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Incentives for health worker retention in Kenya

Health systems reporter, 28 April 2009

Feature: Incentives for health worker retention in Kenya

Recommended readings:

- A review of non-financial incentives for health worker retention in East and Southern Africa
- Retention strategies for Swaziland's health sector workforce: assessing the role of non-financial incentives
- Non-financial incentives and the retention of health workers in Tanzania: combined evidence from literature review and a focussed crosssectional study
- Worker retention in human resources for health: catalysing and tracking change
- Guidelines: incentives for health professionals

Latest additions:

- Repositioning family planning: guidelines for advocacy action
- Severe maternal morbidity from direct obstetric causes in West Africa: incidence and case fatality rates
- Health of women after severe obstetric complications in Burkina Faso: a longitudinal study
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Feature: Incentives for health worker retention in Kenya

In Kenya, a lack of personnel in key areas of the country's health system is worsened by internal migration (from rural to urban areas). This in turn exacerbates the inequitable distribution of health personnel. Communities in the poorest areas of the country suffer most from this.

While Kenya's Ministry of Health actively recruits and posts health workers to poorer areas of the country (sub-district and district hospitals), inferior conditions and out-migration leads to a paradoxical situation of staffing gaps, vacancies and unemployed health workers. This pushes health workers to seek employment in the international market. Push and pull factors for migration include poor remuneration, poor working conditions with limited supplies and no supervision, heavier workloads in rural public facilities (due to greater demand), limited career and educational opportunities for workers and their families, poor communication, and the impact of HIV and AIDS.

In response, the Kenyan government has developed new standards to improve working conditions through a number of financial incentives: paid leave; overtime pay; house or car loans negotiated at lower rates (for highly skilled workers); allowances for transport, entertainment, hardship, responsibility, special duties and uniform; salary increments; and provision of opportunities to engage in private practice. Non-financial incentives include: sponsorship for studies with bonding agreements; housing (or housing allowances); post-qualification training and continuing medical education; life insurance; shorter working hours; medical cover (includes nuclear family); and, the introduction of HIV and AIDS treatment at workplaces.

However, these incentives have not halted the continual loss of qualified professionals. Furthermore, many nurses and clinical officers remain unemployed due to limits on employment and a freeze on filling newly vacant positions. Through a review of the literature and field research, a study led by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) examined the context for and trends in health worker recruitment and retention. In particular, the policies, systems and provisions for providing, managing, monitoring and evaluating non-financial incentive packages for health workers were evaluated.

There is 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 of any changes of services through improved management practices. The same was not the case in public facilities, where management systems and communication with health workers was poor. Although incentives for doctors in the public sector are well implemented, more

studies on incentives for other cadres of staff need to be conducted.

It is clear that the information gap disadvantages human resource managers in strategic planning and weakens their argument for additional resources for retention incentives. Apart from monitoring the implementation of incentives and assessing their impact, there is need for national level policies for retention of health workers in poorer rural districts. This will go a long way in attaining the minimum standard of 20 doctors per 100,000 patients as recommended by the WHO. Health workers value the non-financial incentives put in place. Further investment in these areas should be backed by sound management practices and strategic information to support effective management.

*This feature was written by **Professor David M. Ndetei** and **Dr. Lincoln Khasakhala**, from the University of Nairobi & Africa Mental Health Foundation (AMHF), and **Mr Jacob O. Omolo** of Institute of Policy Analysis and Research (IPAR), Kenya. This feature is based on a study carried out by the Regional Network for Equity in Health in East and Southern Africa (EQUINET) with the African Mental Health Foundation, University of Namibia, Training and Research Support Centre, University of Limpopo in co-operation with the East, Central and Southern African Health Community (ECSA-HC).*

More information:

- Ndetei, DM; Khasakhala, L; Omolo, JO (2008) Discussion Paper 62: Incentives for health worker retention in Kenya: An assessment of current practice
www.equinet africa.org/bibl/docs/DIS62HRndetei.pdf
- EQUINET
www.equinet africa.org/
- The Capacity Project
www.capacityproject.org/
- Global Health Workforce Alliance (GHWA)
www.who.int/workforcealliance/en/
- Human resources for health, Eldis dossier
www.eldis.org/go/topics/dossiers/human-resources-for-health
- Eldis Health systems reporter, February 2008: Focus on community health workers in Africa
www.eldis.org/go/topics/resource-guides/health-systems/health-systems-reporter/february-2008

