



Republic of Zambia
Ministry of Health

Zambian Health Workers Retention Scheme Sustainability Strategy



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Cover photos: Health workers assigned to hard-to-reach, rural and remote health facilities under the Zambia Health Workers Retention Scheme often travel on difficult water and land routes to reach their post. (Credit: Chilweza Muzongwe)

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*Zambian Health Workers Retention Scheme
Sustainability Strategy*

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Abbreviations

CHAI	Clinton Health Access Initiative
CHW	Community Health Workers
DFID	Department for International Development
DHMO	District Health Medical Office
DHRA	Directorate of Human Resources & Administration
DLTM	District League Table Model
DMO	District Medical Officer
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRA	Human Resources and Administration
HRH	Human Resources for Health
HRMO	Human Resources Management Officer
HSSP	Health Services and Systems Programme
HTR	Hard-to-reach
HW	Health Worker
IDI	In-Depth Interview
JAR	Joint Annual Review
KII	Key Informant Interview
LCMS	Living Conditions and Monitoring Survey
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MCDMCH	Ministry of Community Development Mother and Child Health
MoFNP	Ministry of Finance and National Planning
RBF	Results Based Financing
RHC	Rural Health Centre
SADC	Southern African Development Community
TWG	Technical Working Group
WHO	World Health Organisation
ZHWRS	Zambian Health Workers Retention Scheme
ZISSP	Zambia Integrated System Strengthening Programme

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I welcome all partners and stakeholders in the Human Resources for Health sector to join the Government of the Republic of Zambia in implementing the strategy for the benefit of the targeted communities in the rural and hard-to-reach areas in Zambia.

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Executive Summary

Background: The Ministry of Health (MOH) of the Government of the Republic of Zambia (GRZ) and the Zambia Integrated Systems Strengthening Programme (ZIISP) undertook a first evaluation of the Zambia Health Workers Retention Scheme (ZHWRs) in 2013 as part of the regular process for reviewing the scheme's performance. The evaluation report of the ZHWRs¹, finalized in December 2013, recommended further development of a sustainable financial and management strategy for the ZHWRs.

While the evaluation report of the ZHWRs was the first document with evidence for a clear recommendation for the development of a sustainability strategy, the need for a sustainability strategy also emerged through additional supporting information about the ZHWRs, such as trip reports on visits to facilities, verification exercises, presentations and reports². It had become clear during the course of implementation of the ZHWRs that a longer-term strategy for the ZHWRs never existed from its inception, either to guide the operationalization of the ZHWRs to its eventual phase-out, or to adaptively continue the ZHWRs until the national development objectives were reached.

In response to this recommendation, a consultant was engaged in early 2014 with the assignment to develop the first ZHWRs Sustainability Strategy. The core objective of this assignment was to develop a five-year sustainability strategy for the ZHWRs in line with the goals of the Sixth National Development Plan and National Health Strategic Plan. The specific objective of the assignment was to produce findings, which could lead to the development of a sustainable management strategy and a sustainable financing strategy for the ZHWRs, to include evidence-based recommendations. In addition, the strategy sought to tighten the eligibility criteria for facilities to participate in the ZHWRs under a new "facility-based" approach.

Methodology: The ZHWRs Sustainability Strategy adopted a research design comprised of qualitative methods including in-depth interviews (IDIs) and structured face-to-face interviews. The IDIs generated information which was then compiled in specific questionnaires intended to elicit information from technical experts. These methods were complemented by an extensive literature review of all reports, presentations, and documents availed by ZIISP pertaining to the ZHWRs, and literature available on workforce migration and retention.

Main Findings: The findings were categorized into the following five suggested strategies proposed for the sustainability and future of the ZHWRs:

- *Strategy 1:* Adopt new criteria for the selection of health facilities on the ZHWRs using a strictly facility-based approach to providing incentives: Ranking each district as per the District League Table, analysing its level of human resources (HR), and narrowing the eligible districts based upon these criteria. The criteria will prioritise facilities located in districts in the C and D categories.
- *Strategy 2:* Introduce new retention incentives: Phase-in the use of facility-based non-monetary incentives and forge linkages with Results-Based Financing (RBF) pilots as their success becomes known.
- *Strategy 3:* Attach output and outcome indicators to the ZHWRs, to link them to the facility-based indicators in the Health Management Information System (HMIS).
- *Strategy 4:* Re-assign the ownership of the ZHWRs to the Cabinet Office. In addition, improve buy-in and recognition of the ZHWRs through advocacy efforts and resource mobilisation to attract funding.

¹ Bwalya B, Jere E, Johnson D and Hass S. (December 2013). *An Evaluation Report of the Zambia Health Workers Retention Scheme of the Ministry of Health*. Bethesda, MD: ZIISP/Abt Associates Inc.

² Jere, E. (2010). *Status report on the Zambian Health Workers Retention Scheme*. Lusaka, Zambia: ZIISP.

- *Strategy 5:* Build capacity in the operation of the ZHWRS and link the ZHWRS to the National Decentralisation Plan.

The above strategies have been proposed in order to help realise the ZHWRS Sustainability Strategy vision: that Zambia has a fit-for-purpose, sustainable, and measurable retention scheme for health workers (HWs) in the hard-to reach (HTR) facilities of Zambia.

Conclusion: Zambia still struggles to retain its HWs in HTR areas, and the present retention system only encourages HWs to devote energy to securing funds (for themselves) and justifies inputs, rather than focusing on improvements in efficiency or quality of care³. The immediate sustainability goal for the ZHWRS is to revise the baseline for facilities enrolled in the ZHWRS with new criteria, and to reduce the present recurring financial costs of the ZHWRS in the form of phasing-out monetary allowances. The mid-term goal is to have introduced monitoring of the ZHWRS against national indicators for the HMIS. The long-term goal is to support eligible facilities with non-monetary incentives and performance-based financing initiatives, until rural development indicators have shown that the facility is sufficiently developed to graduate off the ZHWRS.

