

**Regional Network for
Equity in Health in east
and southern Africa**

**DISCUSSION
Paper
NO. 68**

Retention strategies for Swaziland's health sector workforce: Assessing the role of non-financial incentives

**Sidumo Masango, Kamanja Gathu,
Sibusiso Sibandze**

University of Swaziland with the Swaziland Ministry
of Health and Social Welfare

Regional Network for Equity in Health in east and southern Africa
(EQUINET) in co-operation with the East,
Central and Southern African Health Community (ECSA-HC)

EQUINET DISCUSSION PAPER 68

December 2008

with support from SIDA Sweden

Valuing and Retaining our Health Workers



**Regional Network for
Equity in Health in east
and southern Africa**

DISCUSSION

Paper
NO. **68**

Retention strategies for Swaziland's health sector workforce: Assessing the role of non-financial incentives

**Sidumo Masango, Kamanja Gathu,
Sibusiso Sibandze**

University of Swaziland with the Swaziland Ministry
of Health and Social Welfare

Regional Network for Equity in Health in east and southern Africa
(EQUINET) in co-operation with the East,
Central and Southern African Health Community (ECSA-HC)

EQUINET DISCUSSION PAPER 68

December 2008

with support from SIDA Sweden

Valuing and Retaining our Health Workers



TABLE OF CONTENTS

Executive summary	3
1. Introduction	6
2. Methods	8
3. Results	12
3.1 Document review	12
3.2 Survey questionnaire	13
3.3 Predicting future levels of health worker retention	19
3.4 Focus group discussions	20
3.5 Non-financial incentives recommended by FGD participants	24
4. Discussion of results	27
5. Conclusion and recommendations	33
5.1 Recommendations	34
References	38
Acknowledgements	41
Acronyms	42

Cite as: Masango S, Gathu K, Sibandze S (2008) 'Retention strategies for Swaziland's health sector workforce: Assessing the impact of non-financial incentives,' EQUINET *Discussion Paper Series 68*. EQUINET, ECSA-HC: Harare.



EXECUTIVE SUMMARY

Retention strategies for Swaziland's health sector workforce: Assessing the role of non-financial incentives

Swaziland faces an exodus of professionals from its health sector to other countries, leaving staff and skills shortages in the country. Urgent measures are needed to address this 'medical brain drain'. One such measure is providing incentives for workers to remain in their jobs instead of leaving.

This country study in Swaziland thus sought to map and assess incentives for retaining health workers, particularly non-financial incentives. Specifically it sought to identify existing policies and measures for incentives for retention of health workers, their relevance to current factors driving exit and retention, and propose inputs for guidelines for introducing and managing incentives for health worker retention to maximize their positive impact. It specifically focused on non-financial incentives. It was implemented with the programme of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) in co-operation with the Regional Health Secretariat for East, Central and Southern Africa (ECSA-HC) on health worker retention and migration.

A desk review of available literature was conducted first, followed by a field study using both quantitative and qualitative research methods. The review consisted of a content analysis of the available documents for each organisation based on the pre-defined set of questions with respect to human resources in the field of health care. Nineteen documents were reviewed in this analysis. A survey of 160 frontline healthcare staff was implemented through a random sample of public and private health facilities in Swaziland between March and April 2008, including four major public hospitals and four major private hospitals were randomly selected (each representing an administrative region), as well as eight health centres (four private health centres and four public health centres) and ten clinics (five public clinics and five private clinics) from each of the four regions of the country. The questionnaires were primarily self administered. Focus group discussions were carried out with a sub-sample of front-line health workers and supervisors; and semi-structured interviews with senior managers from the health regions, as well as representatives of regulatory agencies, professional associations and unions.

The desk review found that only one of the 19 documents referred explicitly to non-financial incentives, namely training and professional development, supervision schemes (supportive supervision and feedback) and staff welfare support (medical aid), but did not give details on how these could be achieved.

Data from the questionnaires was analysed according to eleven variables: job satisfaction, attitude towards your institution, promises, equality, basis of leaving intentions, welfare, sources of anxiety, support, job discretion, workload, helping others.

An analysis of exit intentions by these variables was implemented to find out why health workers choose to leave their jobs. This showed that a workers' attitude towards their institution and how much support they received were the two main variables influencing a worker's decision to leave. Six factors significantly influenced decisions by health care professionals to either change institution or to actively look for a different institution in the next year: Factors positively associated with retention were job satisfaction, equality/treatment by employer, job discretion and helping others. Factors negatively associated with retention were the employee's attitude towards their institution and support.

Our retention analysis evaluated the reasons why employees would consider staying in their current jobs and six factors were also identified: job satisfaction, the employee's attitude towards their institution, their welfare, sources of anxiety, support, and job discretion.

Job discretion has a direct association with *both* exit intentions and retention. It is argued that the end result of high levels of workplace participation and expectation is likely to be gradual work intensification, job insecurity and work stress. If job discretion can contribute to both job retention and intention to leave, it needs very specific attention in retention strategies so that it is properly attuned and regulated.

The prediction analysis, which was intended to predict future levels of health worker retention, indicated that about 65% of health staff in Swaziland are likely to look for alternative employment in the near future (at least in the next year), and about 35% are likely to remain in their jobs; 97% will not be at all interested in staying for whatever reason.

The focus group discussions highlighted both internal and external migration of health care professionals. Professionals were reported to move from government health facilities to private hospitals or from mission health facilities to government facilities because mission hospitals and clinics have fewer non-financial benefits compared to those in government.

The focus group discussions revealed that many factors lead to attrition. Higher pay was not the singular cause, and lack of non-financial incentives was commonly raised, including poor working conditions, poor or a lack of supervision, lack of recognition for workers' achievements and non-work-related push factors such as lack of transport and poor accommodation.

There was a general consensus that, since professionals migrate because of the non-financial benefits offered, the government needs to develop guidelines for the package that should be made available to health care professionals, whether in government, mission or private hospitals. Participants felt strongly that there was a need to re-examine the way in which the Ministry of Health and Social Welfare was operating as there were inefficiencies contributing to the demoralisation of health workers.

Given that job satisfaction, the employee's attitude towards their institution, their welfare, sources of anxiety, support, and job discretion are factors in retention, what can be done to strengthen the incentives for this? The research team made a number of recommendations to improve retention through offering improved non-financial incentives, drawing particularly from the focus groups discussions. Incentives schemes should focus on terms of employment and working conditions, career path and welfare, as well as improvements in management systems. Such incentives schemes can usefully include job security, pay equity, housing, moving expenses or signing bonuses, opportunities for career development and paid time off for professional development. Institutions need to avoid extremes of skill and job discretion. Terms of employment could be negotiated to provide monetary incentives for work on weekends and/or nights and health institutions should encourage staff to take their daily meal breaks and their full annual leave entitlement, to avoid stress due to long hours. Health providers should obtain the necessary support and equipment to do their jobs, both clinical and clerical. As much as possible, tasks relating to clerical or maintenance work should be done by non-clinical staff.

Health institutions need to show employees they are valued, to treat them with respect as professionals. This includes involving front-line staff in planning and decision-making and creating and supporting opportunities for professional development and growth. It is recommended for example that a formalised system of peer support be established for occupational therapists, physical therapists, and community health nurses, including regular case conference consultation with teams of providers as well as regular continuing education conferences. Programs to teach skills to younger, less experienced health providers can also be a tool to gauge their coping skill as they are at a higher risk of developing compassion fatigue. This calls for appropriate management tools, including supervision, feedback, staff appraisals, staff satisfaction surveys, clear leadership and guidance, clear organisational objectives and missions, and staff participation mechanisms (including staff meetings), adequate training, as well as self assessments. The Ministry of Health and Social Welfare must assist regions and their affiliates to develop strategies for keeping employees. This includes holding managers accountable for retention; having a mechanism for identifying high-potential employees; and building across the system a clear understanding of the needs and values of employees.

1. INTRODUCTION

Swaziland's 2007 Health Policy states that the Ministry of Health and Social Welfare seeks to improve the health and social welfare of the people of Swaziland by providing high-quality preventive services that are relevant, accessible, affordable, equitable and socially accountable. Its main objectives are to:

- reduce morbidity, disability and mortality due to diseases and poor social conditions;
- promote effective allocation and management of resources for the health and social welfare sectors; and
- reduce the risk and vulnerability of the country's population and mitigate the impact of social welfare problems (Ministry of Health and Social Welfare Government of Swaziland 2007).

The second objective listed above requires the Ministry to develop a sectoral human resource policy and plan to address human resource issues and, in collaboration with central agencies, periodically review staff establishments at all levels to effectively respond to emerging health challenges. Qualified and motivated health workers are essential for adequate health service provision, but health worker shortages have now reached critical levels in many resource-poor settings in the country, especially in rural and remote areas. Swaziland faces severe shortages of skilled personnel across all sectors, especially in health, with many doctors, nurses, laboratory technicians and social workers emigrating to high income countries (UNAIDS, 2006). Strategies for improving motivation, satisfaction and performance are essential to address shortages in the existing workforce. This includes offering non-financial incentives to health workers to encourage them to remain in their jobs (WHO, 2006). The application and effectiveness of these non-financial incentives forms the focus of this paper.

For Swaziland, like many other developing countries, to achieve the Millennium Development Goals (MDGs), calls in part for effective use of all available resources, including human resources. Many countries are improving their short and medium term financial planning and budgetary processes. Few, however, have made similar improvements in their human resource planning, despite the importance of skills and personnel to improved education and health services that reach poor communities. Indeed, a growing crisis in the numbers and distribution of health workers led the Regional Network for Equity in Health in East and Southern Africa (EQUINET), through the Health Systems Trust (HST), the University of Namibia and Training and Research Support Centre, and in co-operation with the Regional Health Secretariat for East, Central and Southern Africa (ECSA-HC) to explore how to address this constraint to equitable health

systems. Towards this EQUINET and ECSA-HC held a regional meeting in Arusha Tanzania in March 2007, bringing together researchers, country programme managers, health worker associations, regional and international agency personnel and other relevant stakeholders (EQUINET et al, 2007).

