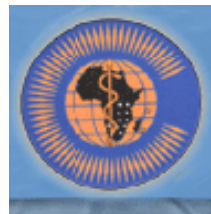


Policies and incentives for health worker retention in east and southern Africa: Learning from country research

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Executive summary

This paper presents a summary of the regional programme on incentives for health worker retention in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) in co-operation with the East, Central and Southern Africa Health Community (ECSA-HC). The programme is co-ordinated by the University of Namibia, Namibia, with support from University of Limpopo and Training and Research Support Centre (TARSC), and the ECSA Technical Working Group on Human Resources for Health. The studies sought to investigate the causes of migration of health professionals, the strategies used to retain health professionals, how they are being implemented, monitored and evaluated, as well as their impact, to make recommendations to enhance the monitoring, evaluation and management of non-financial incentives for health worker retention. They aimed to have some comparability in design to share learning.

The methodology included a literature review, followed by cross section surveys using qualitative (focus group discussions and in-depth interviews) and quantitative (structured questionnaire surveys and an analysis of health information system data) in the different levels of the health sectors in those countries. A major limitation of the studies was the fact that the countries reviewed still operated on manual systems, so researchers had difficulty accessing the data they needed.

The findings revealed that all four countries studied (Swaziland, Zimbabwe, Tanzania, Kenya) have put in place strategies to improve morale and retain staff in the public health sector. These have been designed after some assessment of the drivers of attrition, often through prior surveys of push/pull factors. All the countries studied were applying a mix of non-financial incentives according to their strategies and plans, although implementation was not always uniform at all levels or for all cadres, or reached all those cadres intended. All implement non-financial incentives, together with some form of financial incentives. All studies indicated the presence of policies providing for non-financial incentives. What is of concern is implementation: how they are introduced, the reasons for and measures to address gaps in implementation, how they are managed, monitored and evaluated, and the systems and information needed to support implementation. This area needs more attention, from ensuring the effective performance of institutions and roles set up to manage HRH, to generating the information and processes needed to introduce them, assess their impact and to build trust and credibility around their application. The country studies observed that incentives were not uniformly applied to all health workers, and did not always reach all in the target category.

Most of the countries offered hardship allowances to their health workers, although they were low. For example, Tanzania offers a hardship allowance for remote areas and non-taxable allowances, such as car allowances and overtime pay. Kenya offers a hardship allowance paid to members of staff who are stationed in the designated hardship areas, paid at the rate of 30% of an officer's basic salary – however this did not make much difference if the salary was low already. Zimbabwe offers a rural allowance (10% of basic salary) for remote areas, while Swaziland does not offer such allowances for its health workers. As in the four countries, the background review found that incentives in many countries are focused on a few cadres of staff, such as doctors for rural facilities in Zambia, nurse tutors in Malawi, or nurses and doctors in Botswana.

The studies raised caution about approaches that target specific groups. They pointed to cadres that appear to have been excluded from incentive strategies, particularly those cadres that work at community level and that form a bridge to other actors that play a role in primary health care, such traditional health providers and community health workers. The uneven application of

incentives is not only a matter of policy, but is often a product of the reality of the situation on the ground in terms of management's authority and decisions, and the resources available.

The studies indicated a need to intensify focus on issues of operationalising and implementing non-financial incentives: moving from inserting incentives in policies and strategies to ensuring their application across all providers; moving from focused application for specific cadres of health workers to sector wide application of incentives for all health workers and moving from experiments within the health sector to more sustained multi-sectoral policies that involve other sectors, including public service, finance, public works, education and housing.

A number of proposals were made for follow up for each of the four countries. In Swaziland, the researchers recommended comprehensive approaches to address retention, involving all stakeholders, backed by clear guidelines, and using coherent mechanisms and processes to plan, introduce and monitor non-financial incentives. In Zimbabwe, proposals were made to apply retention strategies and incentives to all staff categories, given the tendency for staff at all levels to migrate, and to give the Zimbabwe Health Services Board (ZHSB) greater decision-making latitude for introducing and managing health worker incentives. In Kenya, proposals were made for government to invest not only in its health workers but also in its facilities by ensuring regular medical supplies, upgrading facilities and improving working conditions in rural and poorer areas. In Tanzania, the research team proposed that, while strategies for specific cadres and places need to be designed and implemented, this needs to be done in a manner that engages across sectors, given that the health sector is a part of the bigger social system. The researchers observe that costing studies are needed to ascertain the feasibility and sustainability of non-financial incentives, and that their introduction calls for improved health worker management styles under the ongoing decentralisation reforms.

The results of the work were reviewed at a regional meeting that was convened on 25-27 February in Windhoek by EQUINET and ECSA-HC, hosted by the University of Namibia in co-operation with TARSC and University of Limpopo, to review the findings from this body of work and to explore the implications for policies and measures aimed at valuing and retaining health workers in ESA, develop proposals and guidelines for policy and action relevant to health worker deployment and retention, and identify knowledge gaps for follow up work.

The meeting proposed a number of policy options for strengthening HRH retention:

- For retention packages to be applied across the whole health sector, based on needs assessment and inter-sectoral and stakeholder input. They should be costed and supported by an HRH monitoring system and sufficient institutional capacity to manage the incentives.
- For HRH policies to aim to build cohesive and functional health teams, respect health workers rights and responsibilities towards patient and community rights, with clear and comprehensive regulatory frameworks.
- For some incentives to be regarded as core, to be applied across all countries, viz: career paths; stimulating training and encouraging deployment through investment in services (including 'centres of excellence'); providing housing mortgages / loans; rewarding performance; and securing health worker health and access to health care.
- For retention strategies to be regularly reviewed and stakeholders informed about the progress and impact of incentives.

Monitoring and evaluation systems need to be strengthened to allow the analysis of primary data on different dimensions of migration and retention, and to assess the effectiveness, including cost effectiveness of incentive schemes.

1. Introduction

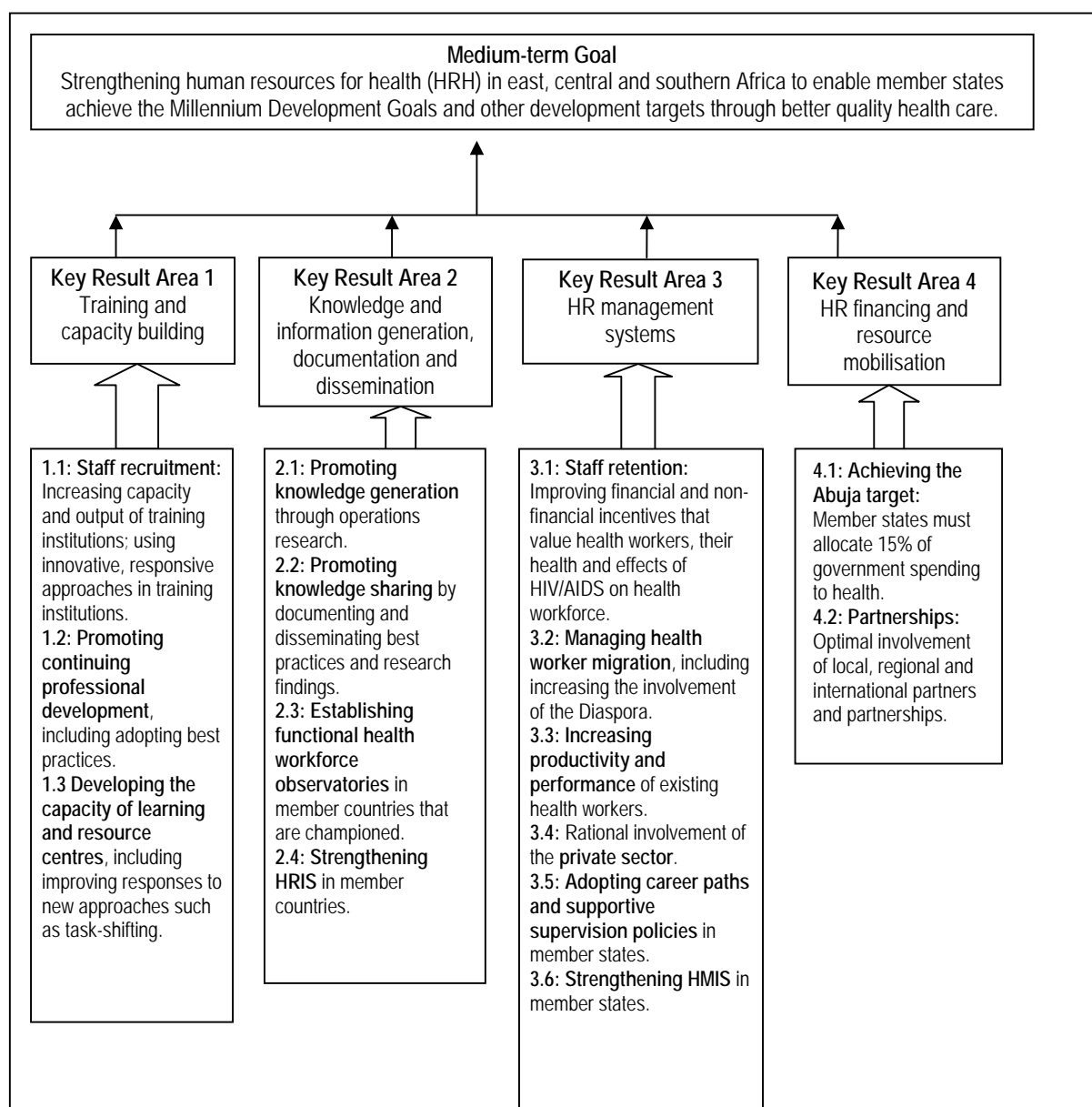
Issues regarding the welfare of health workers in the eastern, central and southern African (ECSA) region have been raised regularly at the recent Regional Health Minister Conferences (RHMCs). At these conferences, health ministers made resolutions to attempt to solve a range of regional challenges, such as weakened health systems, a lack of leadership and training, and the loss of skilled workers migrating to the developed world (popularly referred to as the 'medical brain drain') or from rural to urban areas within the same country (internal worker attrition). Specific resolutions include:

