Regional Network for Equity in Health in east and southern Africa

Health worker retention in east and southern Africa

Report of a Regional Meeting

School of Nursing University of Namibia,
Training and Research Support Centre (TARSC)
School of Pharmacy University of Limpopo
in the 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)

Windhoek, Namibia
25-27 February 2009

with support from SIDA Sweden

Valuing and Retaining our Health Workers

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For the Meeting Recommendations see Section 8 page 38

1. BACKGROUND TO THE MEETING

The Regional Network for Equity in health in east and southern Africa (EQUINET) through University of Namibia, Training and Research Support Centre and University of Limpopo has co-ordinated work on health worker migration and retention, in co-operation with the Regional Health Secretariat for east, central and southern Africa (ECSA-HC). The work has been implemented in support of the East, Central and Southern African Health Community 44th Regional Health Minister's Conference March 2007 Resolutions on Human Resources for Health shown below, and has particularly focused on assessing policies and practices on the implementation of non financial incentives for health worker retention to guide policy in this area.

The East, Central and Southern African Health Community 44th Regional Health Minister's Conference March 2007 Resolutions on Human Resources for Health included resolutions to:

- Develop/revise National Human Resources strategies that address recruitment, motivation and retention of health workers and improve their productivity to include both financial and non-financial incentives by end of 2008.
- Develop mechanisms to harness the potential resource in health workers from the diaspora and retired workers by March 2008.
- Support and endorse policies and protocols to manage and mitigate the costs of migration by December 2008.
- Develop mechanism for distribution of health workers that ensures equity at all levels of the health system by March 2008.

The work, supported by SIDA, examined the design and implementation of policies for nonfinancial incentives for health care worker (HCW) retention, such as career paths, housing, working conditions, management systems and communication. It explored the experience in the region through a review of literature and through field work in five countries (Tanzania, Kenya, Zimbabwe, Swaziland and Uganda). The work was guided by a reference group of key institutions and individuals involved in work on health workers, drawing from international and regional organisations (IOM, ECSA, SADC, WHO), governments, civil society and technical organisations.

A regional meeting was convened on 25-27 February in Windhoek by EQUINET and ECSA HC, hosted by the University of Namibia in co-operation with TARSC and University of Limpopo to:

- review the findings from this body of work and to explore the implications for policies and measures aimed at valuing and retaining health workers in ESA;
- develop proposals and guidelines for policy and action relevant to health worker deployment and retention; and
- identify knowledge gaps for follow up work.

The meeting also reviewed work implemented within other EQUINET themes to explore the impact of migration on health systems in Kenya (carried out in co-operation with IOM and ECSA-HC), to explore the impact of AIDS financing on health worker retention (carried out in co-operation with WHO and ECSA-HC), and to examine the relationship between health workers and communities at primary care level (in a programme of work co-ordinated by TARSC and Ifakara Health Institute). The meeting, held at the Safari Hotel in Windhoek, brought together country partners, researchers, regional and co-ordinating institutions involved in the work. The programme is shown in *Appendix 1* and the delegate list in *Appendix 2*. This report was prepared by TARSC.

While the work has informed input made to the draft WHO code of practice being presented to the 2009 World Health Assembly and the ECSA and SADC health worker strategies, the output from the meeting was intended for report to countries and policy level through the ECSA-HC and SADC, to IOM, WHO and SANNAM, as well as other regional organisations, and through the EQUINET Regional Conference in September 2009, at which a specific parallel session will be held on equitable policies for meeting health worker challenges.

2. OPENING SESSION

Dr Scholastika Iipinge of the School of Nursing at the University of Namibia welcomed participants to the meeting and invited the Dean of the University of Namibia, Dr L Hoases-Gorases to give the welcome address.

2.1 Welcome and official opening

Dr L Hoases-Gorases: Dean of the University of Namibia presented greetings from the Vice Chancellor and his deputy, noting that the meeting was timely and the issue under focus relevant given the exodus of health professionals from the region, despite the high demand for health workers give the disease profile of the population.

"To provide quality care to our populations we need skilled health professionals in all categories of professions. The demand on the ground in ever increasing and retention of health workers in the service is becoming more eminent. Our countries are resourcelimited, but we have to manage with the few on the ground. The answer lies in appropriate remuneration, recognition, promotion possibilities, training in various fields such as HR planning, and a conducive environment".

She called on delegates to look back in history to draw on key declarations like the Alma Ata Declaration, but to update it and in the process examine what is needed to plan for retention of our work force. She also called on delegates to develop feasible solutions to gain support from political will: 'We must also be bold to convince our leadership of the lives of human beings involved.'

Ms Petrina Haingura: Honourable Deputy Minister of Health and Social Services, Namibia conveyed greetings from the Minister to the delegates and welcomed delegates to Namibia. She noted that the Ministry of Health and Social Services was most appreciative of the choice of Namibia as host of what was an important meeting. This is particularly so as while there are a number of problems affecting the delivery of quality health care services, the shortage of health workers is one that has reached crisis level, given its central role in any well-functioning health care delivery system.

She informed delegates that the Ministry of Health and Social Services in Namibia conducted a health and social services system review in 2008 and in relation to human resources found:

- a shortage of health professionals;
- a vacancy rate in the overall public health sector standing at 27%;
- high vacancy rates in the categories of doctors, pharmacists and nurses;
- out-dated staff establishment and non-responsive to accommodate new developments and programmes;
- a long process for recruitment and issuing of work permits;
- a high annual attrition rate of health professionals, of which resignation was the main cause;
- lack of a retention strategy; and
- staff burnout.

"This meeting could therefore not have happened at a better time, as I learned that this meeting will discuss and share evidence of the findings of research on health worker migration and retention in east and southern Africa, including strategies and experiences of implementing retention incentives. This is thus Namibia's opportunity to learn from the research, findings and recommendations on how to address the abovementioned human resource for health challenges".

While globalisation has facilitated migration of health professionals, mechanisms for production and retention of health workers can be put in place at a micro level to provide an enabling environment within the workplace for the development and retention of health workers, to slow down migration and meet HRH requirements. These included strategies to address the determinants of motivation through: achieving satisfactory remuneration; creating positive and conducive work environments and developing supportive systems.

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

She invited delegates to take time to visit Windhoek and Namibia and declared the meeting officially open.

2.2 Aims of the meeting and delegate introductions

Dr Scholastika Iipinge: School of Nursing, University of Namibia explained the aims of the meeting. She noted that human resources for health issues have been at the centre of global, regional and local policy discussions since 2005, with East and southern Africa the worst effected region in sub-Saharan Africa. Dealing with the global inequity and the absolute shortage in east and southern Africa requires efforts from government, regional bodies, development partners and communities. The EQUINET-ECSA-HC programme supports health worker retention drawing from the evidence, experience and objectives set by countries and also set by regional partners at the regional meetings in April 2006 and March 2007 to: 'Adopt a common position on compensation for health workers recruited by developed countries', 'adopt a common position on ethical recruitment of health workers,' and 'develop financial and nonfinancial strategies to encourage retention of health professionals'.

She outlined the work done by EQUINET and ECSA-HC since 2007 (noted in the introduction) to build and exchange knowledge and inform effective national and regional strategies on health worker retention, especially in priority health services. This work forms part of EQUINET's mission to build publicly-funded, comprehensive, people-centred, equitable and universal national health systems. She outlined the meeting aims as to:

- review the findings from this body of work and to explore the implications for policies and measures aimed at valuing and retaining health workers in ESA,
- develop proposals and guidelines for policy and action relevant to health worker deployment and retention, and to
- identify knowledge gaps for follow up work.

Participants in the meeting then introduced themselves, and their interests that the meeting share findings and experiences; identify common lessons that can be taken back; identify areas for further research; use evidence from studies for policy direction; and use the findings through various organisations such as parliament, nurses organisations and the SADC secretariat to input to government level.

3. REGIONAL STRATEGIES AND POLICIES FOR MANAGING HRH

3.1 ECSA HRH Strategy 2008-2012

Professor Yoswa Dambisya, University of Limpopo on behalf of Helen Lugina, ECSA-HC introduced the ECSA Human Resources for Health (HRH) Strategy. The strategy was developed to deal with the HRH priorities in the ECSA region. ECSA is an intergovernmental organisation with ten member states: Kenya, Lesotho, Malawi, Mauritius, Seychelles, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe. The structures of ECSA include the Health Ministers' Conference (RHMC), and Advisory Committee, the Directors Joint Consultative Committee (DJCC), the Director General and Secretariat, and four programme areas with technical committees - Human Resources Development and Management for Health (HRDM); Health Systems and Services Development (HSSD); Policy, Research and Information/Knowledge Management (PRIM); and Disease Control, Prevention and Management (DCPM).

He outlined ECSA's role as an organisation providing technical support to member states and other regional institutions in health, and to promote cooperation, networking, collaboration, joint and cross border actions in health. ECSA is a regional centre for learning, promoting excellence and information brokerage, documenting and promoting exchange of ideas, experiences, innovation, best practices, and knowledge and information in health. It serves as a regional voice for the member states in all matters of health at regional and international decision-making forums. In past work ECSA has identified the main gaps in HRH to include: the lack of accurate data and reliable human resource information systems (HRIS); a low human resources for health training capacity, high attrition rates, poor infrastructure and poor HR management systems; low productivity, poor performance of workforce and low efficiency of health systems; poor funding for the health sector; and a high disease burden and poor health indicators. Therefore, member states need to scale up interventions, e.g. against HIV/AIDS, malaria, TB and other diseases, and to achieve the MDGs.