Recommended readings

1. A review of non-financial incentives for health worker retention in East and Southern Africa

Authors: Y. M. Dambisya

Publisher: EQUINET: Network for Equity in Health in Southern Africa, 2007

This Equinet paper reviews evidence on the use of non-financial incentives for health worker retention in 16 countries in East and Southern Africa (ESA). Health workers are offered a variety of non-financial incentives including: training and career path-related incentives; incentives that address social needs (staff transport, childcare facilities, free food); improved working conditions and access to health care including anti-retroviral therapy. The paper finds that these incentives are not systematically documented in terms of their aims, design, implementation, monitoring and evaluation and timeframes.

The paper concludes that retention strategies improve the performance of the health system by increasing the pool of available skilled health workers and by increasing staff responsiveness to the needs of the patients. From an equity perspective, these strategies are crucial, as they are necessary for retaining health workers in the public sectors and in rural facilities, which largely serve the poorer members of the population.

The author recommends that: ESA countries continue to develop human resources for health information systems and personnel management systems; countries introduce incentive packages; countries use sustainable funding mechanisms to fund incentive schemes, such as national budgets or sector-wide approaches; managers take periodic review of their incentive schemes.

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=32041&type=Document

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

Authors: S. Masango; K. Gathu; S. Sibandze

Publisher: EQUINET: Network for Equity in Health in Southern Africa, 2008

This country study maps and assesses incentives for retaining health workers, particularly non-financial incentives. It explores existing policies, their relevance to current factors driving exit and retention, and proposes guidelines for introducing and managing incentives for health worker retention to maximise their positive impact.

Swaziland faces severe shortages of skilled health professionals, with many doctors, nurses, laboratory technicians and social workers emigrating to high income countries. The report found that six factors significantly influenced decisions by health care professionals to either change institution or to actively look for work in a different institution. Factors positively associated with retention

were job satisfaction, equality/treatment by employer, job discretion and helping others. Negative factors were the employee's attitude towards their institution and support.

Recommendations for retention of health workers include:

- collaboration between the health ministry, employers and the training institutions is needed to develop management training programmes for front line managers, as well as changes in the payment system, such as output-related payments
- government needs to introduce additional annual leave days, either paid or unpaid; additional sick leave or carers' leave; flexible working times and specialist training to meet employee interests
- institutions should provide human related quality management tools, such as supervision, feedback, and staff appraisals
- health institutions need to show employees they are valued and treat them with respect
- unions and health institutions must engage in frank and open discussion as to whether collective agreements present recruitment and/or retention barriers.

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=41590&type=Document

3. Non-financial incentives and the retention of health workers in Tanzania: combined evidence from literature review and a focussed crosssectional study

Authors: M Munga; D Mbilinyi

Publisher: EQUINET: Network for Equity in Health in Southern Africa, 2008

This report, published by EQUINET, details how non-financial incentives are being used in Tanzania as one way of encouraging health workers to remain in their posts. The report is split into two sections – a literature review and a field study involving health workers – and examines a range of non-financial incentives, including training, leave, promotion, housing, and a safe and supportive working environment. It also examines the systems for managing personnel and the implementation of incentives as a factor in retention. These included a participatory personnel appraisal system, worker participation in discussing their job requirements and welfare, supervision, recognition and respect.

There was general consensus from health workers and managers that interventions such as training and education, promotion and the provision of safe working and living environments can be strong motivators if implemented in an

effective and sustainable manner. Interviewees pointed to the demotivating effect of poor implementation of non-financial incentives. Participants in the field study observed that the major weakness with implementing non-financial incentives was the district authorities' inability to implement policies such as promotion and training. Health workers interviewed in the field study also pointed to a lack of transparency in the implementation of programmes, such as those for promotion and training. The report concludes that any analysis of issues that drive retention should take into account both individual and structural factors that shape individual health workers' preferences as well as the complex nature of the health care labour market. This needs to examine factors that not only guide the design of incentive regimes, but also the resources, management systems and other factors that enable their implementation in practice.