It must be envisioned that the future ZHWRS will cost less. Facility-based non-monetary incentives will have demonstratively replaced the use of individual financial allowances. The ZHWRS Sustainability Strategy holds that it is important to consider that facility-based membership in the ZHWRS is a time-bound, temporary arrangement with strict criteria for acceptance and graduation. As national development accelerates (in terms of improved rural infrastructure and reduced morbidity and mortality rates), facilities will no longer require the ZHWRS, and its legacy will be improved staff retention.

Recommendations: Based on the findings and the conclusion of this study, this report makes the following recommendations for implementation of the proposed strategies:

1. Apply the new criteria for selection of facilities in Strategy One with immediate effect.
2. Create a cost-benefit analysis, and an evidence base on non-monetary incentives, in order to establish the opportunity costs of motivating HWs to work in the HTR areas of Zambia.
3. The ownership and operation of the ZHWRS should shift from the MOH to Cabinet Office and the Ministry of Community Development, Mother and Child Health (MCDMCH).
4. Research is needed on how to merge the ZHWRS into other existing Human Resources for Health (HRH) strengthening initiatives; particularly recommended is RBF.
5. Opportunities to decentralise the function of the ZHWRS should be seized upon, and an operational plan for the ZHWRS Sustainability Strategy needs to be created and budgeted.
6. The ZHWRS Sustainability Strategy should not be time-bound to five years' duration, but should link to the duration of the future national health policy and Vision 2030.
7. The existing ZHWRS Guidelines should be reviewed.

³ Morgan, Lindsay. *Performance Incentives in Global Health: Potential and Pitfalls*. World Bank, p. 2.

1. Introduction

1.1 Background to the Zambia Health Workers Retention Strategy

Zambia continues to face a serious challenge in terms of human resources in the health sector. The critical shortage of skilled human resources (HR) is an obstacle to providing quality health care service delivery and to achieving the Millennium Development Goals 4, 5, and 6, related to child health, maternal health, and the combat of priority diseases such as malaria, human immunodeficiency virus (HIV) and tuberculosis. This challenge is partly due to the macro-economic and fiscal limitations, which impact negatively on the country's ability to recruit and retain core HWs. The shortage of HWs is particularly acute in HTR areas of the country. Public health facilities in rural and remote areas have the lowest number of HWs compared to urban areas. As a result, many rural health facilities are understaffed.

Against this background, GRZ through the MOH, developed the Zambia Health Workers Retention Strategy (ZHWRs) in 2003 in a drive to attract and retain qualified HWs to HTR health facilities. A decade later, an evaluation of the ZHWRs reviewed the present status of the ZHWRs, and evaluated the scheme's funding, training, management, and equitability. The core objectives of the evaluation report were to assess the implementation progress of the present ZHWRs and to take stock of the scheme's achievements against planned enrolment targets and intended benefits. The evaluation also aimed to assess the impact of the ZHWRs on the present health service utilisation and its sustainability.

The evaluation report of the ZHWRs⁴, finalized in December 2013, observed that critical modifications were required in order to make the ZHWRs sustainable for the future. This observation led to the creation of terms of reference for development of a sustainability strategy. The production of the ZHWRs Sustainability Strategy was a direct result of the recommendations in the ZHWRs evaluation report.

1.2 Objective of the ZHWRs Sustainability Strategy

The core objective of this assignment was to develop a five-year sustainability strategy for the ZHWRs in line with the goals of the Sixth National Development Plan and National Health Strategic Plan. The sustainability strategy would cover both management of the ZHWRs as well as issues of its financial sustainability. The specific objectives of the assignment were to produce findings which could be used to develop a sustainable management strategy as well as a sustainable financing strategy for the ZHWRs, making evidence-based recommendations. The ZHWRs Sustainability Strategy was developed in accordance with a specific vision, namely: "Zambia has a fit-for-purpose, sustainable, and measurable retention scheme for Zambian HWs in the HTR facilities of Zambia."

1.3 Relevant findings of the ZHWRs evaluation report⁵

Health worker posting and motivation: The ZHWRs evaluation report showed that of the 1,023 HWs officially listed in the ZHWRs, not all were actively working at the assigned health facilities at the time of the evaluation. Two-thirds (or more) of respondents reported that they had been stationed at their current facility longer than they had been a member of the ZHWRs, indicating that the ZHWRs may not be the factor which retains them at the facility. The evaluation report makes reference to cadres who are retained regardless of whether the ZHWRs is in place or not; especially those in the

⁴ Bwalya B, Jere E, Johnson D and Hass S. (December 2013). *An Evaluation Report of the Zambia Health Workers Retention Scheme of the Ministry of Health*. Bethesda, MD: Zambia Integrated Systems Strengthening Program (ZISSP)/Abt Associates Inc.

⁵ Ibid.

urban areas, where other societal factors and opportunities for a secondary income make it an incentivising/stimulating location to work in anyway.

In all cases, individual, cadre-based monetary incentives were provided as a form of retention. HWs in the ZHWRS and facility in-charges anecdotally reported that the ZHWRS payments, when paid on time, were a motivating factor for the staff. However, irregular and late payment of allowances was cited as a major concern and obstacle by ZHWRS members. Given that the application of the ZHWRS presently emphasises individual monetary allowances as the main motivator, it presently diminishes the importance of facility-based incentives and non-monetary incentives. In addition, many non-HTR facilities are presently enrolled in the ZHWRS, defeating the purpose of providing an incentive to HTR facilities.