- Resolution 3 of the 34th HMC (2001), which focused on improving conditions of service and protecting the rights of workers who emigrate;
- Resolution 2 of the 38th HMC (2003), which was concerned with improving the quality of health care by improving training of health workers;
- Resolution 3 of the 38th HMC (2003), which emphasised the need to improve retention of health workers;
- Resolution 4 of the 38th HMC (2003), which aimed at improving leadership and governance for better performance by health workers and an improvement in health systems;
- Resolution 3 of the 40th RHMC (2004), which revisited the need to improve the retention of staff, strengthen human resources information systems (HRIS) and develop human resources for health (HRH) policies that are evidence-based;
- Resolution 4 of the 42th HMC (2005), which reconsidered the need to strengthen HRIS to provide information for the planning and development of human resources for health (HRH), as well as information on retention and migration; and
- Resolution 7 of the 44th HMC (2006), which dealt with the need to establish health workforce observatories, develop effective HRH strategies and conduct country-specific studies to understand better the factors associated with retention and migration (ECSA-HC, 2007).

At the 42nd HMC (2006), health ministers raised concerns about the rapid migration of health workers out of the region and the need for effective responses to this problem. They urged member states to develop national systems of continuing professional development that promote on-the-job and team-based training, in addition to developing a system for tracking continuing professional development, and devising financial and non-financial strategies to encourage retention of health professionals. They also requested member states to develop and strengthen innovative mechanisms for staff recruitment based on norms that are regularly reviewed, as well as adopt a common position on how to compensate for the loss of health workers recruited by developed countries and to develop strategies for the ethical recruitment of health workers globally (ECSA-HC, 2006).

To take the process further, the ECSA-Health Community (HC) secretariat developed a Human Resources for Health Strategy for the region for 2008–2012, which was adopted by member states of the ECSA-HC in February 2008. The medium-term goals of the strategy are provided in *Figure 1*.

Figure 1: Medium-term goals of ECSA-HC Human Resources for Health Strategy, 2008



Source: ECSA-HC in EQUINET et al (2009)

Demand has been growing for policy responses to health worker issues at country, regional and international levels and, as a result, the Southern African Development Community (SADC), in line with its protocol of health of 1999, developed a strategic plan for HRH for 2007–2019, which drew on a situational analysis of the magnitude of the medical brain drain, prevailing conditions of service and working environments, and existing strategies and management systems (SADC, 2006). SADC identified the major issues facing health care workers, namely the migration of health professionals from developing to developed nations, as well as from rural to urban areas in developing countries, a mismatch between supply and demand for health workers, poor workforce planning capacity, and the negative effects of privatisation and HIV and AIDS on

health workers. SADC proposed policies and strategies for retaining health personnel and improving salaries, developing a regional qualification framework on health, identifying, establishing and developing centres of specialisation by 2009, and facilitating continuous training through exchange programmes and attachments, in addition to ensuring adequate numbers of health workers are trained and retained in their jobs between 2010 and 2020. Within the region, recruitment of health professionals is managed through mutual agreements across member states and through exchange programmes to promote skills circulation and the return of health professionals to their home countries when they have finished their training (SADC, 2008).

In March 2008, a global forum on human resources for health (HRH) issued the Kampala Declaration, which identified six interconnected strategies as action points to address the loss of health workers from the region, as well as health worker mal-distribution:

- building coherent national and global leadership for health workforce solutions;
- ensuring capacity for an informed response based on evidence and joint learning;
- scaling up health worker education and training;
- retaining an effective, responsive and equitably distributed health workforce;
- managing the pressures of the international health workforce market and its impact on migration; and
- securing additional and more productive investment in the health workforce (WHO, 2008).

In May 2006, the Global Health Workforce Alliance was launched as a global partnership to address the worldwide shortage of nurses, doctors, midwives and other health care workers. It aims to seek practical approaches to urgent problems, and to serve as an information hub and a monitoring body on health workers. The World Health Assembly is currently discussing a code on ethical recruitment of health workers, to be tabled at the Assembly in 2010 (WHO, 2006).

This policy attention is yet to be fully translated into effective sustained strategies in countries to address problems. This paper synthesises evidence from a programme of work between 2007 and 2009 in the Regional Network for Equity in Health in East and Southern Africa (EQUINET) in collaboration with the East, Central and Southern African Health Community (ECSA- HC). It includes information from a review of secondary evidence from literature by University of Limpopo, from a research methods meeting in 2007 and evidence from four field studies in Zimbabwe, Kenya, Swaziland and Tanzania, and from a regional review meeting in February 2009. The work was coordinated by the University of Namibia with support from Training and Research Support Centre (TARSC) and University of Limpopo, in co-operation with ECSA HC. The programme sought to build capacity and provide support to policies and programmes aimed at the retention of health workers and management of out-migration of health personnel.

Preliminary research and dialogue identified three areas of focus for action on health care workers, namely:

- **Valuing health workers** so that they are retained within national health systems. This includes reviewing and implementing policies on non-financial incentives for HRH such as career paths, housing, working conditions, management systems and communication.
- **Promoting relevant production of HRH**, particularly in terms of the health personnel for district and primary care levels, and drawing on experience in the region on training of auxiliaries.
- **Responding to migration**, which requires closing the evidence gap with respect to migration (levels, flows and causes), financial flows, costs (benefits, losses) and return intentions and mapping the effectiveness of current policies (EQUINET, 2006).

To respond to this, a review of literature and secondary evidence on non-financial incentives for retention of health in east and southern Africa was undertaken between November 2006 and February 2007 (Dambisya, 2007a). A regional research meeting in March 2007 was held to discuss the analytic framework and methods for follow up research health worker and retention (EQUINET, 2007). The meeting was hosted by EQUINET and ECSA-HC, through the Health Systems Trust (HST), University of Namibia and TARSC, and it brought together researchers, country programme managers or focal persons for HRH, health worker associations, regional and international agency personnel and other relevant stakeholders.