Arising from the identified priorities and knowledge gaps, the joint EQUINET/ ECSA-HC programme supported member countries (including Swaziland) in conducting research on health worker retention and migration to promote evidence-based best practices. One focus of this was to assess the effectiveness of non-financial incentives for retention of health workers and for managing health worker migration. The Swaziland Ministry of Health and Social Welfare (MoHSW) participated in this.

An emphasis on strategies based on non-financial incentives is warranted, as previous studies suggest that improving financial incentives in resource-poor countries does not alone stem the loss of health workers (Buchan and Calman, 2004). For example, in 2004, the Swaziland government increased salaries for health professionals by about 60%, but health worker migration continued unabated. South African health professionals have been found to be more likely to emigrate than their counterparts in Uganda, even though they are higher paid (Lehmann and Sanders, 2004).

The factors contributing to the high turnover of staff are likely to be inter-related and dependant on the political, socioeconomic and cultural environment. They are probably rooted in both personal and work-related factors, so that retention strategies must address these multiple causes simultaneously. Interventions must take place at:

- macro-level (or health system level) in the form of health worker policy and planning, rural recruitment and training and bonding systems; and
- micro-level (or facility level) by increasing workers' job satisfaction, improving working conditions, providing incentives and offering professional development.

Interventions can also aim to improve the living conditions of individual workers, or address the needs of specific groups (Dieleman and Harnmeijer, 2006).

This country study in Swaziland thus sought to map and assess current incentives and propose new incentives for retaining health workers, particularly non-financial incentives. Specifically it sought to identify existing policies and measures for incentives for retention of health workers, their relevance to current factors driving exit and retention, and propose inputs for guidelines for introducing and managing incentives for health worker retention to maximize their positive impact.

2. METHODS



A desk review of available literature was conducted first, followed by a field study using both quantitative and qualitative research methods. The desk review was conducted prior to the execution of the field studies to assess whether the health sector stakeholders (government and collaborating organisations) had non-financial incentives for health sector staff that were documented in any of their policies or guidelines or plans or other documents (published, white or grey). The review consisted of a content analysis of nineteen available documents for each organisation based on an identified set of parameters with respect to the objectives above. The study complemented this desk review with original data collection from:

- i. A survey of frontline healthcare staff in a random sample of public and private health facilities in Swaziland between March and April 2008, primarily through self administered questionnaires drawn from all regions of the country.
- ii. Focus group discussions with a sub-sample of front-line health workers and supervisors; and
- iii. Semi-structured interviews with senior managers from the health regions, as well as representatives of regulatory agencies, professional associations and unions.

The questionnaire for this study was adapted and modified from Graffam and Noblet (2005) to measure pertinent dimensions in health care human resource administration, staff retention and motivation factors. The questionnaire contained a standard set of socio-demographic and job-related questions about each respondent's age, sex, position, years of experience and department. Questions addressed intrinsic and extrinsic motivators. While the study focused on non-financial incentives, financial incentives were also incorporated in the instrument to assess their relative role in relation to non-financial incentives. A structured questionnaire was used for ease of completion, to reduce the time burden on the subject and facilitate objectivity and quantitative analysis. In the initial stages of the research, forty completed questionnaires were tested for reliability and summated scales were created for the thirteen sections of the questionnaire (with each section qualifying as a factor influencing retention). Summated scales require a specific reliability criterion (Cronbach's alpha > 0.70) and eleven of the factors met the criterion, with the exception of welfare and promises (see *Table 1*).

Table 1: Reliability assessment of factors influencing retention in this study

Factors influencing retention	Cronbach's alpha (> 0.70 meets the reliability criterion)
Job satisfaction	0.963
Attitude towards your institution	0.897
Promises	0.222
Equality	0.923
Future intentions	0.904
Reasons for staying	0.874
Basis of leaving intentions	0.858
Welfare	0.325
Sources of anxiety	0.925
Support	0.847
Job discretion	0.748
Workload	0.708
Helping others	0.836

Retention strategies for Swaziland's health sector workforce: Assessing the role of non-financial incentives

Multistage sampling was carried out of tertiary, secondary and primary health care facilities.

Three phases were implemented for this:

- i. **A list of health institutions was compiled:** We searched the Ministry of Health and Social Welfare database to obtain:
 - the number of health facilities in both public (governmental) and private (non-governmental or for-profit) sectors; and
 - a detailed (but brief) description of each of the facilities, as well as the overall context of health care provision.

- ii. **A Random stratified sample was selected of the health facilities:** To support generalisations and increase precision of our estimates we stratified health care facilities according to three criteria:
 - the type of facility (hospital, health centre, public health centre or clinic);
 - the sector to which facility belongs (public or private); and
 - the location of the facility (rural or urban).

The health facilities within strata were then randomly selected—four major public hospitals and four major private hospitals (each representing an administrative region), as well as eight health centres

(four private health centres and four public health centres) and ten clinics (five public clinics and five private clinics) from each of the four regions of the country.

- iii. **Health sector personnel were sampled (target population):** We used a quota sampling method with each research assistant being given a quota of employees to interview and told to ensure that all possible cadres were represented in the sample. Due to work commitments, respondents opted to complete questionnaires on their own and assistants collected them later. The study collected 160 staff responses to the questionnaire from all the earmarked facilities from all regions. The representation of staff from facilities is presented in *Table 2*, which excludes three missing cases (due to non-response on this item).

Nearly three quarters (73%) of respondents came from the public sector and almost half were from hospitals. Most of the respondents that participated in the study were nurses (51%), of whom 86% and 14% were from public and private institutions respectively. Technicians made up 15% of all respondents and medical doctors (including dentists) comprised 6%. This distribution was a result of the proportionate sampling used, with Swaziland's health sector dominated by nurses and technicians.

Table 2: Number of respondents by type of facility and sector for this study, N=160

Types of facilities	No. of respondents in public sector	% in public sector	No. in private sector	% in private sector	Total no. of respondents	Total % of respondents
Hospital	49	30.6	26	16.3	73	45.6
Health centre	15	9.4	2	1.3	17	10.6
Clinic	40	25.0	12	7.5	52	32.5
Other	11	6.8	4	2.5	15	9.4
Total	115	71.8	42	26.3	157	98.1 (i)

(i) 3 respondents did not respond to this item

The sample of 160 was analysed as a whole. The thirteen non-demographic sections of the questionnaire were grouped as factors that were analysed through principal component analysis. Summated scales/scores were calculated from the indicators of each factor, averaging the scores on all

the variables loading on a factor/component to create the score for the factor. Reliability of the summated scales was assessed using Chronbach's alpha as in *Table 1* above.

Descriptive analysis formed the first step of the analysis, where the means for each factor was calculated. The analysis was taken further by developing a generalised linear model (GLM) to assess the impact of the human resource factors on two response variables to assess the impact of the retention strategies:

- future exit intentions (likely to leave = 1 and unlikely to leave = 0) and
- reasons for staying (ordinal scale ranging from 1 to -5).

The variable for future exit intentions was dichotomised so that likert scale points were 1–3 = 0 and 4–7 = 1, and the four answers of 'unsure' were omitted to avoid non-sampling errors (central tendency response bias). For the reasons to stay factor as a response variable, ordinal logit regression model was fitted and the future exit intentions a binomial logit regression model was built.

In the focus group discussions (FGDs), we obtained information on:

- levels of job satisfaction of the health workers;
- possible retention strategies for Swaziland's health care system; and
- possible motivation strategies for the workers.

Where possible, we used the data obtained from the FGDs to propose guidelines for introducing and managing non-financial incentives for health care workers in order to improve the retention of the workers and maximise their impact in health care delivery. The FGDs were meant to provide an opportunity for the target sample of front-line health workers and supervisors to interact to generate information that could be used to identify incentives for the retention of health care workers, particularly the non-financial incentives. Three FGDs were planned: one with the health care workers, one with supervisors and managers of health care facilities, and one with union officials and representatives of professional associations. Due to time constraints and unavailability of the respondents whenever meetings were scheduled, however, only two FGDs were finally held. One FGD was convened for the managers and supervisors of the health care facilities, while the other FGD was organised for the healthcare professionals. Participants for the two FGDs were drawn from government health care institutions, mission health care institutions and from private health care institutions. According to the National Health Policy (2007), health service providers in Swaziland include government, religious organisations (mission), industry, and private practitioners.

3. RESULTS



3.1 Document review

Nineteen documents were reviewed according to the relevance of their content, namely those regarding health worker shortages and other problems. The questions we used to establish the relevance of the documents are shown in *Tables 3 and 4*, which list documents according to their nine authors and the figures in each row represent the number of documents that answer yes to the question.

Only twelve of the nineteen documents (63%) actually made it clear how health worker issues would be addressed. Seventy-nine percent, 53%, and 84% of the documents addressed health worker issues at national (macro), facility (micro), and individual levels respectively (See *Table 3*)

Table 3: Documents referring to macro-, micro- and individual levels of health care, N=19

Author	Macro-level (national level)	Micro-level (facility level)	Individual level
World Health Organisation (WHO)	1	1	1
United Nations Children Funds (UNICEF)	2	2	1
UNFPA	2	3	3
Elizabeth Glaser Paediatric AIDS Foundation	2	0	1
Ministry of Economic Planning and Development	2	1	2
Ministry of Public Service and Information	2	0	4
United States Embassy	1	1	1
European Union	1	1	0
Ministry of Health and Social Welfare	2	1	3
Total	15 (79%)	10 (53%)	16 (84%)

Looking at the issue of health objectives, the picture is much the same. Thirteen (68%) of the documents referred to at least one objective with a health worker component. Ten (53%) documents offered some clarity about how the health worker component would be achieved, while seven (37%) documents referred to civil service reform. In seven documents, civil service reform was linked to strengthening the management of health workers and meeting their needs better.