ZHWRS management: The ZHWRS evaluation report also brought out management issues. The administration and monitoring of the ZHWRS are proving cumbersome in practice; leading to slippages in efficiency and efficacy. Management staff at MOH headquarters cited late submission of contracts for both new entrants and renewals; inadequate communication for transfers; and the lack of cooperation towards the management of the ZHWRS by field Human Resources Management Officers (HRMO) in the districts. Other challenges included under- and over-payments due to transfers or movements of ZHWRS members, which remained unreported, leading to loss of funds paid mistakenly to HWs that had left their stations. District Medical Officers cited irregular updates on ZHWRS information and lack of administrative orientation, as well as difficulties in recruiting new staff on the scheme.

ZHWRS financial management: The ZHWRS evaluation report showed that funds have not always been available at the time they were needed for payments; as a result there has been a backlog of monthly allowances for ZHWRS members. The ZHWRS has also incurred unfunded liability.

The cost implications of the ZHWRS could not be adequately addressed in the evaluation, because the evaluation study did not undertake a systematic assessment of value for money, and it is clear that the data necessary to conduct such a value-for-money analysis are not presently captured in the existing scheme.

Monitoring of the ZHWRS: The ZHWRS evaluation report found that formal monitoring and evaluation (M&E) of implementation are weak, and the results of the ZHWRS, if any, cannot be measured. Lack of monitoring ZHWRS outcomes led to the continued implementation of ZHWRS strategies that are missing objectives. For example, it was found that training institutions did not increase their enrolment capacity as a result of employing ZHWRS tutors and lecturers; and therefore continued to graduate the same numbers of students. This falls short of the second objective of the ZHWRS which is to increase the number of graduates. In addition, there was not any evidence of an increase in the number of HWs through the ZHWRS.

Without measurable indicators to measure achievement linked to the ZHWRS at present, this makes it impossible to gather the evidence on the value of retaining HWs at certain facilities. This gap in evidence and communication on the measurable health outcomes of the scheme makes it difficult to defend and promote the ZHWRS and is a prohibitive factor in lobbying for financing. As a consequence, this renders it difficult for the ZHWRS to gain greater buy-in from political leaders, donors, and other interested parties. In particular, this lack of formal monitoring is a chief concern of donors who do not feel that the ZHWRS scores to the development priorities of their respective resource envelopes.

Lessons from regional schemes: The ZHWRS evaluation report included a desk review of HW retention initiatives in the region and found that countries in the southern African region have implemented similar retention schemes through the provision of financial or non-financial incentives. Most countries had both national governments and multiple donors supporting their retention schemes. All five countries reviewed (South Africa, Swaziland, Malawi, Botswana, and Lesotho) provided rural allowances as a financial incentive. Non-financial incentives included training and career development; opportunities for higher level of training; scholarships/bursaries; early promotions; and research. Other regional retention scheme incentives included social needs, such as

provision of housing and staff transport; child care facilities; and employee support centres (in Lesotho). Almost all retention schemes in the region did not have a sustainability plan, which speaks to the future financing of the schemes, and consequently the territory in this area is unexplored. There is an appetite to generate such knowledge.

Box I. Summary of conclusions and recommendations from the ZHWRS Evaluation Report

1. The MOH should evaluate its target enrolment levels by cadre, given its current and projected funding levels, and manage the scheme so that the targeted cadres are represented in the scheme as needed.
2. Existing non-financial incentives should be strengthened in view of inadequate funding available to currently meet the monthly payment of allowances.
3. There is a need to review the eligibility criteria for scheme membership by cadre and health facility to ensure that the scheme remains relevant.
4. A more robust tracking system of staff on the ZHWRS as well strengthening the coordination between the MOH Headquarters, the districts and the facilities is required. In addition, a further analysis is required to find out the reasons why scheme members leave their stations.
5. There is need to decentralize the management of the scheme to the district levels for improved communications with facilities on the scheme.
6. The ZHWRS incentives should be facility-based and paid through the GRZ payroll to ensure transparency.
7. The selection criteria for training institutions for the ZHWRS need to be redefined.
8. A sustainability strategy of the ZHWRS should be developed.

Recommendations from scheme managers included the following:

- Ensure sufficient funding of the ZHWRS.
- Work with the districts on proper management practices.
- Update the list of facilities, which qualify for the scheme regularly, as new health facilities are opening around the country.
- Pay scheme allowances through the payroll system in the same way that rural and remote hardship allowances are paid, as a means of streamlining the payment process.
- Increase the retention allowance and extend other incentives to cadres beyond doctors.
- Include infrastructure improvements to rural health centres.

2. Methodology

The ZHWRS Sustainability Strategy underwent a thorough desk review and data collection process of key informant interviews (KIIs) using in-depth interviews (IDIs) across a wide sampling of respondents⁶ (Annex 1). In these qualitative interviews, the interviewer had a general plan of inquiry coupled with intense probing for deeper meaning and understanding of responses. The IDIs were conversational, with the role of the interviewer being primarily a listener.

The first stage of the interviewing process was to clarify the purpose of the interviews and the concepts to be explored. The line of inquiry took guidance from the recommendations in ZHWRS Evaluation Report and looked at 1) gaps and lapses in the ZHWRS guidelines, 2) the use of financial incentives, 3) the use of non-financial incentives, and 4) the present administration /operation of the ZHWRS.

Interviewing, transcribing, and analysis took place and the validity of the information gathered was ascertained through a process of “triangulation.” Where three types of participants presented the same emerging theme, the information was therefore considered significant.

The ZHWRS Sustainability Strategy has been the subject of peer review at various stages of its creation by key stakeholders, principally the members of the MOH’s Human Resource Technical Working Group (TWG), MOH officials, Ministry of Community Development Mother and Child Health (MCDMCH) officials, ZISSP staff, cooperating partners, and civil society representatives.

