the Author:	12-Sep-2025
Keywords:	Education

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A Political Economy Analysis of Ethiopia's Integrated Emergency Surgical Officers Programme

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Funding: None.

Disclosure Statement: The authors declare no conflict of interest.

Data Availability Statment: There is no data set associated with this paper.

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Following the 2008 recommendation by the World Health Organization (WHO), task-shifting appeared as an essential policy instrument to address health workforce shortages, predominately in low- and middle-income countries.(1) Task-shifting initially focused on expanding the health workforce to respond to pressing public health concerns, such as HIV and essential maternal and child healthcare services, but later its application has expanded into areas with greater clinical complexity such as surgery and obstetrics.

Ethiopia launched the Integrated Emergency Surgical Officers (IESOs) programme in 2010 to expand access to comprehensive emergency obstetric and surgical care. Nurses, midwives, health officers, and other mid-level health professionals were recruited into a two-to-three-year training programme in core surgical skills. Upon completion professionals were then deployed to primary hospitals, general hospitals, and health centers with operating theatre blocks. More than 735 IESOs have been trained so far, and they have been credited for their significant contributions to improvements in maternal and child health.(2) However, the programme currently faces persistent challenges relating to limited career development opportunities, workplace role conflicts, acceptability in the broader medical workforce and concerns related to deskilling of physicians.

To understand the political forces and contextual factors involved in shaping this programme, a political economic analysis (PEA) was conducted. The analysis drew on a policy dialogue in Addis Ababa with government officials, academics and health care providers. The analysis was reinforced by policy documents, including published articles. The PEA considered how institutions, interests and ideas influenced the trajectory of the IESO programme.

The Federal Ministry of Health and supporters of task-shifting promoted the IESO programme as a pragmatic and pro rural approach to workforce expansion.(3) International partners, including UNFPA (United Nations Population Fund) , USAID(United States Agency for International Development) and WHO, provided technical and financial support to enable rapid training scale-up and facility readiness. Proponents of the programme emphasised the cost effectiveness, efficiency gains and alignment with global maternal and child health goals. They argued that non-physician providers with targeted preparation could safely perform essential emergency and obstetric procedures. Recruitment from local communities was further prompted to improve retention and improved service coverage. However, critics, mostly professional medical associations, insisted that longer years of specialist training are necessary for mastering surgery. They expressed concern that prioritising access over the quality of care risks creating a two-tier standard of care and diverts resources from specialist training.

The Ministry of Health coordinates the recruitment and deployment of IESOs along with training institutions and Regional Health Bureaus.(4) The Food and Drug Administration Agency manages the licensing of IESO professionals and the programme is formalised through the Health Workforce Development Plan. Although primary healthcare facilities have integrated IESOs into their surgical provider teams, the lack of institutional readiness for surgery in infrastructure, supplies and incentives have limited their effectiveness and is driving attrition. Despite the Ethiopian government's ambitious goal of training 800 IESOs and staffing health centres' operating room blocks, professionals output has outpaced infrastructure development.

To address the lack of specialisation opportunities for IESOs, recently the Association of Emergency Surgical Officers (PASEO), the Federal Ministry of Health of Ethiopia, and St. Paul's Millennium Medical College have

reached a consensus to allow IESOs to enroll in specially designed PhD programmes.(5) Additional opportunities have also been introduced through the New Innovative Medical Initiative (NEMI) programme, which allows IESOs to undertake training for a medical degree. Discussions are currently in place to provide further training opportunities to allow for vertical career progression since no clear and accessible pathway for professional growth currently exists. As a result, frustration among professionals and subsequent attrition remain significant.

A nationwide task analysis conducted in 2018 identified competency gaps among general practitioners as procedural skills in surgery, obstetrics, and gynecology.(6) This was attributed to lack of opportunities to practice these skills and lack of focused training, which are, to some extent, due to the presence of IESOs. This phenomenon has further reinforced tensions with physicians. The overlapping roles of IESOs with general practitioners and surgeons have contributed to workplace tensions. Although IESOs are mandated to provide perioperative care, screening and referring complicated cases, there have been concerns regarding the redundancy of their role, especially as the number of physicians grows in Ethiopia, leading to technical efficiency losses in some healthcare facilities.

The IESO programme highlights both the promise and fragility of task-shifting. It has enabled the rapid expansion of access to emergency surgery and obstetric care, however, unresolved issues around integration, career progression and stakeholder consensus threaten its long-term sustainability. Attrition from clinical posts remains high, often driven by career stagnation and unappealing career incentives.

Similar challenges are observed in task-shifting programmes in other healthcare systems, such as the UK, where healthcare professionals, surgeons, medical associations and policymakers are debating about regulation, quality of care, reimbursement and the scope of practice for non-physician surgical providers.(7) This is partly due to the shortage of high-quality evidence to demonstrate the quality of care provided by non-physician surgeons and acceptability by patients.(8) However, it is also due to the lack of strategic engagement with different stakeholder groups. This has created workplace disharmony, contributing to a lack of efficiency dissatisfaction among the workforces.

Task-shifting professionals, such as IESOs, are no panacea for increased retention in rural regions.(9) The same challenges affecting the retention of specialised professionals, including unfavorable working conditions, inadequate remuneration, and the lack of enhanced prospects and education also impact IESO professionals.(10) Recent statistics point to a decline in employment opportunities for IESOs, which is also experienced across other healthcare professions in Ethiopia, leaving many grappling with unemployment. This is partly due to the slow growth in surgical infrastructure and facilities that fail to keep pace with the production of professionals. Recent initiatives to improve employment flexibility such as permitting engagement in private practice may partly address this challenge. However, task-shifting programmes need to consider mechanisms of accounting for the longer-term impact of introducing new cadres into the healthcare labour market. Sustainable task-shifting programmes are also required to be pragmatic in their approach and continue to adapt to changing health system needs. A balance must be struck between the short-term introduction of new cadres into the workforce and the long-term need for integration into the existing workforce.

Task-shifting is likely to remain central to surgical workforce policy in many settings globally. Ethiopia's experience illustrates the potential of such initiatives to expand access but also the vulnerability when long term plans for integration, stakeholder consensus and institutional investment are lacking.

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