Drawing on frameworks set in the meeting, country teams prepared proposals for operational research to map and assess incentives for retention of health workers, particularly non-financial incentives. Country proposals from Zimbabwe, Tanzania, Swaziland and Kenya were implemented, and mentored by University of Namibia, in 2007 and 2008. The studies were individually reported in 2008, namely, Chimbari et al, 2008, Ndeti et al, 2008, Munga and Mbilinyi, 2008 and Masango, 2008. A follow-up regional meeting discussed the findings and proposed policy and programme recommendations arising from the work.

2. The health worker crisis in ESA: Why do workers migrate?

Health worker migration, both internal (out of areas of high health need), and external (out of countries in the region), is thus a matter of policy concern, reducing the effectiveness and equity of health systems in the region. Most African countries are challenged by health systems that lack the financial, human and technical resources needed to address the burden of disease, or to prevent ill health. In many east and southern African countries, health infrastructure is poor, essential equipment, supplies and logistics are often lacking, and referral systems function poorly (Dambisya, 2007a; Awases, 2004). One of the crucial obstacles in the effective functioning of health systems is the shortfall of health workers, particularly in the frontline services and in areas of high health need.

Reviewing the status of HRH in sixteen countries in east and southern Africa (ESA) – excluding Mauritius and the Seychelles – Dambisya (2007b) found common problems of absolute shortages of health workers, poor work environments, and a mal-distribution of health workers between urban and rural facilities, and often between private and public sectors. The causes of these problems were found to vary from country to country. In Lesotho, Namibia, Swaziland and Botswana, shortages of doctors are associated with a lack of medical schools, and, as in the case of Tanzania, low output from training institutions. In South Africa, health worker numbers are higher, but there is a severe mal-distribution between public and private sectors, and between rural and urban areas. In Zimbabwe, sufficient training capacity exists, but there are high levels of out-migration of health workers, especially doctors and nurses, due to a recent downturn in the economy (Dambisya, 2007b; lipinge et al, 2005; WHO, 2000).

Table 1 shows health worker densities in the ESA region. It shows significant shortfalls in the numbers of health workers, particularly if compared to high-income countries. Given that the performance of health systems is affected by the knowledge, skills mix and motivation of the people responsible for delivering the services, these shortfalls set a basis for poor performance that, in turn, undermine health outcomes.

Table 1: Distribution of health workers in ESA region (per 100,000 population), 2004

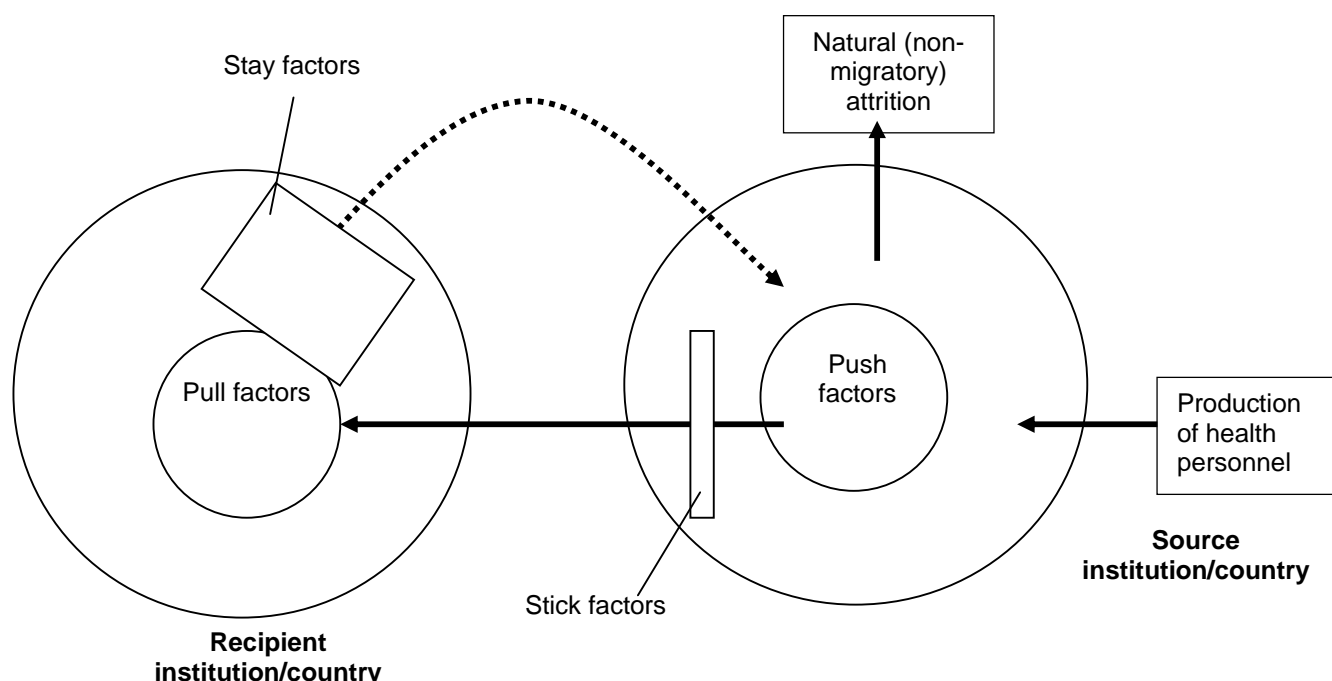
Countries	Physicians	Nurses	Mid-wives	Dentists	Pharmacists	Public health and environment workers	Health management and support workers
Angola	8	115	4	0	0	10	0
Botswana	40	265	0	2	19	0	46
DRC	11	53	0	0	2	0	28
Kenya	14	114	0	4	10	20	8
Lesotho	5	62	0	1	3	3	1
Madagascar	29	32	0	2	1	1	34
Malawi	2	59	0	0	0	0	0
Mauritius	106	369	0	19	116	19	165
Mozambique	3	21	12	1	3	3	50
Namibia	30	306	0	6	14	12	387
South Africa	77	408	0	13	28	6	62
Swaziland	16	630	0	3	6	10	35
Tanzania	2	37	0	1	1	5	2
Uganda	8	61	12	1	3	4	24
Zambia	12	174	27	4	10	9	99
Zimbabwe	16	72	0	2	7	14	4
Africa (2002)	21.7	117.2^(*)		3.5	6.3	4.9	41.1
UK	2,300	1,212	63	101	51	25	2,120

*Except Angola, 1997; Lesotho, 2003; Tanzania, 2002; and UK, 1997. Note that the figures for nurses and midwives are combined for the Africa figures. The UK is included as an example of a recipient country.

Almost all countries in the region have experienced health worker attrition, although the specific cadres affected and the responsible factors for losses vary across countries. All have 'hard-to-staff' areas – typically poor, rural areas with poor infrastructures. Virtually all health systems lose staff from rural to urban areas and from the public to the private sector. In Zimbabwe, South Africa, Malawi, Lesotho, Swaziland and Zambia, outward migration of health workers is a major problem. Mortality and illness due to AIDS has also contributed to high attrition rates (Dambisya, 2007b; lipinge et al, 2005).

There are a variety of factors, including push and pull factors, that impact on the movement of health care workers, arising within, as well as outside, the health system (see model illustrated in *Figure 2*).

Figure 2: Model illustrating factors that influence health personnel availability and distribution



Note: Push factors are those that ‘push’ workers to leave their source countries, and pull factors are those that ‘pull’ or attract workers to recipient countries. Stick factors encourage workers to remain in *source* countries while stay factors encourage workers to remain in *recipient* countries to which they have migrated. While the model here illustrates international migration (between countries), the model can also be applied to rural-urban migration.

Push factors that are endogenous to the health care system in ESA countries include low pay, work-related health risks (including HIV and AIDS and TB) unrealistic workloads, poor infrastructure and sub-optimal conditions of work. Workers are paid low salaries, work in poor, unsafe environments, do not have defined career paths and only have poor quality education and training. Public expenditure ceilings have led to hiring freezes (Padarath et al, 2003; Awases et al, 2004; WHO, 2006). Exogenous push factors (not directly related to the health system) are also noted, including political insecurity, crime, taxation levels, repressive political environments and falling service standards. Migration is also influenced by pull factors, including aggressive recruitment by recipient countries and promises of improved quality of life in recipient countries, as well as study and specialisation opportunities and improved pay (Padarath et al, 2003).