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=41171&type=Document

4. Worker retention in human resources for health: catalysing and tracking change

Authors: F. Yumkella

Publisher: The Capacity Project, 2009

There is increasingly widespread commitment to initiatives to attract and retain skilled workers, especially in rural areas. Retention continues to be a serious challenge in the human resources for health (HRH) crisis. This brief from the Capacity Project updates and documents a previously published resource paper and technical brief which focus on the area of worker retention. The author highlights key findings from three country assessments in Uganda, Tanzania and Liberia. The brief shows how a number of developing countries are employing various strategies to energise the workforce and stem flows. Many practices show promise for wider application across countries, but evidence of successful programmes is seldom documented or shared. Various schemes to improve worker retention are described in countries including Kenya and Zambia.

Key reflections about retention initiatives are offered. It is found that since 2005 activity in the retention scheme area has increased. Before countries embark on schemes to stop workers from leaving their posts, they need more accurate data to establish the real magnitude of turnover. The author argues that based on local conditions, countries should consider an appropriate mix of incentives that will be sustainable in the long term. It is also highlighted that worker shortages and imbalances should not always be attributed to high turnover. Finally, it is concluded that 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.

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=43120&type=Document

5. Guidelines: incentives for health professionals

Publisher: Global health workforce alliance, 2008

The growing gap between the supply of health care professionals and the demand for their services is a critical issue facing governments, managers and professionals seeking to improve international health and development. This paper from the Global Health Workforce Alliance provides an overview of the use of incentives for health care professionals. It describes some of the different approaches taken and presents characteristics shared by effective incentive schemes. The paper also suggests some approaches to their development and implementation.

The authors argue that human resources are the key element of service delivery. Even in the most well resourced and technologically advanced countries the interactions between health professionals and their patients remain at the heart of service provision. Non-financial incentives include provision of work autonomy, flexibility in working time and recognition of work. Financial incentives involve direct payment from employer to employee such as wages, bonuses or loans. The paper shows how incentives, both financial and non-financial, provide one tool that governments and other employer bodies can use to develop and sustain a workforce with the skills and experience to deliver the required care. The authors argue that this demands not just political will and continued hard work, but an acknowledgement by all key stakeholders of the commitment, skills and health benefits provided by health professionals worldwide.

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=43121&type=Document

Latest additions from the Health systems resource guide

1. Repositioning family planning: guidelines for advocacy action

Authors: WHO, Regional Office for Africa; BRIDGE Project (USAID and Population Reference Bureau); Africa's Health in 2010 (Academy for Education Development)

Publisher: Africa's Health in 2010 (Academy for Education Development), 2008

Provision of family planning services in Africa is hindered by poverty, poor access to services and commodities, poor coordination of the programmes, and dwindling donor funding. In addition, traditional beliefs favouring high fertility,

religious barriers, and lack of male involvement have weakened family planning interventions. Yet, it is considered an essential component of primary health care and reproductive health and plays a major role in reducing maternal and newborn morbidity, and transmission of HIV.

This toolkit aims to help those working in family planning across Africa to effectively advocate for renewed emphasis on family planning to enhance the visibility, availability, and quality of family planning services for increased contraceptive use and healthy timing and spacing of births, ultimately, improved quality of life across the region. It was developed in response to requests from several countries to assist them in accelerating their family planning advocacy efforts.

