

Evidence-based Recommendations to Improve Attraction, Recruitment and Retention of Health Workers in Sudan,2022

Abstract:

Background: Current literature systematically reports that interventions to attract and retain health workers in underserved areas need to be context specific but rarely defines what that means. In this systematic review, we try to summarize and analyzed context factors influencing the implementation of interventions to attract and retain rural health workers.

Methods: We searched online databases, relevant websites and reference lists of selected literature to identify studies on compulsory rural service programs and financial incentives. Forty studies were selected. Information regarding context factors at macro, meso and micro levels was extracted and synthesized.

Conclusion: In all the articles we reviewed, policies were in place to retain health workers, but they are not working because workers are still moving from rural to urban areas and from Sudan overseas. There is a greater need than ever before for national-level policy formulation on non-financial and financial incentives if there is to be improvement in the inequitable distribution of health workers across the country.

Key words: Retention, Health workers, Incentive strategies, Policy formulation.

1. Introduction:

Workforce retention refers to the length of time between commencement and termination of employment. Retention does not imply indefinite length of service in one location, employer or organization, but refers to some minimum length of stay.^[1,2] Exactly what constitutes this minimum is unclear and likely to vary according to whether it is defined by the profession, position, or health service, and depending on the location and characteristics of the community which affect the ease with which the health worker can be replaced. Retention thus implies some notion of adequacy or sufficiency of length of service, possibly measured in terms of a return on the investment costs associated with training and recruitment or the effects on patient care that are considered to be optimal.^[1] Workforce ‘retention’ is different from workforce ‘turnover’.^[3]

Retention refers to the time between engagement to a service and separation or departure from that service, and thus is a measure of the length of stay. In contrast, turnover refers to the number of terminations in a specified time period divided by the number of active workers in the same category.^[3,2] Thus, retention indicates who is leaving, who is staying and for how long, whereas turnover reflects the degree of movement of individuals coming into or leaving a service.^[4,5] Because retention is hard to measure and must be tracked over long periods of time, most of the literature has focused on workforce turnover. Usually the workforce goal is to minimize avoidable workforce turnover.

1.1. Incentives for retaining and motivating health workers in Pacific and Asian countries

^[6]:

Study presented by Lyn N Henderson and Jim Tulloch in 2008, find that The shortage of health workers in Pacific and Asian countries is a critical issue that must be addressed as an integral part of strengthening health systems. Health workers migrate, leave the health sector, or use various coping strategies in response to difficult circumstances such as poor or intermittent remuneration, inadequate working conditions, limited training opportunities or weak supervision. To minimize attrition from the health workforce and the negative effects of coping strategies, efforts are required to address the causes of health worker dissatisfaction and to identify the factors that influence health worker choices. The challenges in maintaining an adequate health workforce require a sustained effort in workforce planning, development and financing. This effort requires innovative strategies – such as incentive packages – for retaining and motivating health workers in resource-constrained settings. The health system in each country is different and requires different strategies to stem the loss of skilled health workers, especially in rural and remote areas. Consequently, there is no global model for improving the retention of health workers and their performance. The literature highlights the importance of considering a broad range of incentives that may be packaged to attract health workers and to encourage them to stay in the health sector. It emphasizes that non-financial incentives can be as crucial as financial incentives^[6]. There is potential for health worker incentives schemes to succeed in the Asia-Pacific region. Successful incentive strategies are multifaceted and include:

- Long-term political commitment and sustained effort at all levels.
- A deep understanding of the cultural, social, political and economic context in which the incentives strategy is being developed.

- Involvement of key stakeholders – especially the health workers themselves – in developing the strategy, formulating policy and implementing initiatives.
- Integration of efforts between government sectors, donors, non-governmental organizations and the private sector to ensure the initiatives are sustainable.
- Packages of coordinated and linked financial and nonfinancial incentives that adequately respond to the needs of health workers.
- Monitoring and evaluation tools and systems.
- Strengthened supervision and management capacities.
- Performance management systems that link health worker performance to supportive supervision and appraisal, and
- Continued research on what motivates health workers in order to adapt and adjust the incentives to the changing needs and desires of the workforce.