The process of producing the ZHWRS Sustainability Strategy has been inclusive and participatory. Participants in a stakeholder meeting reviewed the “zero draft” of the ZHWRS Sustainability Strategy after the initial data collection was completed. Feedback from that meeting was consolidated in the form of a Feedback Assimilation Matrix, which informed a first draft that was then widely disseminated via e-mail. Comments were elicited and feedback was reviewed and synthesised in the document’s re-structuring and clarification of multiple points. A pre-final draft was produced by the lead writer and was shared with the TWG, who provided critical analysis and agreed to adopt the document, urging its rapid finalisation so that it can be broadly disseminated as a complete work. The ZHWRS Sustainability Strategy was also presented to the Directors of MCDMCH and MOH, where final comments were received and accompanied by the recommendation to press ahead with finalisation. The process has been iterative and all feedback has been recorded in the Feedback Assimilation Matrix. The final document has been reviewed by a technical writer to ensure the absence of technical flaws.

⁶ Pathfinder International. “Pathfinder International: Sample Key Stakeholder Interview Guide.” <<http://www.pathfinder.org/content/interview>>

3. Findings

3.1 Findings from the Literature Review (theoretical review)

The extent to which HWs can be attracted to and retained in remote areas depends on two interrelated aspects: a) the factors which contribute to HWs’ decisions to accept and stay in a remote post, and b) the strategies employed by governments to respond to such factors.

There are many different theories and models which attempt to explain factors which impact on workforce mobility. The Neoclassic Wage Theory suggests that the choice is driven purely by financial motives and by the likelihood of finding employment⁷. The behavioural theories of Maslow and Herzberg, on the other hand, regard a more complex decision-making process with particular emphasis on job satisfaction⁸.

In much literature on workforce migration, the driving factors have been categorised into “push” and “pull” factors. “Pull” factors are those that attract an employee to a new destination and may include improved employment opportunities, improved career prospects, higher income, better living conditions, or a more stimulating environment. “Push” factors are those which repel an individual from a location, generally the mirror opposite of the “pull” factors. Any decision by an individual employee will be the result of complex interplay between these factors. For the purpose of analysis and strategy development, it is helpful for policy makers and managers to have some way of organising the different factors into the national environment, the local or social environment, and the work environment (Figure 1).

Figure 1. Interplay of “Push” and “Pull” Factors for Workforce Migration and Retention



⁷ Boyle, P.J. & Halfacree K. (1998). *Exploring Contemporary Migration*. 1998.

⁸ Lehmann U., Dieleman M., & Martineau T. (2008). *Staffing Remote Rural areas in Middle and Low-income countries: A literature review of attraction and retention*. BMC Health Services Research, January 2008.

The national environment comprises both “push” and “pull” factors, such as the general political climate, the degree of political and social stability, the situation of the public service sector, salary levels and career opportunities. The local environment is made up of general living conditions and the social environment. The work environment includes “push” and “pull” factors such as local labour relations; management styles; existence or lack of sound leadership; opportunities for continuing education; and availability of infrastructure, equipment and support. Work environment and satisfaction are important retention factors and are worth highlighting in the ZHWRS Sustainability Strategy, as they are quite low-cost and are very effective^{9 10 11}.

As an example of the interplay of these factors in HW attraction and retention in HTR areas, a study among rural HWs in Vietnam revealed that the most motivating factors in their job were identified as appreciation by managers and colleagues, appreciation by the community, having a stable income, and training. Lack of housing, lack of health care, and lack of schools for children were quoted internationally as reasons why people do not join or why they leave health services in HTR areas. There is immense importance in general living conditions, accommodation, schools and qualified teachers, proper sanitation, electricity, good roads, and transport. (These elements, despite the absence of a formal study, were also cited as important by respondents in the KIIs in Zambia.)

There are also some individual factors to be taken into consideration such as age, gender, and marital status. These drivers are more fluid and are likely to change during the course of a person’s life. Some researchers quoted in Lexomboon¹² found that workers who were single indicated a greater intention to leave work in remote areas and had a higher turnover than married workers. In Zambia, several KIIs explained that the status of female nurses is regarded as lower than male nurses or clinical officers, who are afforded more of a “doctor-like” status. Social acceptance and integration opportunities are fewer for female single nurses than for their male counterparts.

The ZHWRS Sustainability Strategy should have the scope to provide suggested opportunities to focus on the “soft element” of promoting the status and reputation of HWs in communities, so that they feel more respected and more welcomed into the community. In addition, the Strategy should include suggestions of how to increase the engagement of civil society in the issue of HW retention, both in the successful leverage of the support of non-formal community health workers (CHW) to support health facilities and ease the burden on the HW. However, in the promotion of health services and the value of the HWs for the community, it is crucial that their status become as elevated as it was in previous times; where, for example, it used to be a matter of great pride to be a nurse in Zambia. In the development of the ZHWRS Sustainability Strategy, this aspect of greater harmonisation with community systems strengthening mechanisms could stimulate donor interest, and attract diversified financial resources should government have the desire for such.

In the literature review, the link between access to continuing education and professional advancement and retention is unclear, and differs between high and low-income countries; being more of a motivator in a high-income setting. Evidence from a six-country study in Africa (Cameroon, Ghana, Senegal, South Africa, Uganda, and Zimbabwe), based on interviews with 5% to 20% of the number of HWs in each country, show a strong correlation between access to continuing education and retention¹³. The ZHWRS Sustainability Strategy makes an assumption about this correlation as being true for Zambia as well.

The literature also differs on the importance of pay and conditions of service to a person’s decision to choose a workplace. While salary was associated with a decreasing intention to leave work amongst

⁹ Kunaviktikul W. et al. (2001). *Development of Quality Nursing Care in Thailand*.

¹⁰ Lambert V.A. & Lambert C.E. (2001). *Nursing Health Sciences Research: Literature Review of Role Stress/Strain on Nurses: An international perspective*.

¹¹ Lexomboon D. (2003). *Recruitment and Retention of Human Resources for Health in Rural Areas: A case study of dentists in Thailand*. Liverpool University: UK.

¹² Ibid.

