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Worker Retention in Human Resources for Health: Catalyzing and Tracking Change

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Background

Retention continues to be a serious challenge in the human resources for health (HRH) crisis. There is increasingly widespread commitment to initiatives to attract and retain skilled workers, especially in rural areas. However, the factors influencing health workers' decisions to move from impoverished rural areas to richer and better equipped urban settings and from low-income countries to those offering higher salaries are complex (Stilwell, 2008). Available evidence consistently shows that health workers are ready to leave because of low compensation, lack of practical and educational opportunities, poor working and living environments and inadequate social amenities (Yumkella, 2005; Lehmann et al, 2008; Dieleman and Harnmeijer, 2006).

In order to help HRH practitioners address the challenge of retention, the Capacity Project selected information from existing literature to compile a resource paper (Yumkella, 2005) and a technical brief (Yumkella, 2006). The purpose of this brief is to update and document some contributions made from 2005 to 2008 in the area of worker retention.

Understanding Retention Drivers: Country-Level Experiences

By understanding the factors that influence workers' decisions to accept and remain in posts, especially in remote areas, HRH leaders can make more informed, data-driven decisions in developing retention strategies. However, senior-level policy-makers need stronger evidence from assessments to make decisions that will contribute to improving the staffing of health systems and worker morale. This section highlights key findings from three country assessments.

Uganda: Looming Discontent

The Ministry of Health and partners conducted a nationally representative facility-based job satisfaction study in 2006. The findings revealed discontent; only half the professionals surveyed from the public sector and the private not-for-profit (PNFP) sector (Uganda Catholic and Protestant Medical Boards) reported being satisfied with their jobs. Higher levels of dissatisfaction were reported in the PNFP sector than in the public sector. The highest levels of dissatisfaction were reported among doctors in the PNFP sector and within the group aged 30 years and below. Surprisingly, even though morale is low, job stability and longevity is high. Over 80% of the skilled professionals surveyed were still in their first jobs and about half indicated that they planned to stay in their jobs indefinitely. On the other hand, over half (57%) of the doctors expressed a strong desire to leave within two years. Skilled professionals considered their salary packages to be inadequate and unfair, and they felt dissatisfied by working in environments with insufficient supplies of drugs and equipment, unmanageable workloads and limited strategies in place to minimize health hazards (Uganda Ministry of Health and Capacity Project, 2007). Because it is not clear what the link is between intent to leave and actually leaving, precise conclusions about retention drivers and linkages to turnover are hard to establish from this study. Still, the Ugandan government cannot ignore the wider implications of the looming discontent in the health sector. There is the risk that unhappy workers will negatively impact the work climate by spreading discontent among those who feel motivated to make the best of a challenging situation. At the other extreme, dedicated professionals who tire of their poor working conditions may be likely to look for employment elsewhere.

Tanzania: Employment Conditions

A literature review of health worker retention drivers in Tanzania (Yumkella and Swai, 2007) revealed high vacancy rates in rural areas, with many unfilled positions for clinical officers, assistant medical officers and nurses. Among final-year medical students, less than half (48.5%) were willing to apply for or accept rural posts even though most of them grew up in rural areas. The literature also showed that adverse working conditions is a key factor keeping health workers from taking open positions (attraction) and leading those who had accepted rural posts to consider or act on the decision to leave (retention). As in the case of Uganda, workers in Tanzania expressed strong feelings about low compensation, overwhelming responsibilities in a challenging work environment, limited training opportunities as well as inadequate supervision from their immediate managers.

Policy-makers need stronger evidence from assessments to make decisions that will contribute to improving the staffing of health systems and worker morale.

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Income Supplements: Some Red Flags

Ghana: well-intended schemes can have unintended negative consequences. *Ghana introduced the Additional Duty Hours Allowance (ADHA) scheme in 1998 as a negotiated settlement to prevent strikes of public sector doctors. The intention was to compensate doctors, particularly junior doctors, for working longer hours. The scheme rapidly expanded across all workers in the health sector, and within a few years it had effectively increased take-home pay between 75% and 150% depending on cadre and location. While there was some evidence that the ADHA initially stemmed the exodus of doctors, this trend did not continue. However, the ADHA did lead to a rise in workers transferring from rural regions to those urban regions considered more liberal in awarding ADHA payments. Also, rather than stemming industrial agitations or pacifying unions, the scheme led to increased strike action in the public health sector. This was due in part to ADHA payments being perceived as a salary enhancement or an entitlement rather than payment for overtime hours approved and worked. Action by the government to impose ceilings or delays in payment triggered industrial action by health worker unions (Ruwoldt et al, 2007).*