With regard to non-financial incentives, only 31% and 26% of the documents refer to staffing levels and sustainability of objectives respectively (which includes non-financial incentives), but it is striking that only one document referred explicitly to non-financial incentives, namely training and professional development, supervision schemes (supportive supervision and feedback) and staff welfare support (medical aid) (See *Table 4*).

3.2 Survey questionnaire

Females constituted 68.8% of the respondents to the survey, while 29.4% were males, and non-response was 1.8%. Most participants were between 20 and 50 years old: 22.5% were from the 21–30 age group, 36.3% were 31–40 and 26.3% were 41–50. Eighty-seven-and-a-half percent were employed full time, with 1.3% part-time/casual, 8.8% contract personnel and 2.5% non-respondents. Sixty-eight percent had worked in the health sector for over seven years, of which 46.3% had been working in their current institution during that time. Sixty-four percent were receiving fringe benefits at the time of the study.

Table 4: Criteria used to determine relevance of documents in the document review for this study

Criteria	Authors of documents											Total no. of documents	% of total documents
	WHO	UNI CEF	UN FPA	EG PAS	ME DP	MO PSI	USA	EU	MOH SW				
Does the document refer to health worker problems in health or offer health worker solutions?	1	2	3	2	1	5	1	1	3			19	100%
Does it go further by describing how such improvements can be implemented?	1	2	2	1	1	1	1	1	2			12	63%
Within the health objectives, does it include a human resource component?	1	1	2	1	0	4	0	1	3			13	68%
Is it clear how the health worker component is going to be achieved?	1	1	1	1	0	2	0	1	2			10	52%
Is civil service reform mentioned?	2	0	0	2	0	1	1	0	1			7	36%
Does it link civil service reform to strengthening health worker management?	2	0	0	2	0	1	1	0	1			7	36%
Is it likely to help human resource problems in health?	2	0	0	2	0	1	1	0	1			7	36%
Does it refer explicitly to non-financial incentives?	0	0	0	1	0	0	0	0	0			1	5%
Does it refer to staffing levels?	0	0	1	1	0	1	1	1	1			6	31%
Is sustainability mentioned (including non-financial incentives)?	0	0	1	1	0	2	0	0	1			5	26%

Table 5 below shows the average scores for each variable by sector (private and public) and gender of respondents (see Table 5).

Table 5: Variables influencing health worker retention in Swaziland, 2007

Variables influencing health worker retention	Score range	Null mean	Public sector	Private sector	Male	Female	Total
Level of job satisfaction	1–7	4	3.9	3.3	3.8	3.7	3.7
Employee's attitude towards their institution	1–5	3	3.8	4.0	3.9	3.8	3.8
Promises	1–5	3	2.9	3.0	2.8	3.0	2.9
Equity	0–5	2.5	2.5	2.8	2.3	2.7	2.6
Future intentions	0 and 1	0.5	0.6	0.6	0.6	0.6	0.6
Reasons for staying	1–5	3	2.8	3.1	2.7	3.0	2.9
Basis of leaving intentions	1–5	3	3.2	3.3	3.3	3.2	3.2
Welfare of health worker	0–3	1.5	1.4	1.4	1.3	1.5	1.4
Sources of anxiety	1–5	3	2.9	2.5	2.7	2.9	2.8
Support	7–1	4	5.0	4.8	4.7	5.1	5.0
Job discretion	1–5	3	4.0	4.0	3.9	4.1	4.0
Workload	1–5	3	2.4	2.6	2.5	2.4	2.4
Desire to help others in need	1–7	4	4.7	4.8	4.5	4.8	4.7

(Scores to 1dp)

Retention strategies for Swaziland's health sector workforce: Assessing the role of non-financial incentives

As can be seen from *Table 5*, the average health worker, whether male or female, or from private or public, is moderately satisfied with their job, as the means are within the 3–4 range. However, about 60% of health staff intend changing their jobs. Their below-average perceptions may be attributed to factors related to: promises, reasons for staying, workload, sources of anxiety, and welfare. Descriptive analysis lays the groundwork for further analysis, hence, these factor averages (means) are utilised in later statistical predictions. The major determinants of staff retention or staff exit intentions can justifiably be evaluated by utilising explanatory procedures (modelling).

3.2.1 Why health workers choose to leave their jobs: Exit analysis

A logit regression model was run with future exit intentions being the response factor with two dichotomous categories (likely to leave = 1 and unlikely to leave = 0). The predictors of the model were all the factors measured by the questionnaire, except the ‘reasons for staying’ variable, which is divergent from future exit intentions and is a response factor in its own right. A breakdown of the analysis is provided in *Table 6*. The objective of our analysis was to evaluate the factors that significantly influence health workers in their decision to change jobs, and also to predict the likelihood of their actively looking for another job in the year following the study.

According to the p-values from *Table 6* (p-values less than 0.05 or 0.01 level of significance), there are six factors that significantly influence the decision by health staff to change jobs or actively look for a new job in the following year: job satisfaction, employee’s attitude towards their institution, equality, support, job discretion, and the desire to help others in need.

If an employee’s job satisfaction score increases by one unit in its seven-point scale (ranging from 1 = extremely satisfied to 7 = extremely dissatisfied), the odds of being likely to change jobs in the next year (with other factors constant) increases by a factor of 1.66, increasing their odds of leaving by 65.8%. Employees’ attitudes towards their institutions were measured on a five-point scale (ranging from 1 = strongly disagree to 5 = strongly agree), and were noticeably negatively correlated to future intentions, as shown by the z-statistic in the table. An increase of one unit with regard to an employee’s attitude towards their institution (with other factors constant) decreases their odds of intending to leave by a factor of 0.29; in other words, the odds are significantly reduced by 70.3%. For the equality variable, an increase of one unit increases odds by 48.3%, support decreases odds by 52% and job discretion (which is on the same scale) increases odds by 79.7%. Helping others is on a seven-point scale and also positively correlated with future intentions to change institution, as an increase of one unit raises the odds of changing by 10.6%.

Table 6: Exit analysis of workers who are considering changing jobs in the year ahead, 2007

Future exit intentions (Y)	Odds ratios	95% confidence interval		% change in odds	'z-value	'p-value ['p > z]
		Lower	Upper			
Job satisfaction	1.66	1.08	2.54	65.8	2.32	0.02
Attitude towards your institution	0.3	0.19	0.47	-70.3	-5.07	0
Promises	0.91	0.47	1.75	-9.1	-0.029	0.776
Equality	1.48	1.39	1.58	48.3	11.91	0
Basis of leaving intentions	0.92	0.81	1.04	-8.2	-1.32	0.186
Welfare	1.33	0.94	1.87	32.6	1.61	0.108
Sources of anxiety	0.98	0.34	2.73	-2.5	-0.05	0.962
Support	0.47	0.32	0.70	-52.6	-3.80	0
Job discretion	1.8	1.42	2.27	79.7	4.90	0
Workload	0.73	0.30	1.72	-27.1	-0.72	0.471
Helping others	1.11	1.01	1.20	10.6	2.4	0.016

An employee's level of job satisfaction and their attitude towards their institution tend to influence future exit intentions considerably more than the other four influential factors.

Adjusting for variation between private and public health staff revealed three more factors that influence future exit intentions that is job discretion, support and helping others. Adjusting for variations in experience of health workers reveals four notable factors influencing exit intentions, i.e.: job satisfaction, attitude towards your institution, equality, and support. Gender clustering depicts three significant factors, which are: attitude towards your institution, equality, and support. Otherwise without any clustering adjustment to the model for the background variables, only two significant factors suffice, namely, attitude towards your institution and support.

These results seemingly signify that attitude towards institution and support are more all-encompassing than the other major factors. When the model is adjusted for gender clustering, equality becomes prominent, signalling that males and females have significant differences in how they see their institutions' fulfilling promises to staff.

3.2.2 Why health workers choose to remain in their jobs:

Retention analysis

Although it was vital to evaluate factors that influence or may influence the future exit intentions of health staff from institutions, it was equally important to examine factors that influence the retention of staff in these institutions. We ran an ordinal logit regression model that also adjusted standard errors for clustering on health facility sector and omitted the 'leaving intentions' variable. The response factor is the 'reason for staying' variable, which was measured on a five-point scale, hence ordinal logit regression (see *Table 7*)

Table 7: Retention analysis of workers who are considering remaining in their jobs in the year ahead (2007)

Future exit intentions (Y)	Odds ratios	95% confidence interval		% change in odds	'z-value	'p-value [$p > z $]
		Lower	Upper			
Job satisfaction	0.60	0.43	0.85	-39.5	-2.94	0.003
Attitude towards your institution	1.28	1.1	1.49	28.2	3.26	0.001
Promises	1.10	0.66	1.83	9.9	0.36	0.717
Equality	1.09	0.97	1.23	9.1	1.48	0.138
Welfare	1.64	1.41	1.89	63.7	6.6	0
Sources of anxiety	1.32	1.13	1.54	31.6	3.45	0.001
Support	2.31	2.3	2.33	131.3	3.47	0
Job discretion	2.22	1.42	3.49	122.3	3.47	0
Workload	1.17	0.55	2.47	17	0.41	0.681
Helping others	1.02	0.82	1.25	1.6	0.15	0.883

Our retention analysis shows that job satisfaction negatively influences an employee's decision to remain in their job because an increase in one unit in

its score (with other factors constant) decreases the odds of remaining by a factor of 0.6, representing a 39.5% decrease. Conversely, an increase of one unit in the variable 'employee's attitude towards their institution' increases their odds of staying by a factor of 1.28, amounting to a 28.2% increase. An increase of one unit in the 'support' variable increases the odds of an employee remaining by a highly significant factor of 2.31 (131.35%), while job discretion is also significant, as an increase in one unit increases the odds of staying by 122.3%. Job discretion tends to affect both future exit intentions and reasons for staying in the same direction (positively), but it is more relevant to retention.