¹³ Awase A. et al. (2004). *Migration of health professionals in six countries: a synthesis report*. Brazzaville Republic of the Congo: World Health Organization.

nurses in Thailand, the World Health Organization (WHO) found that, in a study of reasons for staff mobility in six African countries, only 24% of respondents quoted the quest for better remuneration as being a reason for leaving¹⁴.

This is a timely discussion for Zambia as salaries and terms and conditions have improved over the years, including the recent 100% pay increase in 2013. In Zambia there still appears to be a nagging question of why, given the improved conditions of service, HWs still “require” additional financial incentive allowances, especially in the non-HTR areas. The World Bank’s essay on RBF refers to sceptics of RBF, questioning the idea of paying people for something it is assumed they should do anyway; and that any kind of financial incentive will diminish workers’ intrinsic motivation¹⁵. Others worry that paying for certain targets will lead to a neglect of other important targets, or that the system will encourage people to falsify data in order to receive the incentive or bonus.

The pay issue is undoubtedly a complicated one, and some literature suggests that it should be broadened to cover “the ability to generate income.” “Ability to generate income” might include coping strategies such as a second job, theft, under-the-table payment, or also working in a private practice facility in an urban area. The assumption for the ZHWRS Sustainability Strategy is that factors relating to primary employment may be over-ridden by the availability of secondary employment, thus affecting people’s choice of location. One can assume that more secondary income opportunities exist in the urban areas (Categories A and B of the ZHWRS Guidelines), and therefore these locations may not need to be part of a sustainability phase of the ZHWRS Sustainability Strategy.

Literature on recruitment of HWs from rural areas, and the impact on rural services and retention, also indicates that although it may seem intuitive that people from rural areas would be more likely to work in rural areas, this is not supported by strong evidence. The Clinton Health Access Initiative (CHAI) Applied Analytics Team found that while it is plausible that such interventions could work, the indirect support for potential impact is fairly weak, and no one has attempted to directly evaluate such a programme to date. There is weak evidence that physicians from rural areas are more likely to work in rural areas (South Africa, Ethiopia), and mixed evidence for nurses (no correlation in Kenya, weak positive in Ethiopia)¹⁶. Only three original studies^{17 18 19} from low- or middle-income countries exist, and many secondary sources ultimately rely on these few studies, which are not methodologically strong, and/or group them with more numerous studies from very different contexts to the Zambian one (e.g., United States and Australia). No studies evaluate the impact of an intervention that brings more rural students into health training institutions.

The factors identified from the literature review reinforce the view that HR directorates of Ministries of Health (and even the Zambian MOH itself) have a relatively limited scope to improve attraction and retention of HWs in remote and rural areas. However, they may be able to bring some influence to bear on working conditions (e.g., terms, benefits), management styles, working environments (e.g., infrastructure, safety), and HR policy. Many of the decision-makers who could develop and implement strategies to address attraction and retention are located outside the health sector, such as ministries responsible for infrastructure, rural development, and finance. In light of this, the development of a strategic and coherent HR management approach requires multi-sectoral

¹⁴ Ibid.

¹⁵ Morgan, L. *Performance Incentives in Global Health: Potential and Pitfalls*. World Bank, pp. 2-4.

¹⁶ Electronic communication with the CHAI Applied Analytics Team

¹⁷ De Vries and Reid. (2003). *Do South African Medical Students of Rural Origin Return to Rural Practice?*
<<http://www2.samj.org.za/index.php/samj/article/viewFile/2367/1622>>

¹⁸ Mullei. (2010). *Attracting and retaining health workers in rural areas: investigating nurses’ views on rural posts and policy interventions*.
<http://www.researchgate.net/publication/51444044_Attracting_and_retaining_health_workers_in_rural_areas_investigating_nurses'_views_on_rural_posts_and_policy_interventions/file/9fcfd51014b8662192.pdf>

¹⁹ World Bank. (2008). *Discovering the Real World Health Workers’ Career Choices and Early Work Experience in Ethiopia*.
<http://www.worldbank.org/external/default/WDSContentServer/TW3P/IB/2010/07/06/000334955_20100706050018/Rendered/PDF/555450PUBdisc1EPI1976923101PUBLIC1.pdf>

collaboration involving all the key decision-makers²⁰. The need for multi-sectoral cooperation was a main consideration in the development of the ZHWRS Sustainability Strategy, as was capacity building in HR management and administration of the ZHWRS.

The literature review also indicates that RBF for health may spur the innovation needed in the area of HW retention. RBF is being supported by the World Bank through the Health Results Innovation Trust Fund, which is financing the implementation of six RBF programmes in Africa, including pilots in Zambia²¹. These RBF schemes, (synonymous with performance-based incentives), usually tend to target maternal and child health; however RBF for health can apply to any programme that transfers money or goods to either patients when they take health-related actions (such as having their children immunised) or to healthcare providers when they achieve performance targets (such as achieving the immunisation of a certain percentage of children in a certain area)²².

In Rwanda, the national government selected features from three donor-supported RBF pilots to construct a national approach to paying public and non-governmental organization service providers based on services delivered. Between 2001 and 2004, RBF provinces saw an increase in curative care visits per person, going from 22% to 55%, and institutional deliveries nearly doubled from 12% to 23%.

In short, RBF has the potential to help countries introduce key reforms in health, and the targets can be tailored to suit individual country needs. RBF aims to empower HWs at district levels giving them more control over their work plans and budgets; it has the potential to allow people on the ground to think of solutions that make sense in their own communities and context. RBF for health then fits with Zambia's Decentralisation Plan.

Many countries have been exploring the potential for RBF (e.g., Sierra Leone, Lesotho, Liberia and Madagascar), while other countries (e.g., Tanzania, Ethiopia, and South Africa) are already going ahead with RBF programmes with funding from the United States Agency for International Development, Government of Norway, and other donors. Many potential donors are watching the RBF pilots with keen interest, and are hopeful that evaluations will provide solid evidence that the concept can work in Africa. In terms of potential donor funding for HW retention, governments could be advised to look at RBF.