Burkina Faso: worker perspective is important when setting types and levels for income supplements. *The government introduced a financial allowance scheme under the categories of function, accommodation, extra duty, night shift and risk, with a range from 46 to 245 USD depending on cadre and work circumstances. The financial incentives that translated to pay raises, however, did not reduce flows from rural to urban or from public to private for-profit and international NGOs. The average length of time workers served in public sector facilities in rural areas remained consistent at three years. Workers judged the increased salary as not competitive when compared to levels in the private sector and complained that the risk, night duty and accommodation allowances were inadequate (Bocoum, 2008).*

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Liberia: Job Security
Liberia's HRH predicament typifies a postconflict situation in which the workforce suffers from numeric, skill and geographic imbalances. A large number of health workers lost their lives in the war, and many others migrated in the search for safety. Many workers who stayed in Liberia moved to safer areas, leading to a disproportionately urban concentration. Highly skilled professionals who are able to market their skills abroad left the country, resulting in a scarcity of qualified professionals (Liberia Ministry of Health, 2006). The few who stayed to serve rural populations had to attend to more cases, leading to fatigue and burnout. In addition, health workers profiled for a 2006 rapid assessment were concerned about the high proportion of workers (over 80% according to interviewees) who provide care but are not on the government payroll. Workers employed by nongovernmental organizations (NGOs) expressed concern about future unemployment, given signs that NGOs would exit the country as the situation changed from relief and humanitarian assistance to rehabilitation. For HRH managers in Liberia, a key challenge is to motivate and retain employees in an environment of increased uncertainties (Yumkella, 2007).

Emerging Lessons from Practical Schemes to Improve Retention

A number of developing countries are employing various strategies to energize the workforce and stem flows. Many practices show promise for wider application across countries, but evidence of successful programs is seldom documented or shared. This section describes various schemes to improve worker retention.

Kenya: Work Climate Initiatives
The Capacity Project worked with the Ministry of Health to select and pilot simple, low-cost work climate improvement interventions in ten rural facilities over a period of one year. The primary purpose was to positively impact motivation and job satisfaction and help sites retain their valued staff. Actions taken include more frequent team meetings for sharing information and problem-solving, community outreach days, inexpensive renovation of hospital facilities, purchase of new equipment, more equitable staff shifts, managing inventories to avoid stock depletion, lounges with free beverage facilities for staff, servicing vehicles previously considered unserviceable, introducing safe waste disposal measures, improved signage within several facilities, organized patient flow procedures, less littered yards and cleaner toilets and facilities. New resource centers at each site help to create a culture of continuous learning. A follow-up survey indicated an improvement in worker morale. Nearly all (90%) staff in the ten sites expressed high satisfaction with their work environments, up from 60% at the beginning of the pilot. Most workers said they had no intention of leaving or transferring from their facilities (Adano, Namanda et al, 2008).

Ghana: Human Resource Management (HRM)
At the 2008 Global Forum on HRH, a district health director working in a remote area in Ghana shared a compelling case of how applying simple HRM strategies can make a difference for health workers. The winning principle is a management style that pays attention to staff welfare issues. Through a database, district leaders track when each worker in the team is due for promotion, further training or eligible for leave, and are able to take timely action. The actions contribute to an environment in which workers feel that their supervisors care about their needs. The district director, Anthony Ofusu, emphasized that "having a human face and letting staff know you care is also key to satisfaction and retention" (Ofusu, 2008). Another effective practice is to be clear *at the beginning* how long a worker is to be assigned to a particular facility and to get a clear contract or agreement that indicates when a transfer is to take place.

Swaziland: Health Workers' Own Health Needs
Swaziland's retention story is built on the conviction that adding a dimension in the health system focused on care for health workers will result in improved satisfaction and retention. The Swaziland Nurses Association initiated a wellness center in 2004 for health workers and their families in one region. The center offers a wide range of services including reproductive and child health, HIV/AIDS therapies and services for stress management. According to available records, the intervention region lost 169 nurses in 2004 alone, either through death or migration. There has been a steady decline in attrition since 2004, down to 40 nurses in 2007 (Dlamini, 2008). Implementers dub the period before the wellness center scheme as the "the era before dawn." (See also Galvin and de Vries, 2008.)

Zambia: Financial and Nonfinancial Incentive Packages
Health worker rural retention scheme. Zambia's Central Board of Health initiated a retention scheme in the public health sector as a pilot in 2003. The scheme (which received funding support from the Netherlands) sought to recruit and retain doctors in rural areas by providing a financial incentive (hardship allowance), school fees and loans for large purchases like cars or houses. Funds are also made available for renovation of government housing. At the end of the three-year contract, the doctors are eligible for postgraduate training. A 2005 midterm review found that the program had been successful in attracting doctors to rural areas, and 53 additional doctors joined the scheme. Although four left by the midterm review, attracting 53 doctors in two years was a significant milestone for Zambia. More importantly, some districts

received the services of a doctor for the first time ever (Koot and Martineau, 2005).