We deduce that the 'support' variable is key because, if it is perceived as lacking, staff will want to leave but, if it is perceived as satisfactory, it will motivate staff to stay. All these factors affect both reasons to stay and future exit intentions. Welfare and sources of anxiety uniquely and positively affects reasons to stay in an institution. Welfare changes odds to stay by 63.7%, and sources of anxiety change the odds by 31.6%.

3.3 Predicting future levels of health worker retention

The derived models we used in this study were partly chosen because they were useful in predicting future levels of health worker retention, allowing us to calculate the probabilities of employees exiting or remaining in their jobs in the following year. We used the averages of all the factors in the models, and the logistic regression models allowed us to predict group membership to the response variables. The predicted membership probabilities are shown in *Table 8*.

Table 8: Predicting the odds of health workers leaving or remaining in the year ahead, 2007

Responses to questionnaire	Predicted membership probabilities	95% Confidence Interval	
		Lower	Upper
Future exit intentions			
Likely to leave	0.65	0.65	0.65
Unlikely to leave	0.35	0.35	0.36
Reasons for staying			
None at all	0.97	0.97	0.98
Minor	0.03	-0.04	0.10
Moderate	0.0004	–	–
Large	0	–	–
Major	0	–	–

(To 2 decimal places)

The predictions indicate that, on average, about 65% of health staff in Swaziland are likely to look for alternative employment in the near future (at least in the next year), and about 35% are likely to remain in their jobs. Our analysis predicted that about 97% will not be at all interested in staying for any reason. Note that these predictions take into consideration the average scores of all factors in the model, as well as variations in responses due to whether a health facility is public or private.

The analysis identified six factors that significantly influence the decision by health care professionals to either change institution or to actively look for a different institution in the next year. These factors affect the decision directly and inversely.

Factors that impact directly (positively) are

- job satisfaction,
- equality/treatment by employer,
- job discretion and
- helping others.

The inverse factors are

- an employee's attitude towards their institution and
- support.

The most important reasons for staying in the current job were job satisfaction, an employee's attitude towards their institution, welfare, sources of anxiety, support and job discretion. Similarly, job satisfaction, attitude towards the institution, support, and job discretion also affect retention, but the direction of influence is not the same, as they also affect future exit intentions. Only the 'job satisfaction' variable has an inverse relationship with an employee's reasons to stay in an organisation.

Using the average of all factors in the models, our analysis predicted that, on average, about 65% of health care staff are likely to change jobs within the next year. Almost 97% will consider themselves as having no reason to stay on in their current jobs.

3.4 Focus group discussions

Regarding the recruitment of health professionals in Swaziland, two major issues were raised: delays in filling vacant posts and the recruitment of expatriate health care professionals. It was noted that the MoHSW is not responsible for filling vacancies. It forwards information about vacancies

to the Civil Service Commission (CSC). The CSC is also responsible for advertising the posts, interviewing the candidates and selecting them. This process takes a long time to complete because the CSC also services other Government Ministries and departments and they do not perceive the need to fill in the health posts as urgent.

A concern was also expressed over the recruitment of expatriate health care professionals wishing to join the health care system in Swaziland. It emerged from the discussions that the Professional Council which is responsible for vetting and recommending the foreign professionals, especially the medical doctors, for registration with the Medical and Dental Council does not meet on a regular basis. Reacting to this concern, one participant said: *'Sometimes when you submit your application, it takes up to six months to respond as they do not sit on a regular basis'*. It was noted by the participants that the Professional Council does not have a registrar and the person serving as a registrar has a full time job. This delays the process of calling meetings to deliberate on professional matters. Lack of a clear policy on registration of foreign health professionals was also cited as a problem that delays the registration process and many of them give up and leave for other countries.

Also related to the recruitment of foreign health care professionals was the issue of contracts renewal. Expatriate health care professionals are usually hired on renewable two year contracts. At times the contracts expire before the individuals are informed whether their contracts will be renewed or not. This is likely to create a lot of anxiety on the individuals concerned and affect their performance. Due to uncertainty in the renewal of contracts and lack of job security, the expatriate staff often look for jobs elsewhere and when they succeed, they leave.

Another issue that the FGDs addressed was retention of employees in the health professions. There was a general consensus that once the individuals join the health care professions, they build up relationships with the patients which make them feel needed and become aware that patients would suffer should they leave their places of employment.

3.4.1 Why health workers decide to leave their jobs: Work-related push factors

Why do health workers decide to leave their jobs? The reasons may be negative (push factors) or positive (pull factors). In the FGDs, we explored push factors by raising the issue of job satisfaction. There was a unanimous response by the participants that they were dissatisfied with their jobs. They pointed to Swaziland's overburdened health system, which has had its capacity to respond to current demands reduced as well as its ability

to cope with consistent changes in demand for health care. This national crisis has been felt at facility level, where demand outstrips supply. Many professionals opt to leave for various reasons, including financial reasons, such as higher pay. However, participants acknowledged the fact that people do not necessarily leave for higher pay but also because of a lack of non-financial incentives.

Poor working conditions were mentioned by respondents, as most felt that they have to work under very difficult circumstances without the necessary working tools and equipment such as uniforms or protective clothing. Often the essential working tools and equipment are not supplied on time. One participant described the situation as follows: 'Each time you have to do a procedure, you need to improvise, thus we end up not providing enough care to our client'. When patients fail to get the right treatment if the equipment and tools needed are lacking, they end up blaming the health care workers and this demoralises workers. Most public health institutions were described as consisting of old facilities that have never been renovated. One participant had the following to say in this regard: *'You envy other people working in places like banks with offices that are air-conditioned, while the health facilities in rural areas where we work have dirty walls and floors.'*

A further problem is the lack of ambulance service in clinics. Current policy demands that an ambulance should not be dispatched to an emergency situation without a nurse accompanying it yet there is a serious shortage of nurses in the clinics. The public ends up blaming the nurses for this, yet the problem is beyond their control. A general lack of support was indicated – workers suffer from high levels of frustration at work because the resources needed to do their work effectively are limited. As one participant said: *'If the institutions next door have these resources, one might consider moving there.'*

Respondents were frustrated by their heavy workloads. They cannot attend to the large number of patients arriving at their facilities, which affects the quality of care that they offer to the patients. The hospital managers complained that, whenever the MoHSW established new programmes, no new staff were recruited to manage them. So, the new programmes are run by existing personnel, further increasing their workloads and forcing them to work night shift. There was a general feeling that staff should not be taken from existing programmes when new programmes are established, but instead new staff should be recruited. Having to attend to too many patients affects the quality of care offered to the patients, as one respondent noted: *'If you have to attend to 300 patients as a doctor, you just hand out medication and end up feeling unhappy with yourself since you know you have failed the patients.'* Another participant added: *'The problem of the staff-patient*

ratio needs to be addressed. When you overwork yourself, you end up not knowing what you are doing or end up causing a lot of errors, which affects the quality of care.'

Participants wanted government to take into account the nurse-patient ratio of 1:3, as recommended by the World Health Organisation (WHO), or even the ratio of 1:15, as recommended by the Southern Africa Development Community (SADC).

The issues of poor supervision and a lack of supervision were raised in the FGDs. According to the current structure within the MoHSW, there are no immediate supervisors in each health clinic to attend to its day-to-day operations. Instead, one supervisor is responsible for several outlying clinics in a region. According to participants, this is not practical because the supervisor is not always available to provide help when their workers need it. Some supervisors are not able to create dialogue with the employees and they end up dictating things to them.

Participants did not feel that there was sufficient recognition for their efforts and achievements in other ways besides promotion. A manager claimed that *'there is a need to celebrate achievements by both the employer and the employee but to an extent this is one-sided'*. Individuals who undertake further training outside the country may come back, but they may have to wait a long time before they are hired again in the health sector, so they opt to look for employment elsewhere. One respondent described his experience as follows: *'I put in an application four years ago with the Civil Service Commission but up to now I have never received any communication.'* A lack of recognition was linked to poor promotion prospects and narrow career paths. In most health professions in Swaziland, prospects for professional growth are very limited, as one respondent observed: *'As a radiographer, one can only become a senior radiographer with no other promotion prospect.'* Often, a large number of workers end up competing for the limited number of positions available, generating unnecessary tension.

Conflict also arises between the individual's preferences for training and the MoHSW's training priorities. The Ministry dictates priority areas in training, which may demotivate employees, as they feel that their prospects for professional growth are being curtailed. A manager observed that *'some want to advance their studies only to find that there are no funds. They then opt to finance themselves and decide to go and work elsewhere because they feel they do not owe the government anything.'* One participant summarised the situation neatly: *'These kinds of challenges lead to delivery of poor quality services to our clients and one needs to be self-motivated to continue working in such an environment.'* Perhaps most worrying of all is

Retention strategies for Swaziland's health sector workforce: Assessing the role of non-financial incentives

that participants felt afraid for their own safety and security in many health facilities, as they had been targeted by criminals in the past.