3.2 Findings from document review/situation analysis (empirical review)

The ZHWRS Sustainability Strategy undertook a situation analysis of the criteria presently used to select the districts and facilities to be in the ZHWRS, in order to make proposals for the greater sustainability of the ZHWRS. The situation analysis covered districts, facilities and training institutions and drew upon three major documents:

- The 2010 ZHWRS Guidelines
- The 2013 complete list of districts, facilities and HWs in the ZHWRS
- The 2012 list of facilities in Zambia

²⁰ Lehmann U., Dieleman M., & Martineau T. (2008). *Staffing Remote Rural areas in Middle and Low-income countries: A literature review of attraction and retention*. BMC Health Services Research.

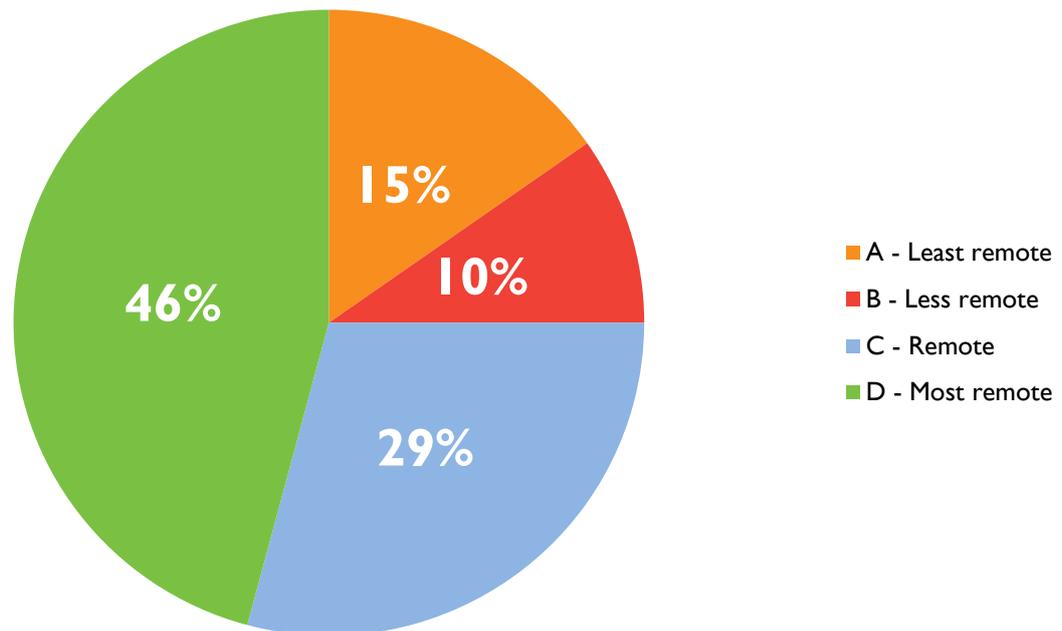
²¹ Morgan, Lindsay. *Performance Incentives in Global Health: Potential and Pitfalls*. World Bank, p. 2.

²² Ibid.

3.2.1 Analysis of Districts

The 2010 ZHWRS Guidelines show that there were 72 districts in Zambia²³. The MOH further identified and divided the country into four categories of districts, designated as “A”, “B”, “C” and “D”. These districts are further described as less remote (categories A and B), and increasingly remote and most remote (categories C and D respectively)²⁴ (Figure 2). MOH categorised the districts based upon analysis of the Living Conditions and Monitoring Survey (LCMS) data and demographic, poverty, epidemiologic, and macroeconomic indicators. MOH uses these same data for its resource allocation²⁵.

Figure 2: Distribution of Zambian Districts by Remoteness, According to LCMS Indicators (n=72 districts)



Out of the 72 districts, 95% (69 districts) are in the ZHWRS. All districts in categories B, C, and D are in the ZHWRS, and the remaining eight districts in ZHWRS are in category A²⁶. There are presently only three districts that are not included in ZHWRS (Chililabombwe and Kalulushi in Copperbelt Province, and Kafue District in Lusaka Province). This clearly shows that presently *all* the districts are eligible to be in the ZHWRS, and therefore there is no clear and strict criteria used to qualify a district to be in the ZHWRS. This is a problem for the sustainability of the ZHWRS, as it means that the ZHWRS is bloated.

The 2010 ZHWRS Guidelines show that a facility in the ZHWRS must be within the designated category C and D districts. It is not clear whether facilities designated within category A and B district should be on the ZHWRS or not, because nearly all the districts in all the categories are on the ZHWRS.

²³ At the time the guidelines were developed, there were 72 districts in Zambia. Since then, the GRZ sub-divided several districts starting in 2011, and the number has exceeded 100 districts as of 2014.

²⁴ Ministry of Health (2010). *Zambia Health Workers Retention Scheme Guidelines*. Lusaka, Zambia: Government of the Republic of Zambia.

²⁵ Central Statistical Office. (2010). *Living Conditions and Monitoring Survey*. Lusaka, Zambia: Government of the Republic of Zambia.

²⁶ Directorate of Human Resources & Administration, Ministry of Health. (2013). List of districts on the ZHWRS.