The ECSA HRH Strategy this intended to respond to country needs, especially in terms of technical assistance in HRH policy development and implementation, research and evaluation; and to contribute to a coordinated approach to the HRH crisis in the region, in line with the AU Health Strategy, WHO Regional HRH Strategy, and other relevant strategies. It has been developed through a process of review, and technical and policy consultations in 2007 and 2008.

"The strategy tackles identified priority HRH issues, identified as:

- *poor HRH planning, management and motivation;*
- *lack of systematic and adequate production and development of HRH;*
- *poor utilisation of available HRH;*
- *high attrition of skilled and capable health workers;*
- *poorly developed management systems; and*
- *low funding for HRH".*

It sets, in response to this, six strategic objectives, to:

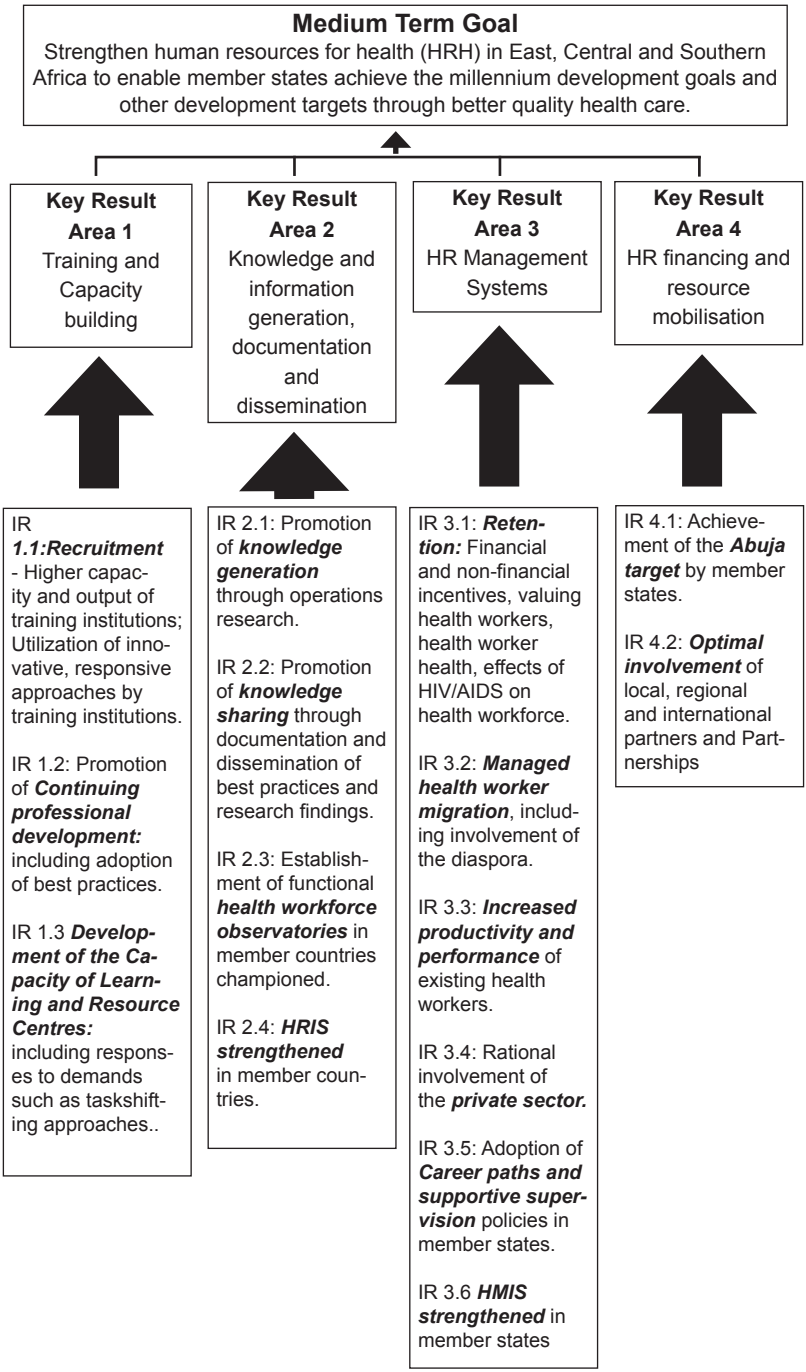
i. contribute to best practice models of HR utilisation in member countries;
ii. strengthen member states capacity in human resource leadership and management;
iii. strengthen HR intelligence in member states;
iv. strengthen ECSA learning and resource centres, including ECSACON and COSECSA, and support their participation in country HR plans and programmes;
v. strengthen capacity in financial resource mobilization, and effective collaboration, partnership and networking between public sector and private sector; and
vi. monitor and evaluate HRH programmes and activities within ECSA-HC (See *Figure 1*).

The strategies to implement these goals are to:

i. Review existing country HRH plans, needs, production and best practices in HRH utilisation in order to inform responses to challenges.
ii. Strengthen HR management approaches based on best practices, including programmes on health worker health, productivity, efficiency, retention and responses to migration.
iii. Promote ECSA HC as a knowledge hub for coordination, harmonisation and standardisation of education and training, the development and functioning of ECSACON and COSECSA, and establishment of the ECSA College of Medicine/Health Sciences.
iv. Develop, strengthen and facilitate partnerships with stakeholders within the member countries, and with regional and international partners.

Based on these strategies, the main activities for member states and the ECSA Secretariat are shown in *Table 1* (the roman numerals in the table correspond to the above list).

FIGURE 1: MEDIUM TERM GOALS OF ECSA HUMAN RESOURCES FOR HEALTH STRATEGY



Source: ECSA-HC (2008) Human Resources for Health Strategy, ECSA-HC, Arusha

Table 1: Main activities for member states and the ECSA-HC Secretariat

	Member states	ECSA Secretariat
I.	• Develop, monitor and evaluate HRH plans/ programmes. • Develop mechanisms for sharing and rollout of best practices. • Establish and/or perationalise national health workforce observatories.	• Carry out a regional analysis on HRH through activities of the national health workforce observatories. • Facilitate the documentation, sharing and dissemination of best practices in HRH in the region. • Develop HR utilisation model(s) for adoption by member states.
II.	• Strengthen mechanisms for enhancing workforce motivation and productivity, including financial and non-financial incentives for health workers. • Document country responses to the HIV/AIDS effects on the health workforce.	• Assist member states to develop and/or strengthen health management systems. • Work with member states to conduct country level HRH retention and migration studies. • Collate and analyse regional data on the effects of HIV/AIDS on the health workforce.
III.	• Support the development and functioning of ECSA colleges, including ECSACON and COSECSA. • Set up mechanisms for the adaptation of regional initiatives towards harmonisation and standardisation of education and training.	• Facilitate harmonisation of accreditation, training and regulation of health professionals and training institutions. • Facilitate the development and adaptation of standards of education and practice.
IV.	• Increase funding for the health sector in pursuance of the Abuja target. • Promote public-private initiatives, including tendering and accountable contract management systems, and training of health workers. • Advocate for greater donor support and higher international investment in HRH.	• Strengthen existing partnerships, and seek new ones, in response to the HRH needs in the region. • Mobilise resources for funding HRH activities. • Review and harmonise approaches to publicprivate engagement in the region.

He presented potential partners for the strategy from international to national level and the proposed steps to launch, disseminate and translate the strategy into operational plans and partnerships, backed by periodic monitoring and review.

3.2 HRH Strategies and policies in SADC

Dr Lebogang Lebese: Health Technical Advisor, SADC Secretariat presented greetings from the SADC Executive Secretary. She reported that the 2005 SADC Health Ministers meeting included a mid-term review of health related millennium development goals (MDGs) that found that the failure to meet targets e.g. on reduction of maternal deaths, was due to nonavailability of skilled health professionals. This meeting was thus timely and was understood to be a meeting that would influence decisions of Ministers in the region. Delegates to a SADC HRH subcommittee were meeting in Namibia and would join the meeting on its second day.

She outlined the policy frameworks within which HRH issues are addressed in SADC, including

- SADC RISDP 2006-2019
- SADC Protocol on Health
- SADC Protocol on Education
- SADC Protocol on the Facilitation of movement of persons
- SADC Ministers of Health decisions - 2005.

The Facilitation Protocol provides that SADC citizens of one Member State have the right to work in another Member State, subject to the laws of that State. SADC migrant workers that meet those conditions must be treated in the same way as national workers in relation to working conditions, wages, taxation, etc.

HRH are a major challenge in all Member States, with issues fragmented in different departments/ ministries, and despite the presence of human resource strategic plans in many countries, lack of a framework at regional level, with member states recruiting from each other. The major human resources issues are the migration of key health professionals such as nurses, doctors and pharmacists, the maldistribution of health workers, poor working conditions, weak planning capacity (fragmented), poor production of health care workers, little regulation and the commercialisation of the health workforce.