3.4.2 Why health workers decide to leave their jobs: non-work-related push factors

We also explored push factors that are not directly work related (in other words, outside the workplace) identified by participants as contributing to the high turnover of staff in health care:

- **Family issues:** For employees in rural areas with children, there was a lack of educational opportunities for their children. In one such situation, the employee reported she either had to ferry her children daily to the nearest urban school or move her family there and commute to work at the rural health facility.
- **Lack of transport:** Public or employer-provided transport to and from rural health care facilities is lacking.
- **Poor accommodation:** Most professionals felt that their accommodation was either too small or non-existent. There was a general consensus that health care workers need to live within or near their places of work and most did not want to share accommodation. As one participant noted: *'You are trying to do your best at work, yet you are given a small house. So when you see a post being advertised where you get more than what you are being offered at present in terms of accommodation, you will apply.'* Improper accommodation was seen as likely to undermine an individual's concentration levels on the job.
- **Lack of incentives:** Workers lacked free medical care, transport, tea/coffee, water and electricity.
- **Lack of recreational facilities:** Despite heavy workloads, there was nowhere for workers to go to de-stress and recover after work.

3.5 Non-financial incentives recommended by FGD participants

From the FGDs, it emerged quite clearly that most respondents are generally unhappy with their work. They experience a lot of frustration in the work environment, related to heavy workloads, lack of essential equipment, poor accommodation, lack of promotion prospects and poor remuneration. Most health care workers do not leave due to the poor remuneration offered, but mainly due to lack of non-financial incentives.

Participants felt strongly that there was a need to re-examine the way in which the MoHSW was operating as inefficiencies there were contributing to the demoralisation of health workers. As one participant put it: *'Too*

many people are involved in the operation of the Ministry. [...] There is a fundamental problem with the way the Ministry works and that is causing a lot of frustration and a lot of people are leaving.' Another participant added: 'If a person's contract has expired, the Ministry might agree to renew it and yet there is still a delay in the renewal because there is a multi-sectoral practice at hand.' (As we noted earlier, the Ministry is not directly responsible for hiring and firing staff.) Some also thought that the creation of public-private partnerships would be beneficial. They believed that public-private partnership would help to reverse the problem of acute skills shortage, especially in government and mission hospitals. A policy needs to be formulated to make it possible for health care professionals to work in both public and private health facilities. This would serve both as an incentive for the individuals concerned by allowing them to earn some extra income and thereby remain in their jobs, where they are desperately needed.

Changes to workers' terms and conditions of employment were also suggested. A clear policy on the terms and conditions of service for the health care professionals needs to be formulated, which should spell out clearly all the career paths and prospects for professional growth for the various health care professions. The terms and conditions of service should also spell out all the financial and non-financial benefits that are available to health workers when they start working in Swaziland. The need for this action is underscored by a respondent's words: 'Generally, employees are not aware of the policy guiding the provision of non-financial incentives. The information is not communicated to them on joining the health profession.'

It was also observed that serious inconsistencies exist between the terms and conditions of service offered to the health professionals working in mission hospitals and those working in government hospitals, and these need to be ironed out. A clear policy is needed on what should happen to those Swazis who are sponsored for further training in the health professions outside the country on completion of their studies. The current procedure for bonding individuals for training is not properly enforced since it is not directly under the control of the MoHSW. Respondents suggested that the mandate to bond the individuals who are sponsored by the MoHSW for further training should be given to the Ministry. This would also help to reduce the chances of individuals getting frustrated as they wait to be re-employed through the Civil Service Commission. As one participant put it: 'When I came back from school, I applied to government but I have not heard anything. As you can imagine, I was just sitting at home'.

Adequate communication was seen as an essential part of any policy changes. All workers should be informed of any new national health care

policy developments by the MoHSW in the form of regular sensitisation workshops. The management team FGD was concerned that a new national health policy had been developed by the Ministry but had not been popularised among the health care workers. They felt that this policy document should be disseminated fully to all health care workers and also made available to all the workers.

Work-related benefits were also raised in the FGDs. There was a general consensus that, if they had easier access to housing and car loan facilities as soon as they joined the profession, health care employees would be more likely to stay on in their jobs because they now had financial commitments to keep. The introduction of a gratuity/endowment would help to ensure that all employees, including those on permanent and pensionable terms, enjoy their pension while still working instead of waiting until they have retired. One hospital manager put it as follows: *'One has to wait for retirement to get benefits while the expatriate staff get their gratuities as they go along'*. As far as their own health was concerned, participants acknowledged the fact that they have difficult and stressful jobs and need to be motivated and healthy at all times. Consequently, they all agreed that the introduction of a contributory medical scheme for all health workers would be necessary. As one participant observed: *'I have a colleague who joined one of the sugar companies from government and he mentioned that a medical scheme is what attracted him.'*

Other non-financial incentives suggested in the FGDs were improved management and support. Improved communication between the health care professionals and the health care managers could be ensured if they met regularly in their respective health institutions so that matters of common interest and concern to both parties could be discussed and a way forward proposed. Regular induction courses for all new employees should be conducted before they are deployed so that they are oriented on government operations and also made aware of their terms and conditions of employment. A local health care training institution should be established to address local health care training needs, particularly in those health care professions where training is not offered locally, such as training for pharmacy technicians, radiographers and dental therapists. A clear training policy and plan for health care professionals both in government and mission hospitals and clinics should be formulated by government. Individuals should be made aware of the training plan in their respective department once they join the profession so that they can foresee prospects for their professional growth. Such training plans should consider the personal training needs of the individual and not simply focus on the training needs of the health institution.

4. DISCUSSION OF RESULTS

Of the documents we reviewed, only one actually specifically mentioned non-financial incentives as a strategy for health worker retention. Earlier researchers have noted a similar gap in existing literature, and pointed out that health worker retention initiatives were mostly concerned with financial incentives (Lehmann et al, 2005). Financial incentives can contribute to retention of health workers, but to be sustainable, schemes must be complemented by non-financial incentives (improved working conditions and human resources management). In most of the documents, a human resources issue or policy would be mentioned with no further explanation or reasoning, begging the questions: Has the issue been founded on known sector needs, was it properly understood, and has the country committed itself to addressing the issue and understood how this could be done? Despite evidence in places that considerable efforts have been made to improve the plight of health workers, there are no coherent mechanisms and processes used to plan, introduce and monitor incentives, specifically non-financial incentives.

The health objectives contained in most documents are disease specific, well thought out in terms of the expected outcome, and often with an associated cost, but the human resource implications of achieving the same objective are largely ignored. Our findings show that a lack of non-financial incentives contributes significantly to the intentions of health workers to leave their jobs. Most organisations are not aware of the cost of a high turnover in staff or they tend to underestimate the cost. They are able to measure lost productivity, yet most cannot measure such costs as loss of organisational knowledge, loss of experience, or the effect on morale among remaining employees (Branham, 2000 in Graffam and Noblet, 2005). A lack of clear policy on non-financial incentives is backfiring on the Swaziland government because it means that the government has to bear the costs associated with the high staff turnover in the health sector, namely:

- the recruitment of replacements, including administrative expenses, advertising, screening and interviewing, and services associated with selection, such as security checks, processing of references and, possibly, psychological testing;
- lost productivity associated with the interim period before a replacement can be placed on the job, the time required for a new worker to get up to speed on the job, and time that co-workers must spend away from their work to help a new worker;
- costs of training, including supervisory time spent in formal training, as well as the time that the worker in training must spend off the job;

- costs associated with the period prior to voluntary termination when workers tend to be less productive;
- in some cases, costs associated with the communication of proprietary trade secrets, procedures and skills to competitor organisations; and
- public relations costs associated with having a number of voluntary or involuntary terminations in the community spreading gossip about the organisation (Graffam and Noblet, 2005).

Macro (national) and individual level approaches to addressing human resources for health were satisfactory, as compared to the micro level (facility level). The low side in micro level implies improving job satisfaction, improving physical working conditions, improving the management of health workers and teamwork, providing local financial and non-financial incentives, offering opportunities for professional advancement, is not prioritised in health sector health worker policies.

Based on the findings from the exit analysis, six factors were identified as significantly influencing the decision by health care professionals to exit their jobs (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, job discretion and the desire to help others. Our retention analysis evaluated the reasons why employees would consider staying in their current jobs and six factors were also identified: job satisfaction, the employee's attitude towards their institution, their welfare, sources of anxiety, support, and job discretion. Job satisfaction, attitude towards the institution, support, and job discretion also affect retention, but the direction of influence is not the same, as they affect future exit intentions.

Baum and Youngblood (1975) and Bartol (1979) reported a low, but consistently positive, correlation between job dissatisfaction and several factors, one of which was high levels of job turnover. Our study has confirmed these findings and it can be concluded that health care professionals who are dissatisfied with their job are more likely to change institutions in the following year. Conversely, a high level of job satisfaction becomes a significant reason for employees to stay with their organisation.

Regarding an employee's attitude towards their institution of work, our statistics showed that those with a negative attitude towards their institution are more likely to leave than those with positive attitude. (A 'negative attitude' is defined as an attitude that demonstrates a lack of organisational commitment or the absence of an employee's staff's psychological attachment to the organisation or Organisational Identification.) Job involvement and

organisational commitment have been found to affect turnover intention (Sjoberg and Sverke, 2000), in that organisations will generally achieve reduced turnover by enhancing their employees' levels of job involvement and organisational commitment.