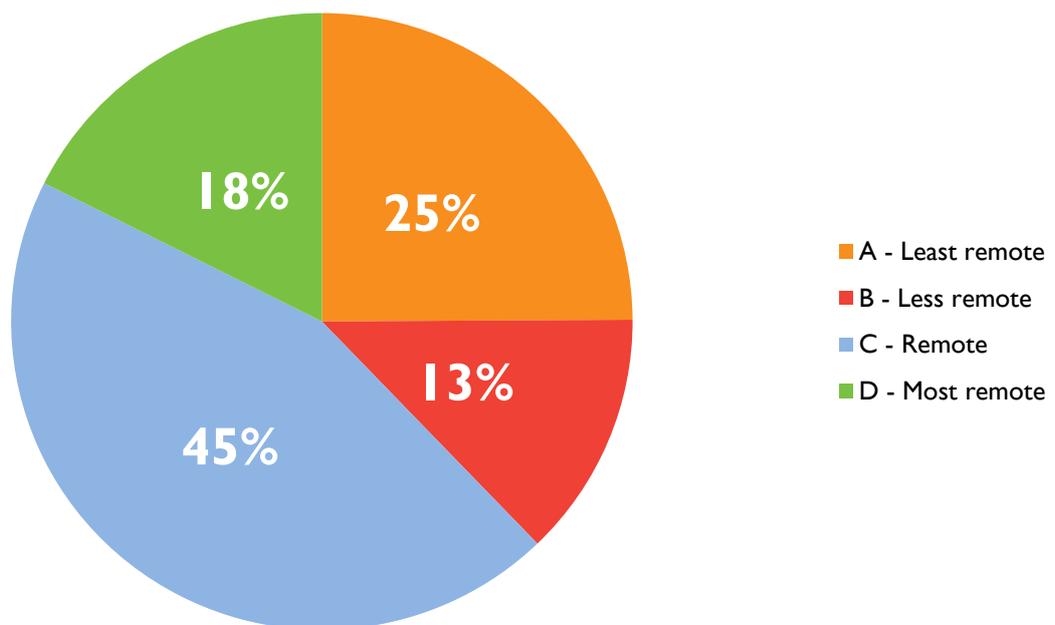
A total of 1,023 HWs are in the ZHWRS (22% under the MOH, and 78% under the MCDMCH); 30% are in district category A and B, while 70% are in district category C and D. A total of 98 hospitals are in the ZHWRS. This includes Level One and Level Two hospitals.

According to the 2010 ZHWRS Guidelines, the aim of having District Health Offices and the district hospitals is to have medical professionals at point of contact, in order to attend to inpatients and outpatients on a full-time, daily basis. The 2010 ZHWRS Guidelines indicate that Medical Licentiates and Medical Officers in the ZHWRS should not be used for administrative purposes; the aim is for them to provide 85-90% clinical care and only 10-15% of their time on administration, and they should be at the facility on a daily basis²⁷. However, approximately 60% of the Medical Licentiates and Medical Officers spent more than 15% of their time on administrative duties²⁸.

3.2.2 Analysis of Facilities

According to the 2012 List of Facilities, there are 1,956 health facilities in Zambia. Almost half of the facilities (n = 872) are located in category C districts, and 18% (344) of the facilities are located in category D districts. Thirty-eight per cent of facilities are located in category A (487) and category B districts (252) (Figure 3).

Figure 3: Distribution of All Health Facilities in Zambia Across Category A, B, C, and D Districts (n=1955 Facilities)



²⁷ Ministry of Health (2010). *Zambia Health Workers Retention Scheme Guidelines*. Lusaka, Zambia: Government of the Republic of Zambia.

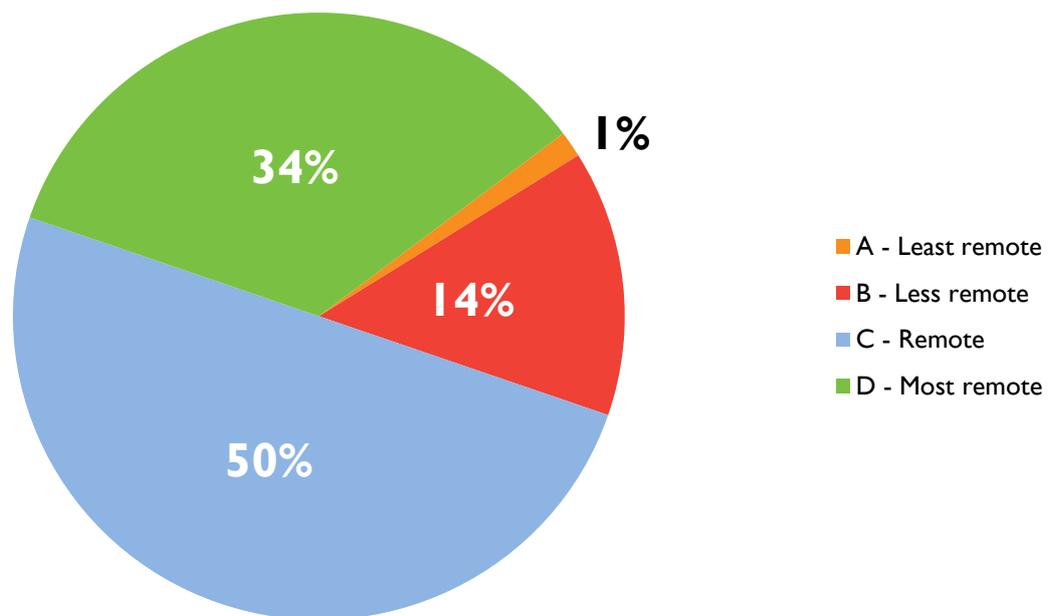
²⁸ Bwalya B, Jere E, Johnson D and Hass S. (December 2013). *An Evaluation Report of the Zambia Health Workers Retention Scheme of the Ministry of Health*. Bethesda, MD: Zambia Integrated Systems Strengthening Program (ZISSP)/Abt Associates Inc.

Of these facilities, the majority (88%) are Government owned, while 13% are owned by private health agencies and 6% are owned by faith-based agencies. The highest proportion of health facilities in Zambia are the rural health centres (RHCs), representing 73% (n=1,438) of the facilities/health posts, followed by urban health centres at 23% (n=409). In 2012, the MOH recorded six third-level health facilities, 19 second-level hospitals, and 84 first-level hospitals²⁹.