These push and pull factors are mitigated by ‘stick’ factors in source countries, which lead to greater personnel retention, including family ties, psychological links with home, migration costs, language barriers and other social and cultural factors. ‘Stay’ factors influence decisions to remain in recipient countries and influence rates of return of personnel. These include reluctance to disrupt family life and schooling, better employment opportunities and a higher standard of living in the recipient country.

Background literature (including Awases et al, 2004; Dambisya, 2007a; and Labonte et al, 2007) has highlighted that these factors are not unique to ESA countries, but are perhaps more severe

in the region, given the high share of low-income countries and the massive pull exerted on workers by higher-income countries (see *Table 2*).

Table 2: Push and pull factors affecting movement of health care workers globally

Push factors (from the poor countries)	Pull factors (towards the rich countries)
<ul style="list-style-type: none"> • Resource-poor health systems • Low salaries • Deteriorating work environments • Inadequate medicine and equipment • Poor human resource planning • Political tension and upheaval • Gender discrimination • Lack of personal security • HIV and AIDS • Poor housing • Lack of transport • Diminishing social systems (education, pension etc) 	<ul style="list-style-type: none"> • Available jobs • Good pay • Regular workload • Reasonable conditions of work • Economically and politically stable country • Safe living environment • Good quality of life • Better social systems • Better opportunities

Source: Labonte et al, 2007

In addition to migration from poor countries to rich and from areas of high health demand to low health demand, the failure to retain staff results in inequitable losses that primarily disadvantage poor, rural and under-served populations (Padarath et al, 2003; Ntuli, 2006). It costs a lot to educate health workers and, for some countries in ESA, training capacity simply does not exist. There are quite long time lags in the health sector between education and practice, and between changes in student intake and changes in supply of a particular category of professionals (Hall, 1998; Zurn et al, 2002). Staff losses erode supervision, mentorship and support from the referral system (Kirigia et al, 2006).

3. Incentives for retaining health workers in ESA

The features of individual countries in east and southern Africa affect the causes of their human resource crises, but some causes are common across countries. For example, most are experiencing financial constraints, which result from structural adjustment and liberalisation policies, and many suffer from poor management of the health workforce, and inadequate human resource information systems to inform policy and planning.

Both causes and options for responses depend on the political, economic, historic and social context of each country. Responses depend on the policies and actions of a range of sectors in countries, as well as the policies and actions of international organisations and stakeholders, including in the private sector. These various demands raise a major challenge for health sectors seeking to manage health workforces to negotiate and co-ordinate effective responses. One policy tool has been the use of incentives. In recognition of this fact, an EQUINET regional meeting in 2005 adopted a consensus statement that called for a focus on policies and measures that will reward health workers through financial and non-financial incentives (EQUINET, 2005).

The World Health Organization (WHO) defines incentives as 'all rewards and punishments that providers face as a consequence of the organisations in which they work, the institution under

which they operate and the specific interventions they provide' (WHO, 2000: p 61). Incentives for health workers are broadly seen as either financial or non-financial:

- **Financial incentives** may be direct or indirect. Direct financial incentives include pay (salary), pension and allowances for accommodation, travel, childcare, clothing and medical needs. Indirect financial benefits include subsidised meals, clothing, transport, childcare facilities and support for further studies.
- **Non-financial incentives** include holidays, flexible working hours, access to training opportunities, sabbatical/study leave, planned career breaks, occupational health counselling and recreational facilities (Adams, 2000).

In most countries, health worker salaries are poor, and financial incentives are essential because most health workers want enough money to meet their living costs, arguably making good remuneration the most influential factor for retaining health workers (Dovlo and Martineau, 2004). Financial incentives tend to have dramatic and immediate results, either slowing the exit of workers from the health sector or attracting them to the system. For example, in Kenya raising doctors' allowances led to hundreds of doctors applying for government jobs (Matheau and Imhoff, 2006). In Swaziland, many health workers opted to work in the public sector after a 60% pay raise (Kober and van Damme, 2006) and, in Malawi, a 52% pay raise reduced worker attrition from the public sector in a few months (Palmer, 2006). Improving pay is an obvious measure to address attrition, but often depends on wider economic factors, such as those that determine the government revenue that finances salaries, as well as the real value of salaries. In conditions of high inflation – for example, those found in Zimbabwe in the past ten years – the gains from pay increases are rapidly eroded by increases in the cost of living.

Health workers do not only seek financial incentives, however. As observed by the head of the Malawi Nurses and Midwives Council, most health workers 'look beyond salary increments ... at personal development, better housing ... education for children ... specialisation...' (IRIN, 2006:3). Non-financial incentives create a stabilising influence, after the more rapid effects of financial incentives, by sustaining health worker commitment and sending signals that health workers are supported. Although non-financial incentives are, ultimately, financial because they cost money to provide, they cater to longer-term career, welfare and systems benefits that may provide greater stability. In many cases, for example, training or workplace investments, non-financial incentives may cost nothing because they can be created by more effectively organising and aligning existing resources to meet the needs of health workers, the systems they work in and the communities they serve, with wider gain to all. Where these investments are applied in areas or services levels where there is high health need, there are potential equity gains. Consequently, EQUINET with ECSA-HC has focused on the use of non-financial incentives as a measure for ensuring the adequate and equitable distribution of health workers. As noted by Namibia's Deputy Minister of Health and Social Services, crucial non-financial incentives, such as improving leadership and management, can be created right now simply by changing negative attitudes in management staff:

We all know and understand that our governments are not in positions to provide huge salaries to our health workers but much more can be done within working environments. Health workers frequently complain and express dissatisfaction with management, poor leadership, lack of support and recognition; supervisors do not even know the word 'thank you' for good performance. I want to point out that we as leaders, managers, supervisors, need to take cognisance of the fact that human capital is the most valuable asset resource that we have. By being caring and supportive, the ability of our countries' health sectors in particular to attract and retain health workers will be greatly enhanced (EQUINET, 2009:5).

The review of secondary evidence by Dambisya (2007a) showed that governments in east and southern Africa have implemented a variety of incentives to motivate and retain health workers in the public sector:

- **Training and career path-related incentives** include continuing professional development, opportunities for higher training, scholarships/bursaries and bonding agreements, and research opportunities.
- **Incentives that address social needs** were used in several countries, such as housing in Lesotho, Mozambique, Malawi and Tanzania; staff transport in Lesotho, Malawi and Zambia; childcare facilities in Swaziland; free food in Mozambique and Mauritius; and employee support centres in Lesotho.
- Most countries have **improved working conditions** or plan to improve working conditions by, for example, offering better facilities and equipment and providing better security for workers.
- All countries (except Madagascar, for which there was no data) have developed or are developing **human resource management** (HRM) and human resource information systems (HRIS). In many countries, these have been instrumental in improving worker motivation through better management.
- In response to the high HIV and AIDS burden, many ESA countries have workplace-specific programmes to care for workers and their families, ensuring **access to health care and anti-retroviral therapy** (ART). Some have special health care worker medical aid schemes, which may include access to private health care (Dambisya, 2007a)

Table 3 provides more details on which countries offer the incentives listed above.