On the issue of equality/treatment by employer, it can be concluded that whenever promises are not fulfilled by management, the employee is likely to leave, even if their points of view are considered, their rights respected and they are treated with respect. Fulfilling the promises made by management is crucial for health worker retention. Breaking a promise represents a violation of the psychological contract between employer and employee. As an employee contributes more to an organisation, their expectations about what is owed to them tend to increase. Naturally, as the organisation meets the various expectations of the employee, the employee's expectations of this, often implicit, contract becomes increasingly fulfilled (Graffam and Noblet, 2005).

Support is essential for health workers to remain in their current employment. When support increases, such as greater appreciation, recognition and feedback and more time off, the probability of the employee remaining increases. A study by Stilwell (2001) shows, by reference to Zimbabwe, that health workers based in remote areas, despite a lack of financial incentives and hard working conditions, frequently exhibited a high level of motivation to perform well. She traces this motivation to good leadership and supportive management, among other factors. Her analysis suggests that certain non-financial incentives can have a beneficial effect on motivation, even under adverse working conditions.

While job discretion showed some positive correlation with intention to leave, it was more strongly correlated with retention. Indeed the finding of even the weaker correlation with intention to leave is anomalous compared to previous studies. For instance Ser (2000) found that respondents who scored highly on skill discretion, job autonomy and job satisfaction are less likely to entertain thoughts of quitting. More consistent with this, the analysis of factors associated with retention confirmed that job discretion contributes positively to retention of employees in the health care system of Swaziland. The more discretion an individual enjoys in his/her job, the higher the chances for them remaining in their current institution. Equally, when employees receive support from the management, they are also more likely to remain in the current institution.

The divergence of findings on job discretion is not unusual. According to Hanson, Jenkins and Ryan (1990), greater autonomy increases job satisfaction, which in turn decreases turn over or desire to leave. However

others argue that from an exit lens, employee involvement and new-found job discretion is a myth (Clegg,1990; Harley, 1999). Instead, it is argued that the end result of high levels of workplace participation and expectation is likely to be gradual work intensification, job insecurity and work stress. According to Corey-Lisle et al (1999) low job satisfaction arises from excessive workloads, increasing employees' intentions to leave an institution. If job discretion can contribute to both job retention and intentions to leave, it needs very specific attention in retention strategies so that it is properly attuned and regulated.

Individuals who help others, for example by doing voluntary work, orienting new employees and assisting in group work, are more likely to leave their current employment, possibly as a result of compassionate fatigue. Compassion fatigue is reported to be a state of exhaustion and dysfunction – biologically, physiologically and emotionally – caused by prolonged exposure to compassion stress, a form of stress resulting from constant demands for compassion (Figley, 1995). It's a unique form of burnout affecting only people in care-giving professions, such as nurses, mental health professionals, emergency rescue personnel and child protection workers (Joinson, 1992). In the context of our study of health workers in Swaziland, their fatigue is exacerbated by the extra burden of having to help colleagues, which only reinforces their intentions to leave.

The welfare of workers plays a crucial role in the retention of employees in the health care system in Swaziland. If the welfare of the employee, namely their general health and well-being, are improved, the employee is likely to remain in their current institution. Underlying absenteeism and high staff turnover is the inability of staff to concentrate on their work because of personal problems (Dieleman and Harnmeijer, 2006). Personal problems may be a result of age, stage in the life cycle, gender, family situation, personal drive, living circumstances (insecure environment, lack of roads and schools), AIDS and so on.

Sources of anxiety in the current job are positively related to the retention of employees in their current institution. From the findings presented, there is a lot of anxiety among the health care employees, though many of them might have no intentions of leaving. This positive relationship between anxiety and retention is associated with 'presenteeism', which occurs when people come to work but are not functioning fully because they have physical or mental health problems (Alliance Work Partners, 2006). These people may be putting in unnecessary overtime because they are either addicted to work or they may fear their career could suffer if they do not. Lost productivity due to presenteeism is, on average, 7.5 times greater than productivity lost to absenteeism (ibid). These employees probably feel trapped in their current

jobs and are likely to stay on until they attain the mandatory retirement age, their productivity is low. Seemingly, addressing issues of retention for the health care workers alone is not sufficient. The total elimination of anxiety at work can resort in lethargy and high levels of anxiety can result in disorientation or presenteeism (Lustenader, 2006). But not all anxiety is bad: moderate levels of anxiety can increase motivation (ibid).

Our predictions for employee retention and exit intentions, using the average of the factors in the models, indicate that about 65% of health care staff in Swaziland perceive that they are likely to change institutions within the next year. Almost 97% of the health care staff are predicted not to perceive certain work-related advantages as reason enough to stay in their current institution: these include interesting work, variations in work assignments, increased salary, flexibility in working hours, a good boss and fringe benefits. Therefore, other factors influencing retention need to be brought into play, such as job satisfaction, the employee's attitude towards their institution, job discretion, welfare, support and sources of anxiety, which all scored above average in our analysis.

In the FGDs, the following factors were identified as contributing to high staff turn over (push factors):

- low salary packages;
- poor working conditions;
- poor working environment;
- lack of essential equipment and tools;
- poor accommodation;
- lack of non-financial incentives;
- limited promotion prospects;
- lack of support;
- lack of recognition of an employee's efforts and achievements;
- heavy workloads;
- lack of immediate supervision;
- conflict between individual preference for training and MoHSW training priorities;
- lack of capacity to respond to consistent changes in demand for health care;
- over-stretched health care facilities (infrastructures);
- lack of recreational facilities after work;
- threats to the safety of employees; and
- failure to meet employee family obligations.

The above findings are consistent with those by USAID (2003), which established that many health workers in Africa are poorly motivated because they are under-paid, lack the proper equipment, are infrequently supervised and informed, and have limited career opportunities within the civil service. Similarly, a staff survey conducted in Zimbabwe, found that the inability to offer effective care for patients due to a lack of equipment, appropriate drugs and other supplies was the reason cited most frequently by respondents for resigning from the government (Zimbabwe MoHCW, 2000). A similar study in Zambia noted that primary care patients often cannot be referred to higher-level facilities because there is no stationery to write out prescriptions and referral letters, record fee revenues or manage and register drug supplies (UNZA, 1995). Another study that analysed the motivation of health-care workers in four developing countries in Africa observed that low job satisfaction and motivation affect the performance of health workers, as well as increasing their odds of emigrating (Stilwell et al, 2004).

Of the various factors mentioned above, that were identified as contributing to high turnover are elements of the significant factors that the quantitative analysis portrayed to influence leaving intentions and reasons to stay in an organisation. The discussions above have thus confirmed their relevance to universal retention strategies. The qualitative analysis puts forward specific issues that health workers perceive to require prioritisation. The convergence of the quantitative and qualitative findings is illustrated in *Figure 1*.

Figure 1: Relationships between the factors influencing health worker retention

Salary package	⇒ Reasons for staying
Poor working conditions	⇒ Job satisfaction/ contentment
Poor working environment	⇒ Sources of anxiety
Lack of essential equipment and tools	⇒ Sources of anxiety
Poor accommodation	⇒ Reasons for staying
Lack of non-financial benefits	⇒ Basis for leaving intentions
Limited promotion prospects	⇒ Job satisfaction/contentment
Lack of support	⇒ Support
Lack of recognition of effort and achievement	⇒ Job satisfaction/contentment
Heavy work loads	⇒ Sources of anxiety
Lack of immediate supervision	⇒ Support
Conflict between individual preference for training and MOHSW training priorities	⇒ Basis for leaving intentions
Capacity to respond to consistent changes in demand for health care	⇒ Sources of anxiety
Over stretched health care facilities (infrastructures)	⇒ Sources of anxiety

Some variables, namely lack of recreational facilities, personal safety of employees and failure to meet family obligations, are not covered in the questionnaire. Most studies on retention strategies cover the worker's individual situation but, although living conditions are generally considered to have an impact on staff retention, little has been published so far on strategies to improve living conditions and their effects on retention (Dieleman and Harnmeijer, 2006). The recognition of the non-work-related needs of workers is crucial in formulating an effective retention strategy because workers normally look for work circumstances that best match their personal and family conditions or motives (ibid). Interventions to improve productivity, responsiveness and competencies may also address the living conditions of health workers in rural areas or the needs of specific groups, such as female health workers or workers in specific age groups. Our findings correlate with those of Dieleman and Harnmeijer – workers in the FGDs identified these issues are crucial to them too.

Retention strategies for Swaziland's health sector workforce: Assessing the role of non-financial incentives

5. CONCLUSION AND RECOMMENDATIONS

From the review of documents, documented guidelines or objectives or strategies on improving the health system through offering non-financial incentives to health sector staff are almost nonexistent. Only one document specifically mentioned non-financial incentives, but these were not thoroughly explained.

We identified six factors that significantly influence decision by health care professionals to either change institution or to actively look for a different institution in the next year. These factors affect decisions to change institutions directly and inversely. Factors that impact directly (positively) are: job satisfaction, equality/treatment by employer, job discretion, and helping others. The inverse factors are the employee's attitude towards their institution and support. Reasons for staying in the current job are also influenced by six factors: job satisfaction, the employee's attitude towards their institution, welfare, anxiety, support, and job discretion. Similarly, job satisfaction, the employee's attitude towards their institution, support and job discretion also affect retention, but the direction of influence is not the same, as they affect future exit intentions. It is only job satisfaction that has an inverse relationship with reasons to stay in the job.

It also emerged from the FGDs that the migration of health care professionals was not only external (to other countries) but was also internal (within Swaziland). There was a trend for professionals to move from government health facilities to private hospitals or from mission health facilities

to government facilities. It emerged from the discussions that mission hospitals and clinics have fewer non-financial benefits compared to those in government. For example, mission hospitals do not provide housing and car loan facilities, while private hospitals provide additional benefits such as medical schemes which attract professionals from government hospitals. There was a general consensus that, since professionals migrate because of the non-financial benefits offered, the government needs to develop guidelines for the package that should be made available to health care professionals, whether in government, mission or private hospitals. The participants were also in agreement that the MoHSW should take responsibility for employing all professionals in government and mission hospitals.

