Regional Network for Equity in Health in East and Southern Africa
EQUINET

Policy Series No. 41

Giving new momentum to strategies for retaining health workers

Produced by the ECSA Health Community with TARSC and University of Limpopo

This brief discusses the strategies used for attracting and retaining skilled health workers in ESA countries, especially to address underserved rural and remote areas, primary care settings and in the public sector. It reviews practice to date and identifies strategic options, given both regional learning and the opportunity of the 2016 Global Strategy on Human Resources for Health. Whereas ESA countries have implemented various attraction and retention regimes, the results have not been well documented, with still limited evaluation and reporting of impact of these strategies. The evidence suggests a need for a comprehensive, multi-sectoral and co-ordinated approach to planning and implementation, to make the case for improved funding and with greater use of information and monitoring systems.

Critical needs, critical gaps

Health priorities of the post-2015 agenda for sustainable development…..will remain aspirational unless accompanied by strategies [for] ……. a skilled, trained and supported health workforce (WHO, 2016).

The health workforce is one of the most important components of a health care system. The health strategies of east and southern African (ESA) countries, the regional agenda and the Sustainable Development Goals (SDGs) all call for a skilled, trained and supported health workforce. A maldistribution of health workers undermines equitable access to health care.

ESA countries have faced long-standing challenges in recruiting and retaining skilled health workers, especially in rural and remote areas, in primary care settings, and in the public sector. Developing strategies for attracting and retaining health workers has depended on limited data. Earlier EQUINET work has shown that non-financial incentives are effective, but need to be combined with appropriate financial incentives, and that financial incentives can become ineffective as they are eroded, or as health worker expectations change.

Some ESA policy actors perceive that the external migration of skilled health professionals is not as much of a concern as it was between 1990 and 2010. They perceive internal migration between public and private sectors and between urban and rural areas to be more significant. However, OECD in 2010 report that international migration of skilled health professionals to OECD countries is increasing, driven by a combination of poor working conditions, weak supportive services in other sectors (such as schools and commercial outlets); and by a desire for improved incomes and living standards. It means that both internal and external migration continue to raise a pressure on health systems. Overall, 11 of the 16 ESA countries have less than the recommended 2.5 skilled health workers per 1000 people, shown in *Table 1* below. A loss and shortage of personnel, especially in peripheral services and poorer communities, translates into poor quality services, low access and poor health outcomes.

The causes of health worker shortages vary across countries, ranging from limited training capacity; public sector employment freezes; high levels of out-migration due to economy or political uncertainty or poor conditions in rural facilities. Even in the face of low health worker densities, a freeze on employment of health professionals can mean that some ESA countries have both a large pool of unemployed personnel and low skilled health worker to population ratios.

August 2016

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Table 1: Density of Skilled Health Professionals in ESA Countries, 2008-2013

Country (ordered by density)	Density of skilled health professionals (doctors + nurses + midwives) /1000 population
Malawi	0.362
Mozambique	0.452
Tanzania	0.467
Madagascar	0.477
Lesotho	0.672
Zambia	0.957
Kenya	1.061
Zimbabwe	1.418
Uganda	1.423
Swaziland	1.772
Angola	1.826
Zambia	0.957
Namibia	3.149
Botswana	3.745
Mauritius	4.791
Seychelles	5.875
South Africa	5.890

Source: WHO (2014) Global Health Workforce Statistics; http://apps.who.int/gho/data/node.country

Applying retention incentives

ESA countries have used different strategies to attract and retain health workers within their countries, to stem international migration, and to limit internal disparities within specific areas, typically hard-to-staff areas (See *Table 2*).

A combination of financial and non-financial incentives have been used to retain health workers within the country and the public sector and to attract staff under-served areas, such as rural allowances in South Africa, free housing in Malawi, or medical education incentives in Tanzania.

Table 2: Application of health worker retention incentives in ESA countries, post 2000 (shaded box implies incentive applied)

COUNTRY	Improved pay	Allow-ances	Dual practice	Car, hous-ing, pen-sion, loan schemes	Profe-ssional develop-ment	Improved working conditions
Angola						
Botswana						
DRC						
Kenya						
Lesotho						
Malawi						
Mauritius						
Mozambique						
Namibia						
South Africa						
Swaziland						
Tanzania						
Uganda						
Zambia						
Zimbabwe						

Source: EQUINET Regional Equity Watch 2012; Information not available for Madagscar

All ESA countries have applied some form of financial incentives with varying degrees of success. Financial incentives have also been applied to retain certain critical skills, such as medical doctors at primary care level in Uganda, where the consolidated package for medical officers at sub-district health centres is higher than that for specialists in urban areas. Some countries have given permission for public sector health workers to do dual practice to retain them in the public sector. While a wide range of strategies have been applied, there is much less evidence of their evaluation to document and share evidence of successful features and strategies. Applying learning from strategies globally, the World Health Organisation in 2010 developed recommendations for effective interventions in four main areas: education, regulation, financial incentives and personnel and professional development (See *Box 1*).