It contains of eight briefs including:

- An overview of regional and country data, trends and challenges (focusing on sub-Saharan Africa)
- Ten steps to developing an advocacy strategy and action plan
- Communicating with influential audiences including policymakers, health sector leaders, community leaders and the private sector
- Tips on how to engage journalists
- Additional resources

The complete toolkit comes with an interactive CD-ROM.
[adapted from the authors]

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=43036&type=Document

2. Severe maternal morbidity from direct obstetric causes in West Africa: incidence and case fatality rates

Authors: A. Prural; M. H. Bouvier - Colle; L. de Bernis; G. Bréat

Publisher: Bulletin of the World Health Organization : the International Journal of Public Health, 2000

Data on maternal morbidity make it possible to assess how many women are likely to need essential obstetric care, and permit the organization, monitoring and evaluation of safe motherhood programmes. In this paper by the World Health Organisation the authors propose operational definitions of severe maternal morbidity and report the frequency of such morbidity as revealed in a population-based survey of a cohort of 20,326 pregnant women in six West African countries. The study showed that certain complications, i.e. sepsis, uterine rupture and eclampsia, carried a very high risk of death for pregnant women in West Africa. This applied even in large urban settings where there was

good access to health care and its utilisation by pregnant women was of a high order.

This finding suggests an unsatisfactory quality of maternal health care. The fact that a quarter of the 81 percent of women who delivered within health services were not attended by qualified health personnel, even though such personnel were present in sufficient numbers, indicates significant malfunctioning of public health services. The authors detail how further analysis is in progress concerning the relationship between the different severe obstetric conditions, the level of care and the individual risk factors. It is to be hoped that a better understanding will emerge of severe maternal morbidity in West Africa, eventually leading to a major decline in maternal and perinatal mortality.

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=42847&type=Document

3. Health of women after severe obstetric complications in Burkina Faso: a longitudinal study

Authors: V. Filippi; R. Ganaba; R. Baggaley

Publisher: The Lancet, 2007

Although maternal mortality is widely used as an indicator of development, the many pathways that link maternal health and illness to long-term economic and developmental indicators are under-explored. This article in The Lancet investigates how severe obstetric complications affect a range of health and other outcomes in the year after the end of pregnancy in hospitals in Burkina Faso. The authors compare the health experiences of women whose pregnancies ended in severe obstetric complications with those of women with uncomplicated childbirth.

The article finds that women with severe obstetric complications were poorer and less educated at baseline than were women with uncomplicated delivery. Women with severe obstetric complications, and their babies, were significantly more likely to die after discharge with 2% of the 337 studied dying within one year. Women with severe obstetric complications were significantly more likely to have experienced depression and anxiety at 3 months. The authors find that the women were increasingly more likely to have experienced suicidal thoughts within the past year at all time points and to report the pregnancy having had a negative effect on their lives at all time points, than were women with uncomplicated delivery. The authors conclude that women who give birth with severe obstetric complications are at greater risk of death and mental health problems than are women with uncomplicated delivery. Greater resources are needed to ensure that these women receive adequate care before and after discharge from hospital.

[adapted from the author]

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=42845&type=Document

4. Make development inclusive: how to include the perspectives of persons with disabilities in the project cycle management guidelines of the EC

Author: C. Naughton

Publisher: Make Development Inclusive: mainstreaming disability in development cooperation, 2008

Although one in five of the world's poorest people are disabled, disability itself has not been included in world leaders' plans to meet the millennium development goals. This manual is designed to be used during the project management process. It is divided into three parts: an overview of concepts and guiding principles to take into account, how to incorporate a disability perspective into each phase of the project management process and a set of downloadable tools such as fact sheets, check lists and case studies.

Part 1 outlines the overall purpose of the manual and provides an overview of concepts including:

- a working definition of disability and why a disability perspective should be included in poverty reduction projects
- a look at whether disability inclusion is relevant to your project and different degrees of disability inclusion
- a look at the legal and policy framework for disability inclusion, particularly as it relates to EC development cooperation
- identifying stakeholders and providing them with support
- combining disability inclusion with the twin track approach, which includes specific support and empowerment of people with disabilities.

In Part 2, for each phase of the project cycle – programming, identification and formulation, implementation and monitoring and evaluation – the authors present:

- what the phase is about and the purpose of including a disability perspective
- expected results of including a disability perspective
- difficulties often encountered and the keys to success
- possible costs implications of including a disability perspective
- case studies and practical tools.

Part 3 is an online toolbox providing both online and downloadable tools (as

Word documents and PDFs). These have been divided into:

- disability-inclusive project planning and management tools for general use
- disability-inclusive project management tools based on EC guidelines
- case studies
- tools for including a disability perspective, listed by sector.