Table 3: Non-financial and financial incentives offered by ESA countries, 2007

ESA countries	Non-financial incentives					Financial incentives: salary top-ups and allowances
	Training and career path development	Social needs support	Minimum conditions of work	Solid HR and personnel management systems	Health and ART access	
Angola	–	–	X	X	–	X
Botswana	X	–	X	X	X	X
DRC	X	–	–	X	–	X
Kenya	X	–	X	X	X	X
Lesotho	X	X	X	X	–	X
Malawi	X	X	X	X	X	X
Mauritius	X	–	X	X	–	X
Mozambique	X	X	X	X	X	X
Namibia	X	–	X	X	X	X
South Africa	X	–	X	X	X	X
Swaziland	X	X	X	X	X	X
Tanzania	X	X	–	X	–	X
Uganda	X	–	–	X	X	X
Zambia	X	X	X	X	X	X
Zimbabwe	X	X	X	X	–	X

Source: Dambisya, 2007a

These incentives are recorded in the human resource policies and plans in the region. The field studies implemented in countries found that all the countries had developed HR strategic plans that incorporated a number of these incentives. Kenya introduced a National Health Services Strategic Plan (NHSSP II) in 2005, locating health worker needs within the context of the delivery of an essential package of health services. Tanzania's Health Sector Strategic Plan (2003–2008) located health worker strategies within the context of policy objectives and strategies for the health sector as a whole, while recognising the crucial role that health personnel play in improving access to quality health care services (MoH, 2004). The strategy provided for measures to retain and distribute health workers. In some cases, there were trade-offs, such as permitting private practice work alongside public sector work (Mogedal and Steen, 1995; HERA/MoH, 2006). In Uganda, a sector-wide approach (SWAp) and Health Sector Strategic Plan (HSSP) in 2000 provided for policies and mechanisms for periodic review, monitoring and evaluation (Hutton, 2004). In Zimbabwe, beyond setting strategies for retention in line with the National Health Strategy (1997–2007), a new legal and institutional framework was established through the Health Services Board to give government greater flexibility in setting and applying measures for health worker retention. The government set up a retention task force and established a performance management system (Chikanda, 2005).

However, countries have experienced challenges in implementing these strategies, as highlighted in regional review meetings. The sustainability of strategies is limited by current, often unstable, political and economic conditions, the context of globalised and liberalised economies, resource constraints, underperforming management capacities and systems, and over-reliance on donor, rather than domestic, funding for incentives. The provisions for monitoring and evaluation of plans are not well developed, undermining the documentation of impacts and best practices and limiting support for sustained investments (EQUINET, 2007). The EQUINET-ECSA HC programme of work, which was an outcome of the EQUINET regional meeting in 2005, thus sought to add to existing documented evidence on non-financial incentives for the retention of health workers, as well as to build and exchange knowledge to inform the design and implementation of effective national and regional strategies on health worker retention, especially in priority health services, drawing learning from the real situation of countries in the region (EQUINET, 2005).

4. EQUINET health worker retention studies in ESA, 2008

Based on policy priorities, information from the literature review and the proposals for design and methods developed at a 2007 regional methods workshop, EQUINET and ECSA-HC commissioned studies in five countries in east and southern Africa (ESA) – Kenya, Tanzania, Uganda, Zimbabwe and Swaziland. These studies were expected to achieve a number of objectives: to establish the context for, and trends in, the recruitment and retention of health workers; to identify existing policies, strategies and interventions in place to retain health workers; to identify how these strategies are being introduced and resourced and assess their sustainability; to analyse management, monitoring and evaluation systems to measure the impact of the health worker retention incentive regimes; and to identify lessons learned and appropriate guidelines for non-financial incentive packages to promote the retention of health workers.

Full field studies were implemented in four countries (Kenya, Tanzania, Zimbabwe and Swaziland) and a desk review of policies and programme documents was conducted in Uganda. The countries have different economic, social, political and health sector contexts, ranging from middle- to low-income economies, from high to declining growth rates, and with levels of

economic inequality as measured by the Gini co-efficient ranging from low in Tanzania to very high in Swaziland (See *Table 4*). While the public sector dominates as provider in health in all these countries, the expenditure on health per capita is very variable, from US\$16 to US\$185. The public resources available for responding to health challenges are thus very different across the countries.

Table 4: Economic and health indicators in Kenya, Tanzania, Swaziland, Uganda and Zimbabwe, 2000–2005

Countries	Population (millions)		Gross domestic product (GDP) per capita (US\$)		Annual GDP growth (%)	Gini co-efficient (i)	Per capita government expenditure on health (US\$)
	2000	2005	2000	2005	2005	2003	2003
Kenya	30.7	34.3	414	524	2.8	0.43	25
Tanzania	34.8	38.3	261	316	7	0.38	16
Swaziland	1.9	1.1	731	2,482	1.8	0.61	185
Uganda	24.3	28.8	244	302	5.6	0.43	23
Zimbabwe	12.6	13	587	259	-7.1	0.57	47

Sources: World Bank, 2006; UNDP, 2005; WHO, 2006

Table 5: Methodologies from EQUINET field studies in Kenya, Tanzania, Swaziland and Zimbabwe, 2008

Countries	Methods used	Sizes of samples	Categories of informants
Kenya	<ul style="list-style-type: none"> • Desk review • Focus group discussions (FGDs) • In-depth interviews 	Not stated	<ul style="list-style-type: none"> • Health workers, including managers, doctors nurses and final-year medical students
Tanzania	<ul style="list-style-type: none"> • Review • Structured interviews • In-depth interviews 	<ul style="list-style-type: none"> • 152 individual interviews with health workers • 21 in-depth interviews with key informants 	<ul style="list-style-type: none"> • Health workers, including assistant medical officers, nurses, health officers, dentists, clinical officers and doctors
Swaziland	<ul style="list-style-type: none"> • Desk review • Self-administered questionnaire • FGDs • Semi-structured interviews 	<ul style="list-style-type: none"> • 160 questionnaires • 2 focus group discussions 	<ul style="list-style-type: none"> • Front-line health workers and supervisors • Representatives of regulatory agencies, professional associations and unions
Zimbabwe	<ul style="list-style-type: none"> • Desk review • FGDs • Structured and unstructured interviews 	<ul style="list-style-type: none"> • 196 individual interviews with health care workers • 21 interviews with key informants • 5 FGDs 	<ul style="list-style-type: none"> • Nurses, environmental health officers and fifth-year medical students

Sources: Ndeti et al, 2008; Munga and Mbilinyi, 2008; Masango et al, 2008; Chimbari et al, 2008

Taking note of these different contexts, the studies aimed to have some comparability in design to share learning. The studies included literature reviews, followed by cross-section surveys, in which researchers gathered qualitative data, via focus group discussions and in-depth interviews, and quantitative data, via structured questionnaire surveys and their analysis of available health information system data in the different levels of the health sectors in those countries. The methodologies of each study in the four countries are summarised in *Table 5*.

The findings revealed that all four countries have put in place strategies to improve morale and retain staff in the public health sector. These strategies have been designed after an assessment of the drivers of attrition, often through prior surveys of push/pull factors. In Swaziland, as in some other ESA countries, health workers report frustration resulting from poor work environments, heavy workloads, inadequate essential equipment, poor accommodation, lack of promotion prospects and poor remuneration (Masango et al, 2008). Health workers, particularly nurses and medical doctors, migrate out of the country due to poor pay and a lack of non-financial incentives. The Swaziland study identified six factors that significantly influence the decision by health care professionals to either change institutions or to actively look for work at a different institution in the following year: level of job satisfaction, the employee's attitude towards their institution, equality/treatment by the employer, support in their jobs, job discretion (the support provided to health workers doing specific activities/functions that appeared to influence their desire to stay or to move out of the public sector) and the desire to help others (Masango et al, 2008). The Kenya study reported that nurses and doctors were leaving the public sector mainly because of poor working conditions, limited career paths and further education opportunities, the risks of HIV and impacts of AIDS at work and poor communication at health facilities. Kenya has also experienced a freeze in the recruitment of health professionals into the public sector for the past ten years, a result of the government's fiscal policies. Consequently, the number of available posts may not reflect the number of posts that need to be filled, based on health need (Ndeti et al, 2008).

In Tanzania, nurses and doctors were found to be leaving the country due to extreme differences in working conditions between rural and urban health facilities, between the public sector and private sector, and between Tanzanian health care labour markets and those in other countries (Munga and Mbilinyi, 2008). In Zimbabwe, the major factor driving out-migration was reported to be economic hardship due to deterioration in the country's economy post-2000. Other causes included poor remuneration, unattractive financial incentives – largely eroded by high inflation – and poor working conditions. Political insecurity and economic hardship were reported to outweigh all other factors and undermine any financial incentives provided (Chimbari et al, 2008).