In response to these issues, SADC developed in 2006-2009 a *Human Resources for Health Strategic Plan* and began developing specific regional frameworks. The objectives of the SADC HRH Strategic Plan include:

- managing the impact of HIV and AIDS;
- managing the "Brain Drain" and migration;
- developing policies and strategies to attract and retain health professionals;
- developing a Regional Qualifications Framework;
- identifying, establishing and developing Regional Centres of Specialisation and Excellence; and
- creating a framework for a suitable skills mix.

In November 2006, the *Policy Guidelines for Attracting and Retaining Health Professionals in the SADC Region* were put in place. These guidelines urged Member States to put in place measures to improve working environments and create conditions of service - such as competitive salary packages, to attract, recruit and retain health professionals. At the same time workplace HIV and AIDS programmes were also recommended to mitigate the impact of HIV and AIDS. Recruitment of health professionals should be based on bilateral agreements between Member States, rather than countries engaging in active recruitment. To reach national universal access intervention targets (treatment and care), in 2007 SADC states agreed to scale up human resource development, including: training, retention and task shifting for health professionals, community health workers and lay providers. In November 2008 SADC produced a concept paper on the 'brain drain' and skills circulation – The Migration and Management of HRH. This concept paper mooted the concept that "brain drain" is when people leave the region or the health sector, and that movement within the region health sectors is 'skills circulation'.

"SADC member states have taken actions on HRH, including: introducing bonding, improving conditions of services, introducing allowances such as rural allowance, developing information management systems, reviewing remuneration systems and linking remuneration to career pathing and performance, increasing intake, and developing bilateral agreements. In addition, the education protocol includes the requirement for SADC students to be charged local fees and 5% intakes from SADC countries; harmonising qualifications frameworks; regional and national centres of excellence. This will also affect training of health workers".

SADC itself has established a Technical Committee to report to ministers; identified and collaborated with key stakeholders on subsidiarity basis; set up the SADC Committee of Deans, AMCOSA and SANNAM; and strengthened collaboration between SADC and international organisations and other partners. She noted that monitoring and evaluation of these existing strategies needs to be strengthened.

3.3 Discussion

In the discussion, delegates raised a number of issues for the regional institutions to consider in their strategies, including:

- The withdrawal of clinical personnel into policy and administrative work, while noting the need for HRH to play a role in policy.
- The need to clarify concepts of internal and external migration (movement within and outside countries respectively); brain drain; skills circulation.
- That internal migration is an issue and needs attention.
- The need to link with partners to disseminate information and make links on websites.
- The knowledge gap on what people who have moved outside the health sector are doing and their motivations for leaving the health sector.
- That SADC and ECSA need to meet with finance, trade, public service ministries on HR issues to harmonise across policies and ensure that trade agreements (such as the current services negotiations in the Economic Partnership Agreements) did not undermine government authorities and policies needed to manage HRH.

SADC is working with deans of health training institutions in implementing its regional quota's on training. Flexibility is being applied to specific situations, such as the Zimbabwe situation, subject to additional resources being provided so institutions do not compromise on quality. Liaison is also made with relevant regulatory bodies. Knowledge on what people who have moved outside the health sector are doing and their motivations for leaving the health sector is an issue that SADC, IOM and others are looking into to explore the issues of reintegration into health sector.

It was agreed that documents from the regional organisations will be given to partners to distribute in their websites.

4. FINDINGS OF THE REGIONAL AND COUNTRY WORK ON HEALTH WORKER RETENTION

Dr Iipinge introduced the programme of work and its major elements as outlined in the introduction. This session of the meeting would review the findings of the regional review of literature and the country studies.

4.1 Overview of retention incentives

Professor Yoswa Dambisya, University of Limpopo outlined the findings of a review of published and grey literature on health worker retention (also published as *EQUINET discussion paper 44* at www.equinetafrica.org). He noted that the focus on HRH retention is motivated by the relatively greater costs of 'brain drain' including in terms of loss of institutional memory, loss of morale and increased workloads for remaining workers; and costs to communities forced to seek care at higher levels. Retention signals that health workers are valued and promotes in that it

- safeguards services in areas of greatest need (those with poor infra-structure, and in rural and remote areas).
- safeguards services for poor populations who have limited access to health care.

He noted the range of direct financial incentives and indirect non-financial incentives used to motivate HRH retention, and that the desk review found some information on retention strategies, there was little information on non-financial incentives, particularly how incentives are managed and monitored, the impact of non-financial incentives and success factors. Typically financial incentives used in ESA include salary top-ups, allowances, dual practice/ moonlighting, per diems, and sitting allowances. Non-financial incentives included those related to:

- training and career paths (career paths; higher training, scholarships/ bursaries with or without bonding; research opportunities; and skills enhancement);
- social needs (housing, electrification, staff transport, childcare facilities, and food);
- working conditions (improved/upgraded facilities and equipment, general conditions of service, and workplace security);

- human resource management (strategic planning, human resource information systems, open appraisal systems and supervision); and
- health worker health (access to ART, medical insurance, free/ preferential treatment).

He outlined the range of training and career incentives, (continuing professional development; enhanced skills and further training, bursaries and undergraduate sponsorship: and bonding. To address social needs of health workers have been provided with housing; staff transport; free food; TV and communication systems; staff welfare centres and childcare facilities in different settings. To improve working conditions, some countries have provided or improved facilities, equipment and security. Health worker health has been addressed by introducing workplace HIV care plans; providing health insurance or medical allowances and providing for favourable and preferential access to treatment for health workers. System wide incentives implemented in several ESA countries have included improved management and information systems; supportive supervision with prompt feedback; recognition of and awards for good performance. (Details of the incentives ands the countries they are applied in can be found in the discussion paper).

The incentives were applied in different countries to attract and retain HRH in rural facilities; attract the return of nationals trained abroad; enhance the skills and productivity of existing workers; and to improve the loyalty of the existing workforce. Incentives have been targeted or included for all personnel within sector wide initiatives. They have been applied in specific programmes, or as part of sector-wide approaches (SWAP) through national health sector or HRH plans. Vertical programmes in the region target only selected heath workers. Few countries funded non-financial incentives from the national budget, and donor funds are used to fund incentives through the SWAP, through general budget support; or through specifically targeted donor funding.

"Non-financial incentives have been successful when they have been deliberately planned, with consultation across the board, as in Uganda; when they meet immediate needs through top-ups and allowances as in Malawi; when a combination of financial and non-financial incentives is used as in Zambia and Uganda; when incentives are used to attract health workers from private to public sector as in Uganda; when incentive programmes are integrated with SWAP or budgets as in Uganda and Malawi; and when national and donor funding were mobilised for an emergency human resource programmes in Malawi and Zambia".

He noted that incentives need to be linked to longer term strategic planning to be more successful and implementation needs to be monitored and evaluated, with the evidence used for feedback and periodic review. While it is easier to notice immediate signals through financial incentives, non-financial incentives create longer term stability. Generally there is inadequate information exchanged on the implementation of non-financial incentives as this is poorly documented or published, and information provided often lacks specific detail on timeframes, design of incentives, categories of affected workers.

"To build long term non-financial incentive packages, therefore, we need to:

- *share and exchange information;*
- *undertake planning that involves consultation and builds trust with health workers;*
- *ensure financial sustainability through integrating external support into SWAP and general budget support;*
- *combine financial and non-financial incentives;*
- *regularly evaluate and review non-financial incentives; and*
- *develop a common strategic approach to health worker retention in ESA countries".*

4.2 Presentation of findings from country studies

Kenya:
Dr Iipinge presented the Kenya findings on behalf of Professor David M Ndetei: African Mental Health Foundation. The full study is published as *EQUINET Discussion paper 62* at www.equinetafrica.org

Kenya lacks personnel in key areas, worsened by external and internal migration. In response, the Kenyan government attempted to develop new standards to improve working conditions in the health sector and retain staff by offering salary increases, providing them with opportunities to engage in private practice and giving them training. Despite these incentives, there has been a continued loss of qualified professionals to other occupations and to international migration. This coexists with unemployment among nurses and clinical officers in the country, due to limits on employment and a freeze on newly vacant positions.

Through literature review and field research the study examined the to context for and trends in the recruitment and retention of health workers, particularly the policies, systems, provisions for providing, managing, monitoring and evaluating non-financial incentive packages for health workers.

Push and pull factors for migration included poor remuneration, poor working conditions with limited supplies and no supervision, heavier workloads in rural public facilities (due to more demand), limited career opportunities with poor communication, limited educational opportunities for workers and their families, and the impact of HIV and AIDS. The evidence suggested that internal migration (rural to urban) is exacerbating the inequitable distribution of health personnel between urban and rural areas and between lower and higher level facilities in Kenya, inequitably leading to worse health care for those with greater health need. While the Ministry of Health is actively recruiting and posting health workers to poor economic settings in the country (sub-district and district hospitals), the poorer conditions and outmigration from these areas leads to a paradox of staffing gaps and vacancies together with unemployed health workers. This scenario pushes health workers to seek employment in the international market.