1.2. Principles to guide the formulation of national policies to improve retention of health workers in remote and rural areas:

A report published by WHO in 2010 summarized the relevant retention strategies in 7 point as a below ^[7]:

1.2.1. Focus on health equity

According to the principle of health equity, all citizens should have an equal opportunity to be healthy. However, wide disparities in health status exist within many countries worldwide. Lack of access to quality health-care providers is one of the primary root causes of health inequity and is disproportionately experienced by people living in remote and rural communities. Adhering to this principle will help in the selection of the most effective retention strategies and in allocating available resources in a way that contributes to the reduction of avoidable inequalities in health. For example, in establishing the number of health workers needed by any given community or population there is some evidence that the health needs of rural populations are greater and thus they would need a proportionately higher number of health workers ^[8,9]. When compared with their metropolitan counterparts, rural health workers are “extended generalists” who provide a wider range of services and carry a higher level of clinical responsibility in relative professional isolation ^[10]. In the context of large distances, geographical factors, transport links, communications and so forth, small communities in rural or remote areas may require a larger number of generalist health-care providers that would not be justified in an urban context.

1.2.2. Ensure rural retention policies are part of the national health plan

This is about the principles of alignment and policy coherence at the country level. Rural retention

policies must be grounded in a costed and validated national health plan. A national health plan provides the framework for holding all partners accountable for producing tangible and measurable

results; it is at the heart of health development that is country-led, country-owned, and fully aligned with national priorities and capacities. A national health workforce plan, which is an integral part of a country's national health plan, sets out the projected numbers and types of health workers needed in the future, the policies and strategies to scale up needed health workers, the strategies to retain and motivate them, and the costs of implementing all the required interventions.

1.2.3. Understand the health workforce

Before embarking on any of the recommended interventions, a clear understanding of the health workforce is necessary. This comprises an understanding of the current levels and distribution of health workers by gender, geographical region, sector and specialty. A comprehensive situation analysis and labour market analysis of current and future needs of health workers should be able to identify any potential mismatches between supply and demand factors. For example, it can identify whether large numbers of unemployed health workers are located in urban areas, or whether high remuneration differentials exist between urban and rural areas, and thus can guide appropriate interventions.

1.2.4. Understand the wider context

Improving the retention of health workers in remote and rural areas poses a number of complex policy challenges that cannot be tackled within the health sector alone. Broader social, economic and political factors at national, subnational and community levels that influence retention also need to be considered to ensure the choice of policy interventions are anchored in and tailored to the specific context of each country.

1.2.5. Strengthen human resource management systems

A core basic requirement for any retention strategy to be effective is management capacity. Remote and rural retention strategies need to be grounded in human resource (HR) management systems, which include key components such as workforce planning, recruitment and hiring

practices, work conditions, and performance management, as well as competent HR managers able to perform these functions.

1.2.6. Engage with all relevant stakeholders from the beginning of the process

Engagement of stakeholders across several sectors is a critical element for the success of rural retention policies, as it is for any type of health system or health workforce policy. In identifying and selecting the most appropriate strategies a wide consultative and coordination effort is needed. Rural and remote communities, professional associations and other relevant decision makers must be included in the design, development, implementation, monitoring and evaluation to obtain and maintain the support of all involved.

1.2.7. Get into the habit of evaluation and learning

A commitment to monitoring and evaluation from the beginning is essential in order to capture valuable lessons learnt and contribute to building the evidence base, which will be of use at the country level and for countries that have similar contexts. Monitoring and evaluation will help identify challenges and limitations during implementation, assess the degree to which the objectives and goals have been achieved, and identify the need for a new intervention or the need to re-design or modify an existing one. Monitoring and evaluation should be part of the design phase and integrated into the implementation plan. In addition, continuing investment in national information systems is necessary to ensure timely and accurate data and information is available to inform the policy-making process.

1.3. Incentives for health worker retention in Kenya: An assessment of current practice:^[11]

In 2008 Ndetei *et al* published a research to assess the incentives for health worker in Kenya, and summarized the reasons why health workers had left their public sector jobs in the 12 months prior to this study were difficult to establish. HR records were not standardized and the information could not be extracted. Some of the reasons for leaving included optional retirement before official age, mandatory official retirement age, golden handshake/retrenchment, resigning for further studies or job opportunities outside the country, joining private practice, dismissal on disciplinary grounds, desertion of duty, retirement on medical grounds, transfer of services and death of the staff member. Income clearly plays a role in the decision to leave. Salaries in public medical facilities are lower than those in private and semi-autonomous government institutions. Private institutions also offer bonuses and special awards to honor and exemplify good service. In public institutions, nurses are given awards but there are no bonuses. Working conditions are