All five countries applied a mix of non-financial incentives according to their strategies and plans, although implementation was not always uniform at all levels or for all cadres, nor reached all those cadres intended. *Table 6* summarises the incentives included in the HRH strategies in the five countries, based on detailed review of their policy and strategy documents. All offer non-financial incentives, together with some form of financial incentive. In Zimbabwe, for example, a retention package was implemented in 2007/8 for health professionals in government institutions including both financial and non-financial incentives. The financial incentives were found in the study to be less effective in retaining staff, as they were eroded by hyper-inflation.

Table 6: Non-financial incentives reported in strategic/policy documents in Kenya, Tanzania, Swaziland, Uganda and Zimbabwe, 2007/8

Non-financial incentives	Kenya	Tanzania	Swaziland	Uganda	Zimbabwe
Post-graduate training, continuing medical education and recognition of higher qualification	X	X	X	X	X
Housing or a housing allowance	X	X	–	X	X
Supervision and support for professional work	X	X	X	X	X
Life insurance	X	–	–	–	–
Personal loan facilities	X	–	–	–	–
Shorter working hours	X	–	–	–	–
National Social Security Fund membership	X	–	–	–	–
Medical cover (including nuclear family)	X	X	X	–	–
Risk allowance	X	X	–	–	–
AIDS treatment	X	X	X	–	X
Annual leave	X	X	X	X	X
Safer and improved supportive working environment/conditions	X	X	–	X	X
Regular promotion	–	X	–	–	–
Participatory personnel appraisal system	–	X	–	–	–
Recognition and respect	–	X	–	–	–
Assistance for child education	X	–	–	X	–

Sources: Ndetei et al, 2008; Munga and Mbilinyi, 2008; Masango et al, 2008; Chimbari et al, 2008

The country studies observed that incentives were not uniformly applied to all health workers, and did not always reach all in the target category. In Kenya, for example, the incentives mainly targeted nurses and doctors. In Tanzania, in July 2005, the government implemented a special accelerated salary package for health workers in the public sector and for seconded health workers working in district-designated hospitals (DDHs) and voluntary agency (VA) hospitals. In these examples, the gross salaries of the selected health workers were increased substantially, on average by 36%. Salary increases were 37% for medical doctors, 45% for assistant medical officers, 32% for clinical officers, 37% for nursing officers and 31% for pharmacists (Munga and Mbilinyi, 2008). In Kenya, junior cadres with basic qualifications are often posted to work in public facilities and district hospitals. Their salaries are low, they do not qualify for responsibility allowances, acting allowances, duty allowances, subsistence allowances or travelling allowances, and are not offered the incentives packages found at better-financed, central services. So, in effect, health workers in more remote areas get fewer financial incentives than more-qualified personnel in central level services, unless there are specific, additional provisions for those in peripheral services.

It is worth noting, however, that most of these countries do offer hardship allowances to their health workers, often to encourage workers to work in rural areas, although these incentives are low. For example, Tanzania offers a hardship allowance for workers in remote areas, as well as non-taxable allowances, for example, car allowances and overtime pay. Kenya's hardship allowance is available to members of staff who are stationed in the designated hardship areas, paid at the rate

of 30% of an officer's basic salary – yet this did not make much difference if the staff member's salary was low already. Zimbabwe offers a smaller rural allowance (10% of basic salary) for remote areas, while Swaziland offers nothing (Ndeti et al, 2008; Munga and Mbilinyi, 2008; Masango et al, 2008; Chimbari et al, 2008).

4.1 How effectively and equitably are incentives being implemented?

As in the four countries, the background review found that incentives in many countries are focused on a few cadres of staff, such as doctors for rural facilities in Zambia, nurse tutors in Malawi, or nurses and doctors in Botswana (Dambisya 2007a). This is understandable because of the (international) mobility of such staff, and the 'market clout' they tend to have in the various countries. However, it has also been found to undermine the 'health team' as a whole and create wider labour problems in the sector. For example, in Lesotho, initially only doctors received allowances for overtime/ night shift duty, and this practice demotivated other workers, until the allowances were extended to the other members of the team (Schwabe et al, 2004). Similarly, provision of free housing to expatriate doctors only in Botswana is a sore point for nationals who feel less valued (Tlhoiwe, 2004; Thula 2006a; Mokgeti 2006). In Tanzania, the application of SASE to top managers has had negative effects on the morale of other health workers (Kombo et al, 2003). While the studies raised caution about approaches that target specific groups, they also pointed to cadres that appear to have been excluded from incentive strategies, particularly those that work at community level, and that bridge to other actors that play a role in Primary Health care, such traditional health providers and community health workers.

The uneven application of incentives is not only a matter of policy, it often relates to the real situation of management authorities and decisions, and the resources available. In Tanzania all districts were found to receive money from central government. They also mobilise their own local resources through taxes, and obtain donor support from a consolidated pool of funds known as a basket fund. In all of these funding pools there is no specific budget vote for improving non-financial incentives. Further it is likely that if incentives are funded through local pooled funds rather than central allocations, they may lead to districts with higher levels of poverty (and health need) having lower levels of funds to finance incentives, exacerbating inequities. While the government, through its district councils, provides specific guidelines for improving some of the non-financial incentives, such as housing for senior officers, there is limited evidence of the extent to which resources are found to implement these in practice, and limited monitoring of whether spending these resources on the incentives provides an effective response to outmigration (Munga and Mbilinyi, 2008).

Perhaps the most clear expression of the influence of resource gaps in implementing incentives was shown in the Kenya and Zimbabwe studies in relation to the different application of non-financial incentives between different public, private not for profit and private for profit health institutions. In Zimbabwe, private sector and municipal health institutions were found to have better retention packages than central government health institutions, with evidence of some association with improved retention indicated by longer terms of employment in those with better packages. These parameters were not routinely monitored or evaluated across these different providers (Chimbari et al, 2008).

In Kenya, private sector health institutions were found to provide more comprehensive, transferable incentives than in public institutions, adding to the improved conditions often found in these services. In private-for-profit hospitals, mission hospitals and semi-autonomous government institutions, all hospital machines or equipments were found to be serviced and in working condition, with medical supplies available. Transport was made available to staff working late or odd hours or coming early on duty. In public institutions, equipment was not

always fully functional, stocks of available medical supplies were limited and support to health workers was significantly more limited if available (Ndetei et al, 2008).

The demand on health workers in public sector institutions was high and, as documented elsewhere, health workers are caught in the middle of high demand or need for public sector services in poor communities with greater levels of ill health and limited resources available to deliver these services. This inequity is reflected in workloads for health workers. For example, working hours in Kenya institutions varied greatly from institution to institution. In private and mission hospitals, staff worked 40 hours per week and, if on night shift (twelve-hour shift), they would work for two nights consecutively, then take the following two days to rest (off duty). In public institutions, staff had to work *four* nights before they received two days of rest. Workers who work extra hours in private and semi-autonomous medical institutions were compensated financially. Those working as locums in public medical facilities accumulate the extra hours and are awarded them as leave days. In contrast, workers at primary health care centres, despite their heavy workloads, are not compensated or recognised by their employers (city council). Health workers in the public sector had limited medical aid packages, which were only available for use within the public sector. Workers in private medical facilities were found to have unlimited out-patient and in-patients facilities and medical costs covered by insurance schemes that give them access to medical facilities in our outside their institutions or country Private and semi autonomous public institutions offered additional incentives, such as staff canteens, or bonuses and special awards to honour and recognise good service. While these incentives are all included in public sector policy, they were less observed in practice. It would thus appear that the *de facto* application of non-financial incentives in the sector as a whole is sometimes inverse to health need, workloads and policies for enhancing equitable access to health care. This calls for incentive strategies that take this existing inequity in resource flows into account, and that reinforce re-distributive policies in the health system (Ndetei et al, 2008).

The literature review by Dambisya (2007a) highlighted a range of approaches used in countries to introduce incentives:

- by first negotiating policy measures between government and trade unions (for example, in Mauritius) and integrating them with wider health sector development plans or medium-term development plans (for example, in South Africa, Lesotho, Malawi and Zambia);
- by collaborating with other sectors (for example, in Swaziland);
- by first consulting with other stakeholders, ministries, development partners and health workers before developing policies (for example, in Uganda); and
- by using experiences from other countries (for example, in Zimbabwe).