A number of financial incentives were being applied, including paid leave and overtime pay, house or car loans at lower negotiated market rates (for highly skilled public sector workers) and transport, entertainment, hardship, responsibility, special duty and uniform allowances. Non financial incentives were also applied including: sponsorship for studies with bonding agreements; housing (or a housing allowance), post-graduate training and continuing medical education, life insurance, personal loan facilities, shorter working hours, membership to the National Social Security Fund (NSSF), medical cover (includes nuclear family) and the introduction of HIV and AIDS treatment in some workplaces.

There was a difference in how these incentives were applied: Terms and conditions of service in private and teaching facilities were reviewed regularly and health workers were informed on any changes of services through improved human resource management. The same was not the case in public facilities, where management systems and communication with health workers was poorer.

"The implementation of incentives was found to depend on the management of the facility, so facilities that are better organised, often in higher-income areas, are more successful in providing incentives. Yet, ironically, it is at the lower levels of the health system (in rural and poorer areas) where incentives need to be implemented most urgently to counteract the strong push factors that force workers out of these areas".

Policies to retain health workers, while in place, were thus found to not be working because workers are still moving from rural to urban areas and from Kenya overseas. There is need for national-level policy formulation on the implementation of incentives so that the approach of allowing individual facilities to set and apply incentives, which stimulates initiative, does not also exacerbate the maldistribution of workers and differences in quality services. The researchers suggest that government put in place national-level policies to retain health worker in rural areas, in lower-income districts and at lower levels of the health system to ensure that all areas reach minimum standards (such as the WHO recommended minimum standard of 20 doctors per 100,000 patients). Health workers value non-financial incentives, such as improved working conditions, training and supervision, good living conditions, good communication, free health care and educational opportunities for themselves and their families. Further investment in these areas is thus recommended, backed by sound management practices and strategic information to support effective management.

The researchers noted an information gap that puts human resource managers at a disadvantage in strategic planning, including for them to argue for further resources needed for retention incentives. This was felt to be a key gap to address, including to monitor implementation and assess the impact of incentives.

Zimbabwe

Moses Chimbari, University of Botswana presented the country work in Zimbabwe to assess the incentives instituted by the Zimbabwe government and non-government sector to retain critical health professionals and their impact. The study focused on medical doctors, nurses, pharmacists, radiographers, laboratory technicians, dentists, opticians, nutritionists, and therapists. The work involved a desk review, cross sectional survey of HRH and key informant interviews of sites in urban and rural settings in three administrative provinces (Mashonaland West, Matebeleland South and Masvingo) and two major cities (Harare and Bulawayo). The full study is published as *EQUINET Discussion paper 65* at www.equinetafrica.org

The study found that 35% of those working in district hospitals to 74% of those working in private hospitals intended to migrate, primarily to South Africa (26%), Australia (17%), Botswana (16%) and the United Kingdom (13%). Their main reasons for leaving were for better remuneration (26) and to join family (24). Of those who intended emigrating, most divorcees, (83%) single (68%) and married people (55%) wanted to leave.

The review indicated a wide variety of incentives in place in 2006:

- Managing movement from rural to urban areas, including a rural allowance (10% of basic salary) for remote areas, support for the relocation of spouses, upgrading of rural health facilities and provision of suitable accommodation.
- Managing movement from public to private sector, including a regular review of salaries and allowances, rewards for high performers, adequate funds for buying necessary equipment and supplies, timeous filling of vacant posts and management training.
- Managing movement to other countries in the region and overseas, including study opportunities to those who have served government for more than two years, bonding arrangements and providing tools of the trade, low-interest loans, accommodation and vehicle purchase schemes for critical members of staff.

In May 2007, allowances were upgraded, with a basic salary for all health staff in line with that payable to members in equivalent grades in the civil service and a medical emolument at a rate of 70% of basic salary. An occupational hazard allowance at a rate of 20% of basic salary was made available to non-medical staff working within health institutions or in hazardous environments, such as mortuary attendants and ambulance drivers. The on-call allowance was upgraded to 1.35 times basic salary and a nurse's allowance equivalent to 67.5% of a nurse's basic salary was offered. A number of non-financial incentives were proposed, such as developing HRH management and information systems, improving working conditions and addressing social needs, such as housing and transport, training and career path-related incentives, and workplace-specific programmes to provide health care to health care workers and their families. Health workers themselves were found to prioritise inflation adjusted salaries, housing schemes/ loans, assistance with transport and improved working conditions. Key informants also pointed to the importance of stabilising the macro-economic environment; improving the professional mix at the ministry head office to reflect the composite nature of health services; restructuring training, establishment and deployment of health workers in all staff categories in accordance with skills required to handle new health challenges and repackaging remuneration for each category of health workers, recognising experience and postgraduate qualifications. Proposals were also given for career advancement pathways and through-grading, recognition of long service and a range of grants and allowances (uniform, vehicle, medical aid, and school fee loans). Some measures were suggested to enhance the economic incentives for rural service, including improving infrastructure (space in health facility, housing, electricity, water, transport and communication networks) and putting in place a quota system that facilitates access to land for rural health workers.

With the primary push factor the unfavourable macro-economic environment, financial incentives are quickly eroded and the researchers recommended that retention strategies target all staff categories given the breadth of HRH erosion. For this it was felt that the Zimbabwe Health Service Board should be afforded more autonomy to gather information, manage and negotiate and implement policy measures to retain health workers.

Swaziland

Sibusiso Sibandze: Ministry of Health, Swaziland presented the research from Swaziland. He noted the time, personnel and resource limitations in implementing the study, as well as the difficulties with accessing data and skills to implement the work. The study was implemented through desk review and field survey (with 160 frontline staff random sampled from public and private institutions) and focus group discussions (with managers, supervisors and frontline staff, as well as union representatives, and regulatory and professional bodies). The full study is published as *EQUINET Discussion paper 68* at www.equinetafrica.org.

The desk review found that only one document explicitly referred to non-financial incentives for HRH, namely training and professional development. No coherent mechanisms were used to plan processes used to plan, introduce and monitor incentives, specifically non-financial incentives. The design, management and sustainability of non financial incentives is yet to be formally supported by policy, strategic or even regulatory instruments.

An exit analysis found that six factors 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. Dissatisfaction with the job, giving support to fellow workers (lead to compassionate fatigue) and having a negative attitude towards their institution tend to influence future exit intentions considerably more than the other three influential factors. About 65% of health staff were likely to look for alternative employment in the coming year and many felt they did not receive adequate support from institution to effectively complete tasks.

Factors contributing to retention were found to be a high level of satisfaction with the job; enhanced levels of job involvement and organisational commitment; fulfilment of promises made by management; maintaining support to employees in terms of greater appreciation, recognition and feedback and more time off; more discretion in executing their job (greater autonomy) welfare (health and well-being). Health workers were concerned with salary, work environment, accommodation, career path, support, recognition and workload issues. They perceived gaps in capacities to respond to changes in demand for health care; and conflict between individual training preferences and government priorities.

The researchers thus recommend comprehensive approaches to address retention problems, with involvement of all stakeholders, backed by clear guidelines, and coherent mechanisms and processes to plan, introduce and monitor non-financial incentives. This calls for collaboration between the Ministry of Health, employers and the training institutions to develop management training programs; harmonising terms and conditions of employment for the civil service to establish a uniform remuneration package for health workers in the public and semi-public sector and ensuring standardised management tools and appropriate systems for HR planning, management and information for HRH. Some specific issues were identified as needing attention, i.e.:

- Reviewing task allocation in light of high demand for healthcare vis-à-vis staff shortages
- Streamlining the operations of different government agencies to improve on the recruitment and deployment of health staff.
- Developing health workers' retention package with clear cost implications.
- Establishing systems for monitoring HRH performance and productivity, and
- Developing a "Code of Conduct" between Government and Development Partners.

Tanzania

Michael A Munga: NIMR, Tanzania presented the study implemented in Tanzania. The study sought to identify the non financial incentives in both the public sector and the private sector currently being applied; ascertain their strengths, weaknesses, impact and sustainability and the mechanisms used for monitoring and evaluating them. The full study is published as *EQUINET Discussion paper 61* at www.equinetafrica.org.

In the study, a desk review was implemented and a field survey in seven districts (five underserved and remote, and two better off urban districts). The literature review highlighted national recognition of the need to design and implement effective retention incentives, but also of the cost of this. Typical non-financial incentives covered by the documents under review included: training, leave, participatory personnel appraisal systems, worker participation in discussing their job requirements and welfare, promotion, supervision, recognition and respect, housing, and a safe and supportive working environment. It was acknowledged that non-financial incentives could be improved by providing extra payments, such as hardship allowances; proactively increasing the health budget in hard-to-staff districts over time;

improving health facility infrastructure; and access to training opportunities and staff loans and ensuring that salary increments and promotions are implemented more vigorously and quickly for health workers working in disadvantaged rural districts.

The field study showed that there are major weakness in the implementation of the non-financial incentives in place. The gaps were found to be due to a shortage of funds and staff available to implement the strategies, including training strategies, and to weak management capacities and practices and blocks in districts power to implement incentives like promotion (due to promotion recommendations being referred higher up and not implemented by clinic managers). More than 70% of the health worker survey respondents had the perception that the available non-financial incentives are not adequate enough to motivate them and increase productivity. Participatory mechanisms to discuss health workers' welfare issues, monitoring and evaluation and management styles were found to be weak and existing feedback mechanisms inadequate due to a lack of funds, equipment and transport.