For links to the PDFs of Part 1 and 2, please check further information on the right-hand side.

Please note: this publication was funded by DG Employment and Social Affairs of the European Commission.

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=42826&type=Document

5. Choice of healthcare provider following reform in Vietnam

Authors: N. T. B. Thuan; C. Lofgren; L. Lindholm; N. T. K. Chuc

Publisher: BioMed Central, 2008

In Vietnam, the health-sector reforms since 1989 have led to a rapid increase in out-of-pocket expenses. This paper by Biomed Central examines the choice of medical provider and household health care expenditure for different providers in a rural district of Vietnam following health care reform. The results are based on twelve monthly follow-up interviews of over 600 randomly selected households in Vietnam. The authors find that the use of private health providers and self-treatment are quite common for both episodes and the poor tend to use self-treatment more frequently than wealthier members of the community. All patients in the study often use private services before public ones. The poor use less public care and less care at higher levels than the rich do.

The results also show that those with higher education tend to choose health care providers rather than self-treatment. Women tend to use drugs or health care services more often than men do. The results are intended for policymakers and health care professionals to formulate health care policies. Of foremost importance are the methods used to reduce self-treatment and no treatment. The authors highlight the importance of management of private practices and maintaining public health care providers at all levels. This is particularly key at the basic levels where poor people can more easily access health care services.

Available online at: www.eldis.org/go/topics/resource-guides/health-systems&id=42565&type=Document

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Announcements

Call for interest: to be a member of a new WHO Scientific Resource Group on Health Equity Analysis and Research

Closing date: 14 May 2009

The World Health Organization (WHO) is establishing a Scientific Resource Group (SRG) on Health Equity Analysis and Research to support WHO on its programme of work on equity and health.

This includes contribution to the development of WHO and other collaborative products or the peer-review of these products. The Scientific Resource Group (SRG) work aligns with a key strategic objective of WHO to address a broad range of determinants of health (social, economic, political, environmental, etc.) and a core value to increase social justice including health equity within and across countries.

Members will advise WHO on strategic directions, work plan content, objectives and priorities, as well as contribute to products and services in particular those relating to measurement, monitoring, evaluation, analysis and research.

More details available online at: www.eldis.org/go/topics/resource-guides/health/health-events-and-announcements&id=43007&type=Item

Conference: Nigerian National Health Conference (NHC 2009) 'Primary Health Care in Nigeria - 30 Years after Alma Ata'

Dates: 8 - 10 June 2009

Location: Le' Meriden Ibom Hotel and Resort, Uyo, Akwa Ibom State, Nigeria

Registration is open to for the Nigerian National Health Conference (NHC 2009). Organised by the NHC 2009 National Steering Committee (NSC), comprising the Senate Health Committee, Akwa Ibom State Government, Federal Ministry of Health, Health Reform Foundation of Nigeria (HERFON), development partners, professional organisations in the health and development sector, and other stakeholders in the health in Nigeria, the National Health Conferences are held to continuously review the country's health sector and offer strategies for further progress.

The theme for the NHC 2009 is Primary Health Care in Nigeria - 30 Years after

'Alma Ata'. Papers will be accepted and discussed under the following subthemes:

- Effective Interventions to Achieve Health Related MDGs in Nigeria
- Governance and Legislation (Stewardship) for PHC
- Resources for Effective PHC Services
- Other Determinants of Health

More details available online at: www.eldis.org/go/topics/resource-guides/health/health-events-and-announcements&id=43011&type=Item

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- Health Resource Guide - <http://www.eldis.org/health/index.htm>
- Health Systems Resource Guide - <http://www.eldis.org/healthsystems/index.htm>
- HIV and AIDS Resource Guide - <http://www.eldis.org/go/topics/resource-guides/hiv-and-aids>

The HRC provides access to technical assistance and information for the Department for International Development (DFID UK), and its partners, in support of pro-poor health policies as well as health systems, service delivery and public health topics and programmes.

Eldis currently includes descriptions and links to over 4,500 organisations and over 22,000 full-text online documents covering development and environmental issues. It can be searched or browsed free over the Internet.

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adding one of our [newsfeeds](#).

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