Box 1: WHO Recommendations on Attraction, Recruitment and Retention of Health Workers in Rural and Remote Facilities

Education strategies:
Including recruitment and enrolment of health care students from rural and remote areas; location of health professional schools and campuses in rural areas; curriculum reforms for education and training of health professionals to reflect rural health issues; clinical rotations of students to different rural health care facilities during their training; creation of continuous professional development programmes for rural health workers; and creation of health professional cadres for work in rural primary health care clinics.

Regulatory strategies:
Included expanding the scope of practice of health care workers, to cover gaps due to shortages of other cadres; compulsory deployment of all types of health workers to remote and rural areas on completion of training for a period prior to full registration; subsidised education with bonding on completion of studies; design and implementation of curriculum for new categories of health care professionals based on the needs of the country.

Financial incentives:
Including competitive salaries for skilled health workers and additional incentives for those working in the rural and remote areas.

Personnel and professional support:
Including improved living conditions, with provision of electricity, sanitation, schools and telecommunication; improved working conditions through supportive supervision and guidance, ensuring the availability of equipment and supplies; strengthened cooperation and outreach activities between health workers in the urban and rural areas; career development programmes, with senior positions in rural and remote areas; development of professional networks, rural health professional associations, rural health journals to uplift the morale and status of rural providers and reduce professional isolation; and recognition and service awards.

Source: WHO 2010

Challenges in implementation

There have been challenges in implementing the range of incentives applied. In particular there has been a chronic under-investment in the health workforce in many ESA countries over the years; with inadequate public sector resources to support the health workforce. A low resource base and fiscal policies limit the wage bill and constrain wage levels for health workers in many ESA countries, limiting the effectiveness of some incentive regimes and the parallel investment needed in other infrastructure, such as roads or schools, to make incentives effective. Applying incentives selectively, for specific cadres or locations, may help to target scarce resources, but have been found to lead to demoralisation of those who are not beneficiaries. Many of the incentives rely on other sector policies and inputs, and call for the political and economic power to effect health workforce interventions across sectors in a co-ordinated manner.

In some countries, incentives have been supported by external funders. Bilateral agreements are envisaged in the 2010 WHO Code on the International Recruitment of

Health Workers (the Code). However in practice, external aid can be unreliable and subject to many conditions. It may cover only specific cadres or functions and may have very limited time frames, posing a challenge for long-term health workforce management.

Strategic options

There is no one-size-fit-all solution to the maldistribution, shortages and migration of health workers in Africa. The experience to date highlights a range of approaches and measures that countries can apply, including:

- Applying retention packages across the whole health sector, based on needs assessment and inter-sectoral and stakeholder input, and strengthening institutional capacity to manage and evaluate the incentives;
- Applying commonly used non-financial incentives including: career paths; training, investment in services; housing mortgages / loans; performance rewards; health worker access to health care; and financial incentives to address extremely low real wages.
- Building complementarity between recruitment, retention and training strategies, with regular stakeholder review on their impact.

There is a window of opportunity to mobilise new attention and resources for such strategies, given the role of health workers in meeting policy commitments to the SDGs and Universal Health Coverage.

The 2016 Global Strategy for Human Resources for Health: Workforce 2030 builds upon existing health worker policy frameworks, including the 2012 Africa Human resources for Health Roadmap. It operationalizes the 2010 WHO Code. It incorporates evidence-based recommendations on attraction and retention of health workers in rural and remote areas through an integrated, multisectoral and multi-pronged approach health workers, linking attraction and retention with production and attrition. The strategy recommends that countries design and implement a comprehensive health worker attraction and retention strategy in a coordinated strategic planning process, involving key ministries - such as ministries of finance and economic planning, public/ civil service and labour - and engaging professional organisations, planners, local health workers and civil society organisations.

ESA countries may leverage this new opportunity to harness the policy co-ordination and resources, and to strengthen the planning, costing, monitoring and review of strategies for adequacy and equity in the distribution of key health workers.

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Produced August 2016 EQUINET
www.equinetafrica.org
Cite as: Dambisya Y (2016) Giving new momentum to strategies for retaining health workers, with ECSA HC, TARSC and U Limpopo, Policy brief 41 , EQUINET Harare
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