The researchers observe that costing studies are needed to ascertain the feasibility and sustainability of non financial incentives, and that their introduction calls for improved health worker management styles under the ongoing decentralisation reforms. Managing both macro and micro structural factors (and not just individual preference structures as conceived in the pull and push factors framework), is essential if researchers are to provide workable policy recommendations for improved management of non-financial incentives.

Uganda

A study in Uganda implemented by the Ministry of Health with the Capacity Project and USAID was presented by **Florence Matte of the Capacity Project, Uganda.** (The lead researcher for the EQUINET study was not able to attend the meeting). Through field survey of health workers the research found stability in the overall workforce, with significant differences in the public and private-not-for-profit (PNFP) sectors. Although the public sector offers better compensation and more job security, the PNFP sector was found to offer better working conditions.

Health workers were found to be given high status and reasonable compensation compared to other professionals but working conditions are poor and the workload is perceived to be unmanageable. Many health workers had ambivalent relationships with health managers, and many nurses also reported a high level abuse by supervisors, physicians, patients and relatives. Their living conditions were poor with many not having

without access to transport, food, water, education for children, etc., and many felt free health care should be provided for their dependents. Some health workers complained that new staff, fresh out of training often received higher salaries than those with more experience, because they had higher qualifications, but still could not perform as well at their jobs. The main frustration cited by health workers was of frequent drug stock-outs, making it difficult to deliver quality health care to patients.

The researchers thus recommended for procurement mechanisms to be strengthened, especially at local level, and government to dialogue with all stakeholders and develop appropriate management and health worker support programmes and to streamline recruitment programs.

4.3 Discussion

Dr Lovemore Mbengeranwa: Health Services Board, Zimbabwe provided discussant input on the first two studies. He noted the usefulness of the studies and the lessons learned in relation to both internal and external migration. This pointed to some areas that need further attention:

- to address HRH within the context of a Health Service Strategic Plan and training of health managers in human resource management;
- to revisit the concept of bonding and replace it with investment in career pathways, conditions of service and a minimum set of retention incentives that have positive results; and
- to close the information gap and design a universally applicable format for gathering accurate data on resignations, infrastructure and basic resources.

He noted that the recommendations need follow up to ensure that they are shared and implemented and that the findings need to be raised in parliamentary and other political processes. He noted that economic and political stability are a fundamental determinant of success for HRH strategies.

Participants raised a number of issues in the discussion on the papers:

- There was general agreement that information gaps in this area need to be addressed through strengthened information systems, while noting sources of bias as people may not be honest about their reasons for leaving services;
- Non financial incentives while not “financial” from the point of view of the worker are a cost to the health care system that needs to be costed and assessed for its sustainability;

- The role of other actors, like banks, in providing some incentives needs to be explored;
- The role of macroeconomic constraints, including fiscal limits set by international finance institutions, on hiring of health workers need to be made clear and addressed;
- Evidence on the performance of bilateral agreements such as the Kenya-Namibia bilateral agreement needs to be gathered;
- The issue of health worker abuse was noted with concern, particularly as it reflects a form of gender violence against largely female health workers. Participants saw this as symptomatic of a break down in professional ethics, a cultural problem with the perception of women, and a sign of a potential chain of abuse with health workers then abusing patients.
- The specific situation of countries with small populations was discussed, noting their difficulties in production of HRH skills, and in matching training to posts. This may lead health workers to leave the country to seek additional training elsewhere and do not return.

In research on HRH it was observed by participants that it is important to involve government from the outset; but also to involve health sector workers and researchers, and to strengthen information systems. All studies pointed to the need for effective information from local level to assess the real implementation of HRH strategies, given the gap between policy and practice. Factors that do not easily emerge, such as interference from local politicians, can lead health workers to migrate out of systems. Other levels of government need to be aware of these types of problems so that they can be addressed more effectively. Management capacities need to be strengthened for this, while operational research should be built in to systems to expose the realities on the ground.

4.4 Synthesis of findings on retention

Dr Iipinge presented a synthesis of the findings. The desk review in ESA showed that in 2007 most countries were working to implant non-financial incentives in their human resources plans, but also have piece-meal policies, that are often not implemented and not properly financed. Documentation of best practices and processes is lacking, as is monitoring and evaluation of strategies. Strategies that do exist frequently only target a small cadre, whereas there is a need for a more holistic approach with incentives targeted at all levels of the health sector.

All the country teams reviewed national documents. Across the countries the most commonly identified non-financial incentive was training, giving health workers options in developing career paths. In a more negative light, all the studies highlighted lack of management skills as a major hurdle to retaining staff, so that capacity building and training is not only needed for health workers but also on human resources for HRH and health service managers across the region. Weak management was commonly identified as a reason for negative HRH outcomes.

Other incentives identified in the studies as having positive outcomes for retention were

- improving conditions at health facilities
- housing support (allowances, loans etc)
- recognition and career path support
- support and supervision.

A common feature was health worker's reported frustration at feeling unable to provide patients with a decent level of care. This was felt to be demoralising and lead to health workers leaving the health sector altogether, or going to work in health facilities where more adequate equipment and medical supplies are on hand.

4.5 Access to health workers in remote, rural areas through improved retention

James Chitsva of WHO presented a paper for David Shaw: WHO pointed to the fact that while the international migration of health workers has received greater publicity, the migration of health workers within countries (public/private, rural/urban) also merits attention by governments. WHO is focusing on this through a programme that aims to improve the retention of health workers in rural and remote areas, given demand from civil society and other quarters, and the renewed interest in primary health care (PHC).

He briefed delegates on the process WHO is implementing which is a time-bound participatory process involving relevant stakeholders.

"The goal of the health worker retention programme is to improve health outcomes (including the health-related Millennium Development Goals) by increasing access to health services. The programme is built on three pillars:

- *building the evidence base on effective retention strategies by conducting literature reviews, holding expert consultations, synthesising the evidence, identifying knowledge gaps and commissioning research;*
- *supporting countries to evaluate and adapt retention strategies by working with them to evaluate past and on-going strategies and to develop and implement country-specific plans; and*
- *developing and disseminating global recommendations on increasing access to health workers in remote and rural areas through improved retention"*.

In the discussion on the paper participants noted the new focus on PHC, commenting on the fact that countries implementing PHC in the past had had inadequate support from WHO when attention was being given to vertical programmes. However beyond raising PHC in policy, it was necessary to define what the critical HRH team is for PHC at the different levels of service delivery. A current focus in WHO on doctors, nurses and pharmacists as critical health personnel does not adequately match the wider HRH needs to deliver comprehensive PHC.

5. HEALTH SYSTEMS ISSUES AND HEALTH WORKERS

Dr Rene Loewenson, TARSC introduced a session reviewing evidence on issues beyond the use of non-financial incentives in retention. External migration poses a number of potentially wide issues, and reviews implemented in EQUINET in co-operation with ECSA-HC pointed to the complexity of calculating the costs of migration, given the distribution of costs in terms of:

- training and attrition;
- functioning of health systems;
- institutional memory and experience;
- disease burdens;
- to households of seeking care; and
- to migrants, families and communities.

At the same time reviews also noted the weakness of current ethical codes as a means for managing fairness in the distribution of these costs between countries.

EQUINET research with International Organisation on Migration (IOM) and ECSA-HC thus focused research on costs to the health system, to identify where these costs accrue to better inform negotiation of bilateral agreements between countries on HRH migration. The results of pilot work on this in Kenya would be reported in this session.

EQUINET with WHO and ECSA-HC has further explored and will present review work on the extent to which international funds have support HRH retention strategies.

At the same time evidence from other EQUINET work has highlighted the need for health systems to strengthen their services at the primary care and district level and to enhance promotion and prevention to address the rising relative inequality that appears to be putting a brake on poverty reduction. Evidence shows that current rates of growth would not produce a sufficient rate of reduction in poverty to meet MDGs unless there was also a reduction in income or asset inequality, and health services play a role in this. This raises the question of how well health workers are oriented towards and rewarded for supporting these essential elements of the health system. This session would also explore the findings from this work.

5.1 Impact of HRH migration on health systems in Kenya

Charles Dulo, Mustang Management Consultants reported on the work implemented with EQUINET, ECSA-HC, IOM and the Kenya Technical Working Group on Migration under Ministry of Labour in Kenya. The full study is published as *EQUINET Discussion paper 55* at www.equinetafrica.org. The study used the WHO framework on health system performance and focused on migration of doctors and nurses to assess costs for the health system, since these are the most mobile cadres. A mix of desk review and field survey of health workers, facility administrators and key informants in government departments, professional bodies and health administrators was implemented.

The costs of migration of health care professionals to the health system was estimated through costing of primary and secondary education and medical and nursing school costs, using 2005 data, while interviews assessed other areas of impact less amenable to costing. An estimate was also made of inward flows from remittances.