In Angola and Mozambique there were post-conflict human resources rehabilitation plans after the civil wars (Pavignani and Colombo, 2001), while both Malawi and Zambia had HRH emergency plans (Palmer, 2004; Koot et al, 2003). The Dambisya review noted that the processes and systems for introduction and management of incentives are important for outcomes and context dependent, and that these processes and capacities may be as important in successfully and sustainably managing migration as the design of incentives. It highlighted the fact that there is no 'one-size fits all' approach to health worker retention in the region, and the best retention strategies appear to be those that combine financial and non-financial incentives, based on sound data and supported by adequate financial resources and management capacities. These incentives should preferably evolve from consultation with key stakeholders and should be owned by the country, as opposed to being donor-driven, although external technical and financial resources may be used to support national plans. The presence of strategic planning and management capacity appears to be critical, given the complexity of the task and environment. In planning to introduce incentives, sustainability should be borne in

mind, as health workers may consider the withdrawal or termination of incentives as variations in conditions of service (Caffery and Frelick, 2006).

In Kenya, Tanzania and Swaziland, health worker retention incentives are managed, monitored and evaluated by the same management authorities that handle other aspects of health systems, namely departments at the Ministry headquarters, district officers or administrators at the provincial and district hospitals (physicians and nursing administrative officers) and heads of divisions in units.

However these structures do not always have the capacities, resources or authorities to properly implement these roles. The Tanzania field study, for example, showed major weaknesses in the implementation of the non-financial incentives that the country had put in place. Gaps occurred due to a shortage of funds and available staff to implement the strategies, including training strategies. Gaps also arose due to weak management capacities and practices, and the inability of districts to implement incentives like promotion as the recommendations are referred higher up and not implemented by clinic managers. More than 70% of the health worker survey respondents perceived available non-financial incentives as inadequate – not enough to motivate them and increase their productivity. Participatory mechanisms to discuss health workers' welfare issues, monitoring and evaluation and management styles were found to be weak, and existing feedback mechanisms were inadequate due to a lack of funds, equipment and transport (Munga and Mbilinyi, 2008).

In Zimbabwe, the Zimbabwe Health Services Board (ZHSB) was set up by Act of Parliament to separate health workers from the core public service and ministry of health administration, and to give greater flexibility in the management of HRH issues in the sector. This move has also been taken in other countries, such as the Malawi Health Services Commission (Palmer, 2004), the Zambia Central Board of Health (Martinez and Collini, 1999) and the Uganda Health Services Commission (Hutton, 2004). The ZHSB set up a strategic plan for 2005–2010 that provides a framework for monitoring and evaluating the incentives programme. Whereas these mechanisms are intended to cut bureaucratic red tape and ease processes such as hiring, their establishment may not be problem free. The Zambia board faced stiff opposition from health workers who preferred the public sector conditions of service (Martinez and Collini, 1999). The Zimbabwean study found that the ZHSB was not reaching its full potential, in part due to under financing, given the general economic situation in the country, and also due to lack of clarity regarding the division of authorities between it and other sections of government.

The information gathered and used to manage HRH was largely driven by routine administrative demands, and did not always yield information useful for strategic planning. For example, there was no evidence of use of evidence to monitor and assess impact of non-financial incentives as part of routine information. In Kenya, for example, managers monitored staff to ensure that job openings were filled expeditiously by promoting the most appropriate staff in accordance with career progression guidelines (including recognised qualifications, merit, ability, seniority and work experience). This action was partly intended to encourage health workers to further their careers, as successful completion of studies improves prospects for promotion, changes in job descriptions and movements higher in the salary scale. New information is continually added to the staff records, such as information on promotions, number of years served, positions held, any disciplinary measures taken against workers, any interdicts issued against them and any new qualifications (Ndeti et al, 2008). In Zimbabwe data is routinely gathered on appointments, resignations and retirement (Chimbari et al, 2008).

A major study limitation, reported in all countries, was that most record-keeping systems in the public sector services were still manual systems, and had not yet been upgraded to electronic

systems, which made retrieving information very difficult. Furthermore, there were no records demonstrating effectiveness of the implementation and monitoring of non-financial incentives, which meant that no impact evidences were available at the time of four studies (Ndetei et al, 2008; Munga and Mbilinyi, 2008; Masango et al, 2008; Chimbari et al, 2008).

There are proposals in the region to improve the quality of information for HRH planning through the African observatories, and several countries were found in the document review to have undertaken plans to establish human resource information systems (HRIS) (Dambisya, 2007b). By providing timely, proper and reliable data, HRIS makes it possible to plan for HCW requirements and, even more importantly, allows government to employ health workers and process their payments without delay (Perry, 2005; Ferrinho and Omar, 2006; Gilson and Erasmus, 2005; McQuide and Mattee, 2006).

The paucity of data made it difficult to assess the impact of the incentives applied in the four countries. The studies suggested, however, that there was no documented evidence on the impact of incentives on retention. Providing and analysing this evidence is important, as it will allow authorities to go beyond introducing retention incentives for their health workers to developing plans for their sustainability. This problem seemed to have received little attention, perhaps because most countries were dealing with a HRH crisis, often in a situation of wider economic uncertainty, and needed to address immediate political and policy needs, sometimes through increased external funding of incentives. All of this makes predictable, long-term planning a difficult, but the exercise is nevertheless necessary.

5. Conclusion and recommendations

5.1 Conclusion

There are a variety of non-financial incentives being introduced in ESA countries to motivate and retain health workers in the public sector. The strategies valued by health workers and authorities, and may well benefit communities when they also improve service quality. There has been a lot of focus on their design, and this is reflected in the common presence of policies and strategies incorporating incentives in all countries studies, and in the region more widely.

All four field studies found the non-financial incentives to be an appropriate response to the push factors for health worker movement, including poor work environments and conditions, poor communication resources at facilities and poor communication within the health system, inadequate management and supportive supervision, heavy workloads and inadequate recognition. Non-financial incentives are complementary to financial incentives, as they offer a means to addressing these factors. All studies indicated the presence of policies providing for non-financial incentives. What is of concern is implementation: how they are introduced, the reasons for and measures to address gaps in implementation, how they are managed, monitored and evaluated, and the systems and information needed to support implementation. This area needs more attention, from ensuring the effective performance of institutions and roles set up to manage HRH, to generating the information and processes needed to introduce them, assess their impact and to build trust and credibility around their application.

The studies indicated a need to intensify focus on issues of operationalising and implementing non-financial incentives: moving from inserting incentives in policies and strategies to ensuring their application across all providers; moving from focused application for specific cadres of health workers to sector wide application of incentives for all health workers and moving from experiments within the health sector to more sustained multi-sectoral policies that involve other sectors, including public service, finance, public works, education and housing.

In the countries of the field studies, the results were provided in separate reports (namely, Ndeti et al, 2008; Munga and Mbilinyi, 2008; Masango et al, 2008; Chimbari et al, 2008) and discussed with the relevant national authorities. Beyond these more general conclusions, a number of proposals were made for follow up for each of the four countries. In Swaziland, the researchers recommended comprehensive approaches to address retention, involving all stakeholders, backed by clear guidelines, and using coherent mechanisms and processes to plan, introduce and monitor non-financial incentives. These approaches call for collaboration between the Ministry of Health, employers and the training institutions to develop management training programmes. They also require harmonising terms and conditions of employment for the civil service to establish a uniform remuneration package for health workers in the public and semi-public sector and ensuring standardised management tools and appropriate systems for HR planning, management and information for HRH. Some specific issues were identified as needing attention:

- reviewing task allocation in light of high demand for healthcare vis-à-vis staff shortages;
- streamlining the operations of different government agencies to improve on the recruitment and deployment of health staff;
- developing health workers' retention package with clear cost implications;
- establishing systems for monitoring HRH performance and productivity; and
- developing a 'code of conduct' between government and development partners.