The ZHWRS Guidelines indicate that the objective of the ZHWRS is to reward those HWs who are providing clinical care and support to patients at RHCs which are defined as rural, remote, and hard to reach (HTR). The term “rural” is used to mean rural and remote within the districts and provinces, while “HTR” means that there should be a greater degree of difficulty in reaching the facility, due to bad or seasonally impassable gravel or dirt roads and/or having to use a boat to get to the facility. The centres located along tarred roads do not qualify to be defined as HTR. The guidelines indicate that the facility should not be near to any other health facility and that it should not be near to the District Health Medical Office (DHMO)³⁰.

According to the 2013 *List of Facilities* in the ZHWRS, a total of 360 RHCs met the rural, HTR criteria, and 580 HWs were posted in these same facilities. There are facilities in the ZHWRS in all the four district categories³¹ (Figure 4).

Figure 4: Distribution of Rural Health Centres Participating in ZHWRS, by Category A, B, C, and D Districts (n = 360)



²⁹ Directorate Policy & Planning Monitoring and Evaluation Unit, Ministry of Health. *The 2012 List of Facilities in Zambia*. Lusaka, Zambia: Government of the Republic of Zambia.

³⁰ Ministry of Health (2010). *Zambia Health Workers Retention ZHWRS Guidelines*. Lusaka, Zambia: Government of the Republic of Zambia.

³¹ Ministry of Health Directorate of Human Resources & Administration: List of districts in the ZHWRS, 2013.

The distance of the facilities in the ZHWRS varies from 1 km to about 500 km from the DHMO. Over a third (39%) of the RHCs are located at least 81 km from the DHMO.

These data clearly show that all facilities are eligible to be in the ZHWRS because there is no difference between the facilities in the ZHWRS and those which are not in the ZHWRS. It can be concluded that either the ZHWRS Guidelines stipulating how a facility qualifies to be in the ZHWRS are not followed, or the terms used to describe the criteria (i.e., rural, remote, and HTR) are not followed, or both. This finding constitutes a major failing of the ZHWRS.

3.2.3 Analysis of Training Institutions

The second objective of the ZHWRS is to increase the number of health professional graduates by increasing the number of tutors and lecturers so that the schools can increase student intake. The ZHWRS is meant to attract more tutors and lecturers to the health training institutions; which would result in an increase in turnover of graduates. According to the 2013 *List of Training Institutions in the ZHWRS*, there are 27 training institutions in the ZHWRS with a total of 221 tutors. Forty-four per cent (12) of these training institutions are located in category A, followed by 26% (7) located in categories B and C.

The ZHWRS Guidelines do not clearly indicate how a training institution qualifies to be in the ZHWRS, apart from stipulating that the facility must be a GRZ-registered health training school, such as the GRZ Schools of Nursing, Schools of Biomedical Sciences, the Dental Training School, and the Chainama Health Sciences College. In these training institutions, not all tutors who are eligible to participate in the ZHWRS are enrolled in the scheme. The reasoning of this leads to the logical conclusion that some training institutions can exist and function optimally without any ZHWRS support.

According to the September 2013 evaluation report of the ZHWRS, training institutions did not increase their enrolment capacity as a result of employing ZHWRS tutors and lecturers, and therefore continued to graduate the same numbers of students³². A number of training institutions were opened in some areas, and this was viewed to have had a direct impact in increasing the number of graduates. The ZHWRS, therefore, may not be operating on correct assumptions of the impact of placing tutors and lecturers in the scheme.

3.3 Findings from Key Informant Interviews

In addition to carrying out an extensive literature review, the assignment also undertook IDIs involving questioning of a wide range of respondents and systematically recording their responses.

The first major theme that emerged from the KIIs was a general powerful recognition of the sacrifice that HWs make in being stationed in some of the facilities in the ZHWRS, and the need for Zambia to have a sound retention strategy in place.

“[When you visit]... it is only then [in the field] that you truly appreciate [the situation]. You get there and you see terrible [conditions] – one is a mission hospital; the staffing is not so bad. That one place the electricity, the road is there. Then you find another place in the same district that is [worse]. The other, the facility that is there is bad, they have just two people, and there is a queue. And you realise this person is really sacrificing. This nurse will be like ‘...sleeping? me I don’t have time’. After visiting, you feel for them.”

Respondent, In-Depth Interview, December 2013

³² Bwalya B, Jere E, Johnson D and Hass S. (December 2013). *An Evaluation Report of the Zambia Health Workers Retention Scheme of the Ministry of Health*. Bethesda, MD: Zambia Integrated Systems Strengthening Program (ZIISP)/Abt Associates Inc.

This sentiment was frequently coupled with assertions that the use of financial allowances is meaningful to the HWs and should be maintained as/when possible. This assertion was, however, caveated with the recognition by most respondents that money for the ZHWRS is increasingly difficult for GRZ to provide.

Other respondents completely opposed this same assertion that financial allowances should be maintained, questioning why HWs should receive additional “bonus” pay for doing the job they are supposed to be doing anyway. In general, representatives from the donor community and those involved in strategic planning indicated that financial allowances are unsustainable and would never attract future funding. This links to the findings of the ZHWRS Evaluation Report which did not find any evidence to say that the use of financial allowances either kept HWs in post, or guaranteed improved health outputs, but alluded only to the fact that HWs liked the extra money, when it was paid on time.

The second major theme which emerged from the KIIs was a recognition that if the environmental factors (i.e., living conditions) can improve at some of the HTR facilities, then this will provide a great motivation to HWs to go and stay there. This was frequently coupled in the KIIs with the assertion that the ZHWRS is not at present equitable, inasmuch as some HWs in some facilities participate in it and others do not. There was also a common sense that the focus of the ZHWRS should be on the Level Three facilities and health posts, and that living conditions in such locations should be improved.

“What I feel really is [that] the most basic thing that one needs is housing. If there can be some project to build housing that could be helpful.”

Respondent, In-Depth Interview