also important. Working hours vary from institution to institution. In private and mission hospitals, staff work 40 hours per week – if on night shift (12-hour shift), they work for two nights consecutively, then take the following two days to rest (off duty). In public institutions, workers have similar schedules, but have to work four nights before they are allowed two days to rest. Workers who work extra hours in private and semi-autonomous medical institutions are compensated financially. If they work as locums in public medical facilities, the extra hours are accumulated and awarded as leave days. In contrast, workers at PHC centers, despite the heavy workload, are not compensated or recognized by their employers (city council) for the extra responsibilities they have to undertake. For these extra responsibilities, the workers have to use their own initiative to acquire the necessary skills to meet the needs of the populations they serve. The most notable problem with working conditions was poor and inadequate supplies of medical equipment and drugs. The essential drug list covers all health centers in the country and they all receive equal amounts and types of drugs, despite differing population densities and medical needs. Specialized services in the PHC centers are initially piloted and programmed by NGOs and later rolled out into PHC services. The NGOs train the health workers at the program sites in the new specialized clinical areas to provide services to the poor populations they serve. Once the NGOs have finished their activities, the trained workers take over running of these services without compensation from their employers. Medical supplies also stop, frustrating workers with new expertise in clinical areas. This frustration means that when donor support is provided for services in specific areas (such as TB, HIV/AIDS and mental health), health workers prefer to move from general jobs into newly created specialized jobs, often in NGOs, causing a 'brain drain' from public sector to private sector ^[11].

In private, for-profit hospitals, mission hospitals and semi-autonomous government institutions, all hospital machines or equipment's are serviced and in working condition, with medical supplies available. Transport is made available to staff working late or odd hours or coming early on duty. In public institutions, systems are not usually fully functional, and stocks of available medical supplies are limited. For staff working late or odd hours, transport is unavailable most of the time. Health workers in primary health care facilities and sub district hospitals are most affected because they have no security systems in place and lack non-financial incentives (unavailability of communication systems). There are also no ambulances to transport acutely ill patients to better-equipped medical facilities ^[11].

1.4. Analysis of context factors in compulsory and incentive strategies for improving attraction and retention of health workers in rural and remote areas: ^[12]

A systematic review published in 2015 by Xiaoyun *et al* represent that context factors are widely considered important in the literature, these factors are rarely reported and analyzed systematically. The context factors presented in this review are derived only from the available literature which may not necessarily cover all relevant context factors, due to lack of research in this specific area. For example, limited evidence was found to discuss the role of universal health coverage policy and health worker attraction and retention ^[13]. Although the selected studies in this review reported different context factors, there is very limited information in the original studies analyzing whether or not these context factors have positive or negative influence on the development and implementation of the strategies. The review tries to discuss the potential influence of different context factors on the various policy stages. Policy analysts usually tend to break down health policy process into a series of stages though acknowledging this does not necessarily reflect the exact process in the real world ^[14]. This theoretical model usually consists of agenda setting, policy formulation and policy implementation.

1. Conclusion

In all the articles we reviewed, policies were in place to retain health workers, but they are not working because workers are still moving from rural to urban areas and from Sudan overseas. There is a greater need than ever before for national-level policy formulation on non-financial and financial incentives if there is to be improvement in the inequitable distribution of health workers across the country. An approach that allows individual facilities to set incentives stimulates initiative, but the misdistribution of workers between urban (rich) and rural (poor) areas calls for policies that directly address workers in low-income areas, which are usually those with the greatest health needs. These policies should, in other words, address the issue of vertical equity, where those with the greatest needs get the most help. This approach is particularly important to avoid the vicious cycle of poorly staffed facilities, which creates increased workloads and reduced morale, leading to further out-migration. Further out-migration further weakens service provision and quality for low-income rural communities, who have to pay for poor quality services with their minimal resources.

Recommendations:

- Retention packages should preferably be applied across the whole health sector, based on needs assessment and inter-sectoral and stakeholder input. They should be costed and supported by an HRH monitoring system and sufficient institutional capacity to manage the 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 incentives valued by workers across most countries include: career paths; stimulating training and encouraging deployment through investment in services (including 'centers of excellence'); providing housing mortgages / loans; rewarding performance; and securing health worker health and access to health care. Delegates proposed that these incentives be considered as core retention strategies that are 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 programs, to guide proper selection of training courses.
- Retention strategies should be regularly reviewed and stakeholders informed about the progress and impact of incentives.

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