5.1 Recommendations

The study reveals the importance of comprehensive approaches to address retention problems, requiring sufficient financial resources and the contribution and commitment of all stakeholders, such as the ministries of health, finance and education, professional associations, funding agencies, etc. Also, there is urgent need for the Ministry to formulate clear guidelines, and coherent mechanisms and processes to plan, introduce and monitor non-financial incentives.

Collaboration between MoHSW, employers and the training institutions is needed to develop management training programs for front line managers, as well as changes in the payment system, such as using output-related payments. Government needs to introduce additional annual leave days, either paid or unpaid; additional sick leave or carers' leave; nine-day fortnights and rostered days off; flexible start and finish times; and specialist training to meet employee interests.

Institutions should provide human related quality management tools, namely supervision, feedback, staff appraisals, staff satisfaction surveys, clear leadership and guidance, clear organisational objectives and missions, and staff participation mechanisms (including staff meetings), adequate training, as well as self assessments. An internal marketing mechanism must be established to continually assess the needs of people who work within the health care system and to articulate and disseminate a vision for the direction of the system that can be embraced by those charged with delivering programmes and services.

Health institutions need to show employees they are valued and treat them with respect. They also need to build organisational commitment among their employees by involving front-line staff in planning and decision-making by creating and supporting opportunities for professional development and

growth and by showing their appreciation to those on the front-line. Health institutions have to offer job security, address issues of pay equity, provide incentives such as moving expenses or signing bonuses, demonstrate to new recruits there are opportunities for career development; guarantee sufficient money is available to attend, and paid time off for, professional development, and sell potential employees (and their spouses) on the job and on the community. Unions and health institutions must engage in frank and open discussion as to whether collective agreements present recruitment and/or retention barriers. They must work together to create collective agreements that enhance the ability of the health care system to have adequate human resources. This discussion might include such strategies as interest based bargaining. Continuous formal induction necessary for significant cost savings by ensuring that new employees have the training they require in an organisations policies and procedures so that they can undertake their role effectively. It is also vital that employees are inducted into the organisation's culture and values right from the start.

Additional housing dedicated to staff be constructed and medical services must be offered to relatives with AIDS. Guards should be supplied to families living in an insecure environment. Most health workers in the health sector are women, and they need to be protected from violence and sexual harassment at work or need childcare support in order to reduce absenteeism.

Terms should be negotiated to provide special monetary incentives to work weekends and/or nights exclusively. Health institutions should encourage staff to take their daily meal breaks and their full annual leave entitlement, while discouraging them from working long hours or taking work home on a routine basis. Retention strategies must be tailored to the life-cycle stage of employees.

Work should be organised to equip health providers with the necessary supports to do their jobs. This includes such things as adequate office and filing space, ward clerks, porters, receptionists and physical equipment and supplies. As much as possible, tasks relating to clerical or maintenance work, the coordination of non clinical activities or paper work not directly related to clinical obligations or expertise should be done by someone else. Institutions must allow moderate skill discretion to avoid lethargy and disorientation (presenteeism) that is associated with extremes of job discretion.

It is recommended that a formalised system of peer support be established for occupational therapists, physical therapists, and community health nurses. This network should include regular case conference consultation

with teams of providers as well as regular continuing education conferences. The MoHSW must assist regions and their affiliates to develop strategies for keeping employees including:

- holding managers accountable for retention;
- having a mechanism for identifying high-potential employees;
- having a clear understanding of the needs and values of employees; and
- having effective succession management systems.

Full time positions need to be created and offered to new graduates and out-of-province applicants. Seniority of providers from other health sector regions needs to be transferable, even if the courtesy is not reciprocated. More flexibility must be built into the system so that people may opt for full time or part time work according to their needs.

5.1.1 Equity and solidarity

Health institutions should offer job security; address issues of pay equity; provide incentives such as moving expenses or signing bonuses; demonstrate to new recruits there are opportunities for career development; guarantee sufficient money is available to attend, and paid time off for, professional development; and sell potential employees (and their spouses) on the job and on the community. Programmes should be established to teach skills to younger, less experienced health providers as a tool to gauge their coping skill because they are at a higher risk for developing compassion fatigue.

Since decisions to migrate are influenced by a broad range of factors, some of which are beyond the control of policy-makers within the health care sector such as salary, it is prudent for the health care policy-makers to identify those policy options that they have control over and act on in order to retain health care professionals. According to Stilwell et al (2004), targeted incentives may be more realistic possibility, particularly if traditional donor rules (that do not support recurrent health sector costs, such as wages) can be relaxed in the face of the crisis in human resources in many countries.

The FGDs clearly indicated that most health care workers do not migrate purely due to the salaries that are paid but due to the poor conditions within the work environment. They identified the following as constituting poor working conditions; lack of working tools and equipment, poor accommodation, lack of medical schemes, lack of support, lack of recognition of effort, lack of transport, lack of incentives (such as free water and electricity) and insecurity. This finding is consistent with the findings in other studies (USAID 2003), which established that many health workers in Africa are ill-motivated because they are poorly paid, poorly equipped,

infrequently supervised and informed, and have limited career opportunities in the civil service. Addressing these non-financial incentives would go along way in attracting health care professionals and assist in retaining them within the profession. Most of the above concerns are within the country's budget and some do not involve financial commitments from government. For example, non-financial incentives such as motor-vehicle and housing loans only require government to guarantee loans for the employee with their respective banks.

Health professionals do not only migrate out of the country but also within the country from government to private health institutions, and from mission health institutions to government. Hence harmonising the terms and conditions of employment between the three major health employment sectors could assist in reversing the trend. This calls for clear health care policy that addresses the health worker situation within the country holistically. As already established from the review of documents, strategies on improving the health system through offering non-financial incentives to health sector staff are almost nonexistent. This clearly indicates lack of appropriate information systems on human resources within Swaziland. According to Stilwell et al (2004), having reliable data about the health-care workforce is key to good workforce planning. Hence, the need to develop appropriate and updated information systems on human resources in Swaziland.

Implementing non-financial incentives is an expensive venture for the government, it is therefore recommended that the government undertakes comparative cost studies to assess the cost effectiveness of putting into practice such a policy.

REFERENCES



1. Adams O and Hicks V (2001) 'Pay and non-pay incentives, performance and motivation', prepared for WHO's December 2000 Global Health Workforce Strategy Group, Geneva. Department of Organisation of Health Services Delivery, World Health Organisation: Geneva.
2. Alliance Work Partners (2006) *Working Solutions: Present and unaccounted for: Presenteeism*. Workers Assistance Program Inc: Austin, Texas.
3. Awases M, Gbary A, Nyori J and Chatora R (2004) *Migration of Health Professionals in Six Countries: A Synthesis Report*. WHO Regional Office for Africa: Brazzaville.
4. Backman A (2000) *On Job Satisfaction, Retention, Recruitment and Skill Mix for a Sustainable Health Care System: Report to the Deputy Minister of Health for Saskatchewan, Canada*. www.ci.san-arcos.tx.us/departments/HR/Docs/WS_OCT_2006.pdf (accessed 11 July 2008)
5. Barcillano MC (1999) 'The Technology of Participation (TOP) and its application' <http://www.adnu.edu.ph/Centres/CLG/clg-> (accessed on 11 July 2008)
6. Bartol KM (1979) 'Individual versus organisational predictors of job satisfaction and turnover among professionals', *Journal of Vocational Behavior* 15:55-76.
7. Baum JF and Youngblood AA (1975) 'Impact of organisational control policy on absenteeism, performance, and satisfaction', *Journal of Applied Psychology* 60:688-694.
8. Branham FL (2000) *Keeping the People Who Keep You In Business: 24 Ways to Hang on to Your Most Valuable Talent*. AMACOM: Boston.
9. Bennett S, Gzirishvili D and Kanfer R (2000) 'An in-depth analysis of the determinants and consequences of worker motivation in two hospitals in Tbilisi, Georgia', Major Applied Research 5, Working Paper 9. Partnership for Health Reform Project: Bethesda, Maryland.
10. Buchan J, Thompson M and O'May F (undated) 'Incentive and remuneration strategies in health care: a research review (unpublished).
11. Buchan J and Calman L (2004) *The Global Shortage of Registered Nurses: An Overview of Issues and Actions*. International Council of Nurses (ICN): Geneva, Switzerland. <http://www.icn.ch/global/shortage.pdf> (accessed 11 July 2008)
12. Clegg S (1990) *Modern Organisations: Organisation Studies in the Postmodern World*. Sage: London.
13. Dieleman M and Harnmeijer J (2006) *Evidence and Information for Policy Report 2006: Improving Health Worker Performance: In Search of Promising Practices*. World Health Organisation: Geneva.
14. Dielemann M, Viet Cuong P, Vu Anh L and Martineau T (2003) 'Identifying factors for job motivation of rural health workers in North Vietnam', *Human Resources for Health*, 2003. <http://www.human-resources-health.com/content/1/1/10> (accessed 20 July 2008)
15. Dolea C and Adams O (2005) 'Motivation of health care workers: Review of theories and empirical evidence', *Cah Sociol Demogr Med* 45(1):135-161.
16. Franco LM, Bennett S, Kanfer R and Stubblebine P (2000) 'Health worker motivation in Jordan and Georgia: A synthesis of the results'. Major Applied Research 5, Technical Paper 3. Partnership for Health Reform Project: Bethesda, Maryland.