The study found that the Kenya government has lost an estimated US$95 million invested in training doctors alone (schooling and university) due to migration, excluding compound interest and the hidden costs to families and health services. Adding the costs of nurse training this figure would be substantially higher. The study estimated that about US$90 million flows inwards annually for nurses and doctors. These inward flows are, however, not made available to the health system. While these are rough estimates, given the exclusion of nurse training and the undercount of other costs it appears that even if remittances were to be accounted for, there still appears to be a net outflow of resources from the country and its health system due to external migration.

The study found other costs from migration to the health system, including:

- increased workloads for remaining staff, especially at peripheral facilities and in some rural districts, which may negatively impact on health service provision and on the referral chain.
- understaffing resulting in stress, burn out and demotivation, that become push factors for further migration.
- Weak training and supervision support undermining career path incentives for the remaining health workers.

Beyond the measures for improved retention discussed earlier in the meeting, the study highlighted the need to negotiate bilateral agreements to encourage skills exchange and return and to invest in career paths and training opportunities to address both retention and the negative impact of migration on the health system.

This study also found a paucity of strategic data on health worker migration and its health systems impacts and the researchers suggested that government invest in a strategic information system that links evidence on HRH with health system performance indicators. Such routine data set needs to be complemented by more focused studies to further assess the costs and benefits of migration and to review staffing norms and standards, using the Kenya Essential Package for Health (KEPH) to estimate workloads, define roles and calculate optimal staff levels.

5.2 Global and international funding for HIV and AIDS and health worker retention

Prof Dambisya, University of Limpopo outlined the findings of a review of literature on funds from Global health initiatives (GHIs) for their impact on HRH retention, commissioned by EQUINET, WHOand ECSA-HC.

"GHIs are now a major mechanism in development assistance for health. Three GHIs – PEPFAR, the World Bank MAP and the Global Fund – provide approximately twothirds of external resources going to HIV/AIDS. Global funding for HIV and AIDS has increased over the past 20 years: US$59 million in 1986, US$292 million in 1996, US$8.9 billion in 2006 and US$10 billion in 2007".

He noted a number of positive impacts of GHIs on HRH outcomes, including

- high prestige, high morale and high levels of motivation associated with HIV and AIDS programme;
- improved prognosis of AIDS patients, lower morbidity and mortality rates, with less stress on HCWs, better working conditions (e.g. through facility upgrades);
- HCW wellness programmes, with HCWs on anti-retroviral therapy (ART) improving, returning to work and being more productive;
- funds providing for training, paying and protecting the health of workers;

- improvement of facilities, establishment of supply chains for medicines and diagnostic supplies, purchasing of necessary equipment;
- creation of information systems and building management competency; and
- improved salaries or salary supplements, in some cases for all health workers in operational districts or for all HCWs.

Negative outcomes were however also noted, particularly:

- selectively applied incentives demoralising and discouraging those who are excluded;
- redistribution of medical professionals to target programmes e.g. HIV/AIDS, TB, and malaria, displacing skilled workers from other programmes;
- worker redistribution that may include the migration of workers across national borders; and
- flight of HRH from the public sector, including an internal brain drain of senior managers and public health specialists to institutions funded through GHI programmes.

He observed that there has now been an increase in attention to health systems strengthening aspects of GHI funding, including on service delivery, the health workforce, health information systems, medical products, health financing, and leadership and governance. Over a third of Global Fund resources have been spent on health systems strengthening, namely on human resources, infrastructure and monitoring and evaluation and the GAVI Alliance announced an increase of its financial commitment to health systems strengthening by $300 million, bringing the total HSS budget to $800m in 2008. Global initiatives for health systems strengthening include strengthening regional and country based UN agency provision of technical support (GAVI Alliance), building the capacity of regional institutions to deliver and mentor countrybased technical support (GHWA), the provision of secretariat-led technical support towards development of a broader network of regional suppliers managed by an independent organisation (Health Metrics Network), and secretariat web-based tools and databases (Stop TB) and coordinating technical support through partners (Roll Back Malaria, Stop TB). PEPFAR is responding to health worker scarcity as the single most serious obstacle to scaling up treatment.

As a conclusion, the review suggested that when used for general system improvements, and with proper planning, GHI funding can be used to support health workers for the whole system. An approach based on an 'emergency response' leading to fragmented vertical programmes was however felt to undermine these outcomes. This points to the need to address programme effectiveness within frameworks of systems support such as through SWAP or budget support, coupled with country driven processes.

5.3 Health workers interactions with communities - pulling together or pulling apart?

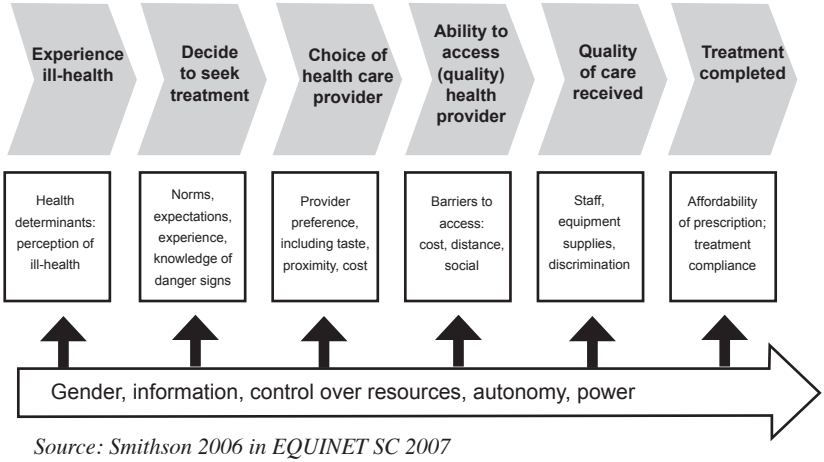
Dr Loewenson, TARSC suggested that the health worker crisis not only raises attention to get the numbers and distribution right with respect to HRH, but is also an opportunity to build new types of relationships between HCWs and communities to support the universal comprehensive PHC-oriented health systems that close inequalities and improve health. There is a chain of disadvantage in access to health interventions that starts within the community and relates to various barriers to health promoting environments, health seeking behaviours and health service uptake (see Figure 2). This indicates that health workers need to engage with other actors and sectors and within the community to address these issues to effectively promote health and manage ill health. Engaging these barriers calls for various interfaces between communities and health workers, through

- Services: Outreach and health promotion oriented, client and community centred/ friendly services, expert patients, peers.
- Participatory planning: communication, assessment, joint surveys, budget processes.
- Mechanisms for decision making: committees, boards, etc.
- Accountability: public hearings, targets/charters and monitoring, information exchange

How prepared are health workers to facilitate this aspect of health systems? From a programme of seven participatory action research studies in five countries exploring different aspects of health worker-community interaction a number of problems were found:

- poor uptake of services for priority health problems;
- fear and power imbalances undermining communication between communities and health workers;
- poor communication undermining the correct use of services;.
- health workers and communities excluded from top down resource planning; and
- undiagnosed occupational illness in health workers.

Figure 2: Chain of disadvantage in access to health interventions



Source: Smithson 2006 in EQUINET SC 2007

The participatory work showed that:

- closing the communication and perception gaps between health workers and communities led to improvements in service compliance and uptake;
- communication and perception gaps can be closed by changes in work organisation, client networks and client roles in clinics and joint meetings;
- increased awareness in communities supports detection and longer term management of chronic conditions like mental illness;
- activating joint mechanisms increased local resource inflows, and improved prevention and trust between services and communities;
- improved communication led to changes to work organisation and care environments (reduced queuing, improved interviews, etc.) and better interaction with community support roles such as expert patients, client interpreters, and client networks, reducing work stress and improving morale of health workers; and
- increased dialogue with health workers strengthened action on occupational health and safety issues in health sector workplaces.

Achieving such changes calls for systems that provide policy signals, incentives, resources andcapacities for communication, for joint planning and information exchange in health workers as a part of institutionalising PHC approaches. This should be embedded in health worker curricula and in the legal provisions, policies, guidelines and performance incentives for health workers.

This calls for updating of outdated industrial relations approaches often used in the health sector.

5.4 Discussion

Philemon Ngomu of the Southern African Network of Nurses and Midwives initiated the discussion as a discussant on the session. He pointed to the inequalities in the current global village that drive migration:

"If the current global village were to represent 100 people: six people would have 59% of the village's wealth, 80 would live in substandard houses, 70 would not be able to read, 50 would be malnourished, only one would have tertiary education, 23 would have mobile phones, and ten would have personal computers. The African village has 10% of the global population, 25% of the global disease burden and 60% of people living with HIV/AIDS. The continent also has the highest disease burden from TB and Malaria. However, only 1% of the global health spending is spent in Africa, and only 2% of the global health work force work in Africa".

He noted the loss of health personnel through external migration combined with AIDS to make health work a less popular career at the same time as rising workloads combine with needs for new skills. Addressing these multiple issues calls for intervention at the level of creating enabling systems and environments.

Participants in the discussion suggested that strategies should be based on the realities of health systems in the region, including roles for cadres such as traditional healers and community health workers. Participants warned about building systems that are dependent on external funds, questioning what would happen when such funds withdraw, and calling for increased investment of such funds in skills transfer to avoid such funds being cycled back out of the region through paying for 'technical support'. It was noted that EQUINET's focus on 'reclaiming the resources for health' calls for a policy focus that strengthens control and use of the many African resources that are currently lost (financial, trade, natural and people).