In Zimbabwe, proposals were made to apply retention strategies and incentives to all staff categories, given the tendency for staff at all levels to migrate, and to give the ZHSB greater decision-making latitude for introducing and managing health worker incentives. In Kenya, proposals were made for government to invest not only in its health workers but also in its facilities by ensuring regular medical supplies, upgrading facilities and improving working conditions in rural and poorer areas. A number of non-financial incentives were seen to be highly valued, including improved working conditions; training and supervision; and good living conditions, communications, health care and educational opportunities for workers and their families. It was noted that these incentives need to be more widely applied in the public sector, and greater attention should be given to tracking the implementation of retention policies across different providers. In Tanzania, the research team proposed that, while strategies for specific cadres and places need to be designed and implemented, this needs to be done in a manner that engages across sectors, given that the health sector is a part of the bigger social system. The researchers observe that costing studies are needed to ascertain the feasibility and sustainability of non-financial incentives, and that their introduction calls for improved health worker management styles under the ongoing decentralisation reforms. Managing both macro- and micro-structural factors (and not just individual preference structures as conceived in the pull and push factors framework), is essential if researchers are to provide workable policy recommendations for improved management of non-financial incentives.

The evidence presented reinforces the existing policy understanding of the crisis in human resources for health (HRH), reflected in inadequate numbers of critical health personnel, high levels of external and internal migration, poor distribution of staff in areas of high health need, low staff morale and some report of health worker abuse within the region. There has, until recently, been inadequate attention given to systems planning and many ministries of health lack information systems and management capacities to plan responses. Fiscal thresholds have diminished state leeway to increase health worker employment in some of the countries. Underlying this, delegates recognised the critical contribution of economic decline and political instability as factors driving out-migration of health workers. The 2005 SADC health ministers meeting identified non-availability of skilled health professionals in member states as undermining achievement of key Millennium Development Goal targets.

At the same time, opportunities exist in the political and policy recognition of the crisis at national, regional and international level, in the capacities for training in the region, in the availability of significant global and international resources for systems strengthening, and in numerous examples of good practice from within the region. Tapping these opportunities and improving the health worker situation depends fundamentally on improving the economic conditions and political stability of countries in the region.

The country studies demonstrate that, beyond salaries, the push factors for health worker movement commonly include poor work environments and conditions, poor communication resources at facilities and poor communication within the health system, inadequate management and supportive supervision, heavy workloads and inadequate recognition. HRH policies and a number of non-financial incentives are being applied across all countries, but gaps exist with respect to implementation, monitoring and evaluation, sector-wide vs cadre-specific non-financial incentives, and the impact assessment of the incentives.

The country studies indicate a need to intensify focus on issues of operationalising and implementing non-financial incentives sector wide, taking the influence and role of other sectors beyond health –including public service, finance, public works, education and housing – into account.

5.2 Policy recommendations

The results of the work were reviewed at a regional meeting that was convened on 25-27 February in Windhoek by EQUINET and ECSA-HC, hosted by the University of Namibia in co-operation with TARSC and University of Limpopo, to review the findings from this body of work and to explore the implications for policies and measures aimed at valuing and retaining health workers in ESA, develop proposals and guidelines for policy and action relevant to health worker deployment and retention, and identify knowledge gaps for follow up work.

In line with the ECSA Health Ministers Conference (HMC) resolutions 2006–2008, the SADC Resolutions on Health workers, and the ECSA and SADC strategies on health workers, the meeting reviewed evidence from the regional review papers, country field studies and delegate experience to propose areas for policy, guidelines and research on health worker retention, especially in priority health services. The meeting noted that producing and retaining health workers is a priority for addressing the health worker crisis, within the context of national health strategic plans and strengthened HRH planning, information and management that addresses HRH demand and supply. The meeting proposed a number of policy options for strengthening HRH retention:

- Retention packages should preferably be applied across the whole health sector, based on needs assessment and inter-sectoral and stakeholder input. They should be costed and supported by an HRH monitoring system and sufficient institutional capacity to manage the incentives.
- HRH policies should aim to build cohesive and functional health teams, respect health workers rights and responsibilities towards patient and community rights, with clear and comprehensive regulatory frameworks.
- Non-financial incentives valued by workers across most countries include: career paths; stimulating training and encouraging deployment through investment in services (including 'centres of excellence'); providing housing mortgages / loans; rewarding performance; and securing health worker health and access to health care. Delegates proposed that these incentives be considered as core retention strategies that are applied across all countries, even while further locally relevant strategies are considered.

- Training should be in line with labour market demands and support career guidance programmes, to guide proper selection of training courses.
- Retention strategies should be regularly reviewed and stakeholders informed about the progress and impact of incentives.

HRH retention strategies can be financed in a number of ways. Governments must increase budgets for health to meet the Abuja commitment of 15% government spending on health, and encourage donors to pool funds into sector-wide incentive schemes for HRH. Financing schemes for HRH should be owned by countries, aligned with countries' needs (through needs assessments), strategies, systems and procedures, and external funder actions harmonised with national plans, with issues of governance and management addressed where external funds are reported through existing local financing systems. Sustainability of resources for HRH incentives needs to be addressed in each country's national strategic plan, including provision for transfer of skills and knowledge to local personnel. Countries and regional organisations need to enhance coordination at regional and country level to increase effectiveness of development aid, and SADC should adopt a common position, or draft guidelines, on externally funded projects based on the five principles of the Paris Declaration on Aid Effectiveness.

To strengthen health systems so that HRH retention incentives can be effectively implemented, the following steps can be taken:

- training of health workers in use of healthcare management tools (standards, guidelines);
- strengthening institutional capacities for improved governance and delegating more power and authority to and capacitating the district level of health systems;
- developing and/or reviewing staff development policies to address current issues relating to training, promotion, career paths and other incentives; and
- establishing or improving performance management systems with clear-cut rules of performance and independent evaluations.

Delegates proposed that a network of HR professionals be formed in the region, including HRH management and research personnel, with provision for annual meetings for information and professional exchange.

In addition to retention incentives the meeting reviewed evidence and proposed policy options for strengthening the effective performance of HRH in relation to primary health care and ethical migration that are captured in the meeting report (EQUINET et al, 2009). The meeting identified areas and recommended work at regional level to develop guidelines to support health systems responses on HRH:

- to support the development of, and analysis of, data from information systems for planning, monitoring and evaluation, including indicators on: reasons why staff are leaving; resignations; infrastructure; basic resources; types of non-financial incentives, target groups; funding agents; and sustainability; and the perceived effectiveness of incentives;
- to introduce, manage, monitor and evaluate non-financial incentives (including on nature and purpose of the incentives; beneficiaries; and funding of incentives); and
- to support the sustainability of financing schemes for HRH and the management of external funds for HRH, including in terms of capacity building (such as training, knowledge transfer, mentoring, under-studying and systems building); remuneration; ethical recruitment; and the relevance and appropriateness of technical assistance.

5.3 Recommended areas for follow-up research

A number of areas have been identified by stakeholders in the region, through the regional meeting, as knowledge gaps meriting further audit or research specifically in relation to retention incentives:

- Monitoring and evaluation systems need to be strengthened to allow the analysis of primary data on different dimensions of migration and retention, including numbers of migrating professionals; out-migration to other sectors (with destinations and motivations); migration and return intentions and motivations; remittance flows; and training capacities in countries by cadre.
- Evidence is needed to inform our understanding of the 'stay' factors of health workers who remain in their posts (such as support for own housing) to better integrate these factors in HRH policies and programmes.
- A cost-benefit analysis should be conducted for non-financial incentives to assess their sustainability and impact on retention and to further explore career path strategies (including training, promotion and education qualification systems).
- An assessment should be made of the impacts of migration on health systems and the performance of retention incentives on health and health care outcomes.

These areas may be added to research priorities identified on other aspects of HRH, including studies that assess the role of externally financed programmes and measures in HRH strategies, the role of community health worker schemes and the practices around task shifting as examples of strategies for responses to health worker shortfalls. In all of these issues, there is need for an equity lens, to assess whether or not the resources applied are reaching communities with the greatest health needs.

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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