17. EQUINET, ECSA-HC and HST (2007) Health worker retention and migration in east and southern Africa: Regional meeting report of March 17–19, Arusha, Tanzania. EQUINET: Harare.
18. Figley C (1995) *Compassion fatigue as secondary traumatic stress disorder: An overview* in Figley CR (ed) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. Brunner-Routledge: New York.
19. Graffam J, Noblet A, Crosbie J and Lavelle B (2005) 'Keeping quality people engaged: Workforce satisfaction within the disability employment industry', Final report, May 2005. Deakin University, Australia.
20. Hanson CM, Jenkins S and Ryan R (1990) 'Factors related to job satisfaction and autonomy as correlates of potential job retention for rural nurses', *Journal of Rural Health* 6(3):302–316.
21. Harley B (1999) 'The myth of empowerment: Work organisation, hierarchy and employee autonomy in contemporary Australian workplaces', *Work, Employment and Society* 13(1):41–66.
22. Joinson, C (1992) 'Coping with compassion fatigue', *Nursing* 22(4):116–121.
23. Hornby, P and Sidney E (1988) *Motivation and Health Service Performance*. World Health Organisation: Geneva.
24. Initiatives Inc. (2000) *Human Resources Study, Volumes 1 and 2*. A study conducted by Initiatives Inc. for the Zimbabwean Ministry of Health and Child Welfare. Initiatives Inc.: United States of America.
25. Jennings BM (1994) 'Stressors of critical care nursing' in Thelan LA, Davie JK, Urden LD et al (eds) *Critical Care Nursing: Diagnosis and Management*. Mosby: St Louis, Missouri.
26. Kanfer R (1999) 'Measuring motivation', Major Applied Research 5, Working Paper 1. Partnerships for Health Reform, Abt Associates: Bethesda MD.
27. Kingma M (2003) 'Economic incentives in community nursing: Attraction, rejection or indifference?' *Human Resources for Health* 1(2).
28. Lehmann U and Sanders D (2004) 'Human resources for health in South Africa', background and overview paper for JLI National Consultation 3–4 September 2004. Joint Learning Initiative: Cape Town.
29. Lehmann U, Martineau T, Dieleman M, Lexomboon D and Matwa P (2005) 'The staffing of remote rural health services in low-income countries: A literature review of issues and options affecting attraction and retention', Third Public Health Conference 'Making Health Systems Work', South Africa, 15–17 May 2006.
30. Lustenader D (2006) *Employee Retention: What you can do to improve it!* Lake Associates: United States of America.
31. Iiping SN, Hofnie K, van der Westhuizen L and Pendukeni M (2006) 'Perceptions of health workers about conditions of service: A Namibian case study', EQUINET Discussion Paper 35. EQUINET: Harare.
32. Mathauer I and Imhoff I (2006) 'Health worker motivation in Africa: The role of non-financial incentives and human resource management tools', *Human Resources for Health* 4(24).
33. Ministry of Health and Social Welfare (2007) *National Health Policy*. Government Printers: Mbabane.
34. Mitchell TR (1997) 'Matching motivational strategies with organisational contexts', in Cummings LL and Shaw BM (eds) *Research in Organisational Behavior* (19)57–149). JAI Press: Greenwich CT.

Retention strategies for Swaziland's health sector workforce: Assessing the role of non-financial incentives

35. Mutizwa-Mangiza D (1998) 'The impact of health sector reform on public sector health worker motivation in Zimbabwe', Major Applied Research 5, Working Paper 4. Partnership for Health Reform Project: Bethesda, Maryland.
36. Reid S (2004) *Monitoring the Effect of the New Rural Allowance for Health Professions*. Health Systems Trust: Durban.
37. Schmidt-Ehry B and Seidel W (2003) 'Human resources development', in Eschborn GTZ (2003) *The District Health System: Experience and Prospects in Africa: Manual for Public Health Practitioners*. Deutsche Gesellschaft für Technische Zusammenarbeit: Eschborn, Germany.
38. Ser T (2000) 'Job satisfaction, turnover propensity and workplace power', *Labour and Management in Development Journal* 1(8):9–13.
39. Sjöberg A and Sverke M (2000) 'The interactive effect of job involvement and organisational commitment on job turnover revisited: A note on the mediating role of turnover intention', *Scandinavian Journal of Psychology* 41:247–252.
40. Stilwell B (2001) 'Health worker motivation in Zimbabwe', unpublished paper/internal report for the Department of Organisation of Health Care Delivery. World Health Organisation: Geneva.
41. Stilwell B, Diallo K, Zurn P, Vujicic M, Adams O and Dal Poz M (2004) 'Migration of health-care workers from developing countries: Strategic approaches to its management', *Bulletin of the World Health Organization* 82:595–600.
42. Ministry of Health and Social Welfare Government of Swaziland (2007) *National Health Policy*. Government Printers: Mbabane.
43. UNAIDS (2006) *UNAIDS Global Report 2006 Data, Country Situation Analysis*. United Nations: Geneva, accessed on 23 July 2008 at: <http://www.unaidsrstaesa.org/countries/swaziland/swaziland.html>
44. United States Agency for International Development (2001) 'Management sciences for health: Basic group facilitation methods: Technology of participation (TOP 1)', Training Report, Second Batch.
45. United States Agency for International Development Bureau for Africa, Office of Sustainable Development (2003) 'The health sector human resource crisis in Africa', Issues Paper. Academy for Educational Development: USA.
46. University of Zambia (1995) 'Motivational survey of health workers in Zambia', report prepared for the Ministry of Health. University of Zambia: Lusaka.
47. Vujicic M, Zurn P, Diallo K, Adams O and Dal Poz M (2004) 'The role of wages in the migration of health care professionals from developing countries', *Human Resources for Health* 2(3).
48. Weisman CS and Nathanson CA (1985) 'Professional satisfaction and client outcomes: A comparative organisational analysis', *Medical Care* 23(10):1179–1192.
49. Wolfe MN (1997) 'Nursing compensation: A historical review', *Hospital Topics* 75(2):27.
50. World Health Organisation (2003) *Migration of Health Professionals in Six Countries: A Synthesis Report*. World Health Organisation Regional Office for Africa: Brazzaville.
51. World Health Organisation (2004) *The Role of Health Services in Protecting Young from HIV and AIDS*. World Health Organisation: Geneva.
52. WHO (2006) *World Health Report: Working Together for Health*. World Health Organisation, Geneva. <http://www.who.int/Geneva,nt/whr/2006/en/> (accessed 10 July 2008)

Acknowledgements

We would like to express our sincere appreciation to the EQUINET team who supported this study both technically and financially. In particular, we appreciate the technical and administrative support and advice provided by Dr. Scholastika Ipinge (University of Namibia), Prof Yoswa Dambisya (University of Limpompo) and Dr. Rene Loewenson (Training and Research Support Centre) all in EQUINET. We recognize the significant role played by the East, Central and Southern African (ECSA) Health Community who provided a forum for discussion of the Human Resources for Health issue leading to the birth of this important work. The HRH team also would like to thank Dr K Mensah for externally reviewing the reports and Rebecca Pointer and Pierre Norden for their edit work.

We are most grateful to the Principal Secretary at the Ministry of Health and Social Welfare, Ms. Nomathemba Dlamini for rallying behind the completion of this study and advising on its proper execution.

The efforts of the HRH technical Working group are also greatly acknowledged. Special thanks go to Ms. Nelsiwe Skhosana (Statistician) and Ms. Zanela Bhembe (Assistant Statistician).

Finally, gratitude is extended to respondents who shared their insights and views regarding non-financial incentives for health workers.

• Retention
• strategies for
• Swaziland's
• health sector
• workforce:
• Assessing
• the role of
• non-financial
• incentives

Acronyms

CSC	Civil Service Commission
ECSA-HC	East, Central and Southern African Health Community
EGPAS	Elizabeth Glaser Paediatric AIDS Foundation
EU	Commission of the European Union
EQUINET	The Network on Equity in Health in Southern Africa
FGDs	Focus Group Discussions
HST	Health Systems Trust
HR	Human Resources
MDGs	Millennium Development Goals
MEPD	Ministry of Economic Planning and Development
MOHSW	Ministry of Health and Social Welfare
MOPSI	Ministry of Public Service and Information
MYFP	Multi Year Funding Programme
NERCHA	National Emergency Response Council on HIV/AIDS
UNAIDS	The Joint United Nations Programme on HIV/AIDS
GLM	Generalised Linear Model
WHO	World Health Organisation
NGO	Non-governmental Organisation
SADC	Southern African Development Community
UNICEF	United Nation's Children Fund
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Treatment
WHO	World Health Organisation



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.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET: R Loewenson, R Pointer, F Machingura TARSC, Zimbabwe; M Chopra MRC, South Africa; I Rusike, CWGH, Zimbabwe; L Gilson, Centre for Health Policy/ UCT, South Africa; M Kachima, SATUCC; D McIntyre, Health Economics Unit, Cape Town, South Africa; G Mwaluko, M Masaiganah, Tanzania; Martha Kwataine, MHEN Malawi; M Mulumba, HEPS Uganda, Y Dambisya, University of Limpopo, South Africa, S Ipinge, University of Namibia; N Mbombo UWC, L London UCT Cape Town, South Africa; A Mabika SEATINI, Zimbabwe; I Makwiza, REACH Trust Malawi; S Mbuyita, Ifakara, Tanzania.

For further information on EQUINET please contact the secretariat:

Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

Series Editor: Rene Loewenson

Issue Editors: S Ipinge, P Norden, R Pointer, R Loewenson

DTP: Blue Apple Designs

ISBN: 978-0-7974-4021-0

EQUINET, 2009 www.equinetafrica.org