The role of health workers at different levels was debated, and it was questioned whether strategies such as task shifting can be included as part of PHC. It was noted that task shifting as applied in some settings had had a negative impact on service delivery due to the limited nature of the training involved and that what was needed was a review of roles based on task analysiswith clear integration in career paths to support PHC models. Task shifting thus needed further exploration as an approach.

Finally researchers were urged to communicate evidence in a manner that influences policymakers.

6. PANEL DISCUSSION: POLICY FORUM

A final review of the policy uptake of the issues raised in the meeting was managed in the form of a panel discussion, moderated by Prof Dambisya.

Lebogang Lebese of the SADC Secretariat noted the windows of opportunity for uptake of the proposals from the meeting; HRH is a permanent item on the SADC agenda. She suggested presenting a minimum package of non financial incentives with positive impact to the SADC meeting based on evidence from the work.

"For SADC issues of management are key, and need to look more at how we can develop performance management systems to recognise good performing health workers".

She noted the collaboration between SADC and EQUINET, invited communication on the meeting outcomes through the SADC directorate and suggested that EQUINET collaboration with SADC be further formalised through communication to the SADC Executive secretary.

James Chitsva of WHO noted that WHO's policies draw from the member states, such as through the World Health Assembly, and that recommendations coming from country level have weight. He further noted that a number of issues raised in the meeting are on the WHO agenda, such as the focus on retention, or the encouragement WHO gives to donors to develop integrated programmes. He suggested that standardisation of qualifications to ensure skills circulation would be useful, and called for greater focus on the implementation of programmes and policies.

Philemon Ngomu of SANNAM noted that health workers can and have put the issues raised at the meeting on the policy agenda, through labour bodies and in an advisory position with SADC, but that perhaps what is needed is strategic review to identify strategies that will have greater impact with partners.

The panel presentations were followed by a discussion on the issues and gaps.

There was a major concern that the issue of task shifting be tackled not as a stop gap for HRH shortages but within a more holistic framework of task analysis, career paths for health professional development and training responsibilities and needs across countries. A great deal of task shifting is already informally taking place and a clearer processes needed for assessing and formalising appropriate tasks within the different levels of the system. It was noted that SADC has not yet agreed on task shifting policies, and participants felt consultation was needed before making decisions due to the still poorly assessed impact on existing systems.

A further concern was of the sustainability of externally funded approaches to addressing HRH issues. This calls for improved financing of health sector to meet the 15% Abuja declaration that most countries have still not met it. More aggressive advocacy was called for to finance the health sector adequately and reprioritise it within government funding. It was noted further that this too may not be adequate to meet the gap in HRH needs if production and retention issues are not addressed. It also means making choices about where resources are allocated, to have the greatest gain in health.

7. WORKING GROUPS

Two sets of working groups were held during the meeting:

- the first on day 1 focused on the guidance on health worker retention; and
- the second on day 2 focused on the guidance in other areas.

In each case the groups explored recommendations for policy and guidelines, and identified knowledge gaps and follow-up actions.

The reports of these group discussions were compiled into a synthesis documented presented, discussed and adopted on the last day, shown in *Section 8*.

Further to the synthesis document delegate discussions pointed to:

- the need to address countries' absorption capacities to effectively use additional funding, to make sure that such funding does not lead to reductions in government budgets and that funds are effectively applied.
- The preference for retention strategies rather than restriction of movements, given the realities of global processes and trends
- Recognition of a diversity of issues to monitor and evaluate at regional level, including the non return of people sent for training to other SADC countries; the need to explore the effectiveness of current bilateral agreements in managing migration; the stable handling of return migration for both migrants, sending and receiving countries;
- The need to set and manage explicit and legally bilateral agreements to provide for compensatory investments in areas where costs outweigh benefits, such as in training losses
- Concern to clarify the role of community health workers as part of the community and part of the health system, what guidance exists on their 'migration' into formal roles in the health system and the need for policy coherence on their health sector links and career progression.

It was noted that region wide positions need to take into differences between countries and country specific strategies that need to be recognised at regional level. Further more attention should be given to the maldistribution of health workers within countries and the incentives needed to address this. The region should develop guidance on the minimum package of non-financial
incentives that should be included in HRH strategies to address this, and on the other policies that affect this, such as on the guidance for forms of decentralisation that match capacities, responsibilities, resources and authorities.

The draft synthesis of recommendations, guidelines and research issues arising from the meeting were presented and reviewed by participants and amendments integrated. The final version is shown in *Section 8* below.

8. RECOMMENDATIONS FROM THE REGIONAL MEETING ON HEALTH WORKER RETENTION IN EAST AND SOUTHERN AFRICA

The EQUINET –ECSA HC regional meeting on health worker retention in east and southern Africa (ESA) was held in Windhoek, Namibia February 25-27 2008 and involved 32 delegates from government, academic and research institutions, health worker organisations, parliament and civil society from 10 ESA countries and from regional organisations including SADC and WHO (*see delegate list, Appendix 2*). In line with the ECSA Regional Health Ministers Conference (RHMC) resolutions 2006-2008, the SADC Resolutions on Health workers, and the ECSA and SADC strategies on health workers, the meeting reviewed evidence from two regional review papers, five country field studies (*see reference list, Appendix 3*), a multi-country participatory research programme and delegate experience to propose areas for policy, guidelines and research on health worker retention, especially in priority health services.

Context

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

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

The country studies presented at the meeting demonstrated that, beyond salaries, the push factors for health worker movement commonly include poor work environments and conditions, poor communication resources at facilities and poor communication within the health system, inadequate management and supportive supervision, heavy workloads and inadequate recognition. HRH policies and a number of non financial incentives (NFIs) were being applied across all countries, but gaps existed with respect to

- implementation, monitoring and evaluation
- sector wide vs. cadre specific NFIs
- impact assessment of NFIs.

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

Policy recommendations

The meeting noted that producing and retaining HRH are a priority focus for addressing the health worker crisis, within the context of National Health Strategic plans and strengthened HRH planning, information and management that addresses HRH demand and supply. The meeting proposed a number of policy options for **strengthening HRH retention**, i.e.

Planning and implementing HRH retention strategies

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

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

Financing HRH retention strategies

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

On capacity and systems support for HRH retention

Capacity strengthening necessary to implement HRH retention incentives includes:

- training of health workers in use of healthcare management tools (standards, guidelines);
- strengthening institutional capacities for improved governance and delegating more power and authority to and capacitating the district level of health systems;
- developing and/or reviewing HRH /staff development policies to address current issues relating to training, promotion, career paths and other incentives;
- establishing or improving performance management systems with clear-cut rules of performance and independent evaluations;
- Delegates proposed that a network of HR professionals be formed in the region, including HRH management and research personnel, with provision for annual meetings for information and professional exchange.

In addition to retention incentives the meeting reviewed evidence and proposed policy options for **strengthening the effective performance of HRH,** i.e.:

Strengthening the Primary Health Care (PHC) orientation of health workers

Noting the policy priority expressed by countries in ESA to strengthen PHC as an approach across the health system as a whole, to mainstream specific programmes within PHC and to strengthen the community, primary and district levels of the health system, delegates proposed that:

- Governments take leadership in the provision, supervision and support of Community Health Workers (CHWs), that HRH strategies include the Community Health Worker cadre, and provide for the resources for their training and functioning.
- Health sectors involve primary care level health workers and community representatives in local health planning.
- Primary level health worker roles in facilitating and managing community programmes / interactions be recognised in health worker performance appraisal incentive and management systems
- Training modules be developed for HRH on public health planning and management and on communication and facilitation skills; with training integrated into HRH training and induction;
- Incentive schemes address specific non financial incentives for primary level health workers in rural communities, including but not limited to support for housing construction (to stabilize them in these areas) and schooling for children.
- Personnel in other sectors, such as transport, infrastructure, water, be oriented and encouraged to play their role for PHC to be effective.

On task shifting

Policy dialogue on task shifting needs to be backed by more evidence on current practice and skills needs, to be based on task analysis, to be linked to policies on career path development and to take into account industrial relations implications.

On HRH migration

- The right to move and free movement of labour needs to underpin responses to migration, together with the need to protect health care services. This calls for capacities to negotiate agreements on migration, supported by databases and information on HCW migration and its impact, including on health systems.

- Legally binding bilateral and multilateral agreements should respect the rights of migrating workers and of communities from sending countries, ensure that migrating workers are not paid less than those in receiving countries, and provide for receiving countries to meet costs of losses to the health systems in sending countries, such as through investment in the retention incentives, working conditions and training programmes of sending countries.
- Delegates encouraged SADC to implement its proposals to standardise the systems for qualification, registration, training and the curricula and for this standardisation to be more widely applied within the ESA region.
- Delegates recognised that internal migration within ESA countries is a major factor affecting access to quality health care and encouraged strategies and agreements for management of migration within and beyond the region to explicitly address this issue.