Performance-based incentive scheme. The Central Board of Health implemented a performance-based incentives pilot study in 2004, in two districts in Lusaka Province, with support from USAID. The pilot tested two models: financial incentives derived from 10% of user fees with modifications in distribution; and nonfinancial awards in the form of trophies. Teams, rather than individuals, received the awards and made decisions on how to share them. In Luangwa, a small district that tested nonfinancial awards, the pilot was well received. Facility staff felt motivated and encouraged by the provision of the awards. District managers agreed that the process led to more and better support from district supervisors. Alternatively, in Chongwe, a large district where financial incentives were provided, staff expressed frustration with and suspicion of the process. The district health management team experienced challenges in providing routine support to health centers, making implementation of the performance assessment system difficult. Perceived lack of transparency on the scoring system for awards led to distrust of the system. While staff motivation increased in Luangwa over the period of the pilot study, it remained virtually unchanged in Chongwe (Furth, 2006).

Uganda: Space for Communities to Contribute to Retention

The Uganda health system makes provision for a strong facility-community link through health unit management committees. Committees promote transparency, accountability and ownership of the quality of health care delivery. In Mbale district, active committees emerged as strong lobby groups and developed practices that district leaders say have led to improved staffing levels, provider satisfaction and retention. For example, committees lobby with local government authorities for the deployment of priority staff to facilities (e.g., midwives); for the hire of additional support staff paid out of local government budgets; and for increased allocation of resources to health facilities (personal communication from District Health Officer Dr. Francis Abwaimo, 2008).

Key Reflections about Retention Initiatives

Activity in the retention scheme area has increased since we conducted research in 2005 for our first technical brief; now nearly every African country is doing something to address turnover (Adano, McCaffery et al, 2008). As we review recent progress in the retention area, the following reflections seem particularly important to note:

- *Before countries embark on schemes to stop workers from leaving their posts, they need more accurate data to establish the real magnitude of turnover.* If better data indicate that substantial numbers of workers are indeed leaving their posts, health sector leaders are urged to continue to test and document innovative retention schemes. Ultimately, knowledge gained will help isolate the most promising practices and lead to scaling up interventions. Furthermore, in building the evidence to guide the design of retention schemes, health leaders need not start from scratch. Rather, they are encouraged to use publications like this technical brief and to expand south-south dialogue to draw on lessons from existing schemes in similar contexts, take advantage of promising schemes and avoid practices with hidden disadvantages.
- *Stronger HRM systems need to be in place to enable successful implementation of many kinds of retention schemes.* As the Ghana ADHA study (see sidebar) demonstrates, weak HRM systems led to incentive pay becoming an entitlement, failing to reach the right providers and continuing even through performance breaks. The Ghana delegate at the 2008 Global Forum on HRH reinforced the point that many retention schemes will fail or be hampered if the HRM systems to implement them are weak.
- *Worker shortages and imbalances ought not always be attributed to high turnover.* Sometimes absenteeism or hiring system problems cause inadequate staffing, and are a different manifestation of weak HRM systems. Leaders need to keep in mind that to tackle this shortage issue, it is important to strengthen hiring systems so allocated positions are filled, attract health workers to take up rural posts and reduce absenteeism by motivating employees to go to work and serve clients for the full hours for which they receive pay.
- *Based on local conditions, countries should consider an appropriate mix of incentives that will be sustainable in the long term.* Equally important is to make a clear distinction, at the outset, whether incentive schemes are meant for improving retention or increasing worker and service productivity, as there are subtle—but very important—differences between the two purposes. (The Capacity Project is preparing a report on these issues.)
- *Building a strong team and systems at all levels of health care delivery to lead HRH planning and management* is one untapped practice that may yield good returns for addressing shortages and imbalances, including high turnover (Stilwell et al, 2008). In the Zambia performance-based incentive pilot study, the relative weakness or strength of leadership in the two districts had a direct correlation with the success of program implementation (Furth, 2006).

Income Supplements: Some Red Flags (continued)

Malawi: externally driven and differential benefits favoring one sector or cadre run the risk of failure. *The Christian Health Association of Malawi (CHAM), with support from Cordaid, introduced salary "top-ups" for medical officers to stimulate doctors to take up positions and entice them to stay at remote mission hospitals. Evidence showed that the higher salaries helped to attract and retain physicians. However, these higher salaries pulled doctors from government to CHAM, and the supplement threatened the arrangement for government to cover salaries for other CHAM personnel. Limiting the benefit to doctors caused dissatisfaction among other cadres, especially clinical officers, who report having equally heavy workloads. Finally, the scheme was not sustainable over the long term as funding from Cordaid had a time limit. In spite of the benefits of the scheme, CHAM decided to discontinue the salary supplement, recognizing that the scheme is not sustainable and can strain relations with the government (Aukerman, 2006).*

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