Guidelines

The meeting identified areas and recommended follow up work at regional level to develop guidelines to support health systems responses on HRH:

- Guidelines to support development of, and analysis of data from information systems to support planning, monitoring and evaluation, including indicators on: reasons for why people are leaving; resignations, infrastructure, basic resources; NFI type, target group, funding agent and sustainability, perceived effectiveness of incentives.
- Management and Implementation guidelines for introducing, managing, monitoring andevaluating non financial incentives (including on nature, purpose; beneficiaries and funding of incentives).
- Guidelines to support the sustainability of financing schemes for HRH and the management of external funds for HRH, including in terms of capacity building (e.g training, knowledge transfer, mentoring, under-studying and systems building); remuneration; ethical recruitment and the relevance and appropriateness of technical assistance.

Knowledge gaps

A number of areas were identified as knowledge gaps meriting further audit or research, including the need for:

- Strengthened monitoring and evaluation systems and analysis of primary data on different dimensions of migration and retention, including numbers of migrating professionals; outmigration to other sectors - with destinations and motivations; migration and return intentions and motivations; remittance flows; training capacities in countries by cadre.

- Evidence to inform understanding of the "stay" factors of health workers who do not move (eg support for own housing) for better integration of these factors in HRH policies and programmes.
- Cost benefit assessment of non-financial incentives, to assess their sustainability and impact on retention; and to further explore career path strategies (including training, promotion and education qualification systems).
- Assessment of the performance of the regional strategy for building centres of excellence, including in terms of investments in capacities and uptake of such centres.
- Assessment of mechanisms for managing external funds, including mechanisms at country level to sustain or take over externally financed programmes, for capacity building for this and options being used to overcome fiscal constraints to expenditure on HRH, such as using local contributions to recruit additional staff.
- Assessment of impacts of migration and the performance of retention incentives on health and health care outcomes.
- Cross country research to map, understand and exchange information on the functioning and shortfalls of the current CHW schemes in different countries.
- A needs and capacity assessment in countries to align any dialogue on task shifting to the reality of what is happening on the ground in services.

Follow up on these issues will be taken up at national and regional level with relevant authorities and institutions. Research should encourage multi-actor teams that involve policy, government and research co-operation from design stage. It was proposed that the regional institutions (ECSA-HC and SADC) set up a regional fund that can be used to carry out small scale country specific research to support HRH planning, policy development and management. The meeting also proposed that EQUINET facilitate a follow up process based on work done to date to develop guidelines for robust research methodologies for the assessment of HRH retention incentives and their impacts, sustainability and costs, to stimulate and support further research.

9. FOLLOW UP AND CLOSING

The follow up to the meeting was discussed, including submission of the recommendations to the ECSA HC and SADC for presentation at their next ministerial meetings in March and April respectively.

The individual studies reported at the meeting are already published, but a synthesis across the country reports on retention will be published and made available via website and email. It was noted that EQUINET encourages research teams to publish their work in peer reviewed journals, has a skills manual online to support this and can provide some mentoring to its researchers to assist in this if needed.

The next steps in work in EQUINET will be further developed after the feedback from the ECSA and SADC policy meetings and the EQUINET Regional Conference on equity in health in Uganda, in September 2009, where research on this area will also be included in a parallel session. Areas that still need further development like the work in migration need to be taken up through a lead organisation in the network and in dialogue with ECSA, SADC, IOM and WHO including for be support of identified research priorities.

Dr Iipinge, University of Namibia drew the meeting to a close. She thanked the participation of ECSA-HC, SADC, the SADC HR committee, parliamentarians and government departments involved the process, including the HRH department in the Namibia Ministry of Health, as an important link to the policy and political levels needed for this work. She welcomed the participation of SANNAM for putting forward the workers viewpoint and expressed delight to have Angolan colleagues in the meeting.

"This meeting was held to strengthen ourselves and our work, as well as to feed into SADC, ECSA and WHO and we hope researchers will take on the challenge of further research to help strengthen health systems and build institutions of excellence in the region. We will do away with borders and talk about health in the whole region, not just on a national level".

She urged participants to come back to Namibia to explore the country, and to travel safely home.

APPENDIX 1: PROGRAMME

Wednesday February 25th		
	Opening	
8.45-9.45am	Opening remarks Official Opening Introduction to the meeting- aims, delegate introduction, admin issues	Dr L Haoses, Dean, Faculty fo Medical and Health Sciences, UNAM Hon Petrina Haingura, Deputy Minister of Health, Ministry of Health Namibia S Iipinge, UNAM
9.45-10.45am	Strategies and policies for managing health worker retention and migration in ESA: issues and progress Presentation Discussant Discussion	 Y Dambisya for Helen Lugina, ECSA-HC L Lebese, SADC
10.45-11.15	Tea/coffee break	
	Overview of the EQUINET-ECSA work	
11.15am	Introduction to the regional programme of work Overview of retention incentives in ESA Presentation of findings from country studies Zimbabwe Kenya Discussant Discussion	S Iipinge, UNAM Y Dambisya U Limpopo M Chimbari, NUST S Iipinge for D Ndetei, AMHF L Mbengeranwa, ZHSB
12.55pm	Lunch	
	EQUINET-ECSA work continued	
2.00pm	Presentation of findings from country studies Swaziland Tanzania Uganda Discussion	 S Sibandze, MoH Swaziland M Munga, NIMRI F Matte, Capacity Project
3.15pm	Tea	
3.30pm	Synthesis of findings on retention Improving access to health workers in remote and rural areas through improved retention Discussion	S Iipinge, UNAM J Chistva, WHO
4.15pm	Introduction to working groups Gp 1: policy recommendations and guidelines Gp 2: areas for capacity, systems support Gp 3: knowledge gaps Working group session	
Thursday February 26th		
8.30-9.30am	Working group session continued	
9.30-10.30	Presentation and discussion of group reports	
10.30-11.00	Tea/Coffee	

	Other health worker issues	
11.00am	Introduction to wider health worker concernsmigration, workloads, funding Impact of migration on health systems in Kenya Effect of global funds on health worker retention Health workers at PHC level and interface with communities Discussant Discussion	R Loewenson TARSC/ EQUINET C Dulo, Kenya TWG Y Dambisya, U Limpopo R Loewenson, TARSC P Ngomu, SANNAM
12.45pm	Lunch	
	Policy forum	
2.00pm	Panel discussion on policy issues and options: Introduction 10 minutes briefings from panelists on policy issues, guidelines and progress from their institution SADC WHO SANNAM Questions to panelists and discussion Wrap up 2 minutes remarks from panelists Closing	 Y Dambisya L Lebese D Shaw P Ngomu Moderator Y Dambisya Panelists Y Dambisya
3.30pm	Tea	
3.45pm	Introduction to working groups Gp 1: policy recommendations, guidelines, knowledge gaps on health worker migration Gp 2: policy recommendations, guidelines, knowledge gaps on financing and HCW policies Gp 3: policy recommendations, guidelines and knowledge gaps on health workers and PHC Working group session	
Friday February 27th		
9.00-10.15	Presentation and discussion of group reports	
10.15-10.45	Tea/Coffee	
10.4512.00pm	Presentation of the synthesis of the meeting proposals: Policy recommendations Guidelines Follow up research and capacity support Plenary discussion Policy submissions to ECSA RHMC, SADC Future work Session at the EQUINET conference	S Iipinge, R Loewenson
	Closing	
12.00- 12.30pm	Meeting assessment Closing remarks	 S Iipinge UNAM/EQUINET

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APPENDIX 3: COUNTRY STUDIES AND REVIEWS ON HEALTH WORKER RETENTION:

1. Chimbari, MJ; Madhina, D; Nyamangara, F; Mtandwa, H; Damba, V (2008) An assessment of the Zimbabwe government strategy for retention of health professionals. EQUINET Discussion Paper Series 65. NUST Zimbabwe, EQUINET, ECSA HC: Harare.
2. Dambisya YM, Modipa SI, Nyazema NZ and the Health Systems Research Group, Department of Pharmacy, University of Limpopo, South Africa (2009) 'A review on the impact of HIV and AIDS programmes on health worker retention,' in co-operation with WHO, ECSA-HC, TARSC, UNAM EQUINET Discussion Paper Series 71. EQUINET Harare
3. Dambisya, YM (2007) A review of non-financial incentives for health worker retention in east and southern Africa. EQUINET Discussion paper 44: University of Limpopo EQUINET: Harare.
4. 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. Ministry of Health Swaziland, EQUINET, ECSA-HC: Harare.
5. Munga MA and Mbilinyi DR (2008) 'Non-financial incentives and retention of health workers in Tanzania: Combined evidence from literature review and a focused cross-sectional study,' EQUINET Discussion Paper 61. NIMRI Tanzania, EQUINET, ECSA-HC: Harare.
6. Mwaniki, DL; Dulo, CO (2008) 'Migration of health workers in Kenya: The impact on health service delivery,' EQUINET Discussion paper 55. EQUINET, ECSA HC and IOM: Harare.
7. Ndetei, DM; Khasakhala, L; Omolo, JO (2008) 'Incentives for health worker retention in Kenya: An assessment of current practice,' EQUINET Discussion Paper 62. AMHF, EQUINET, ECSA-HC: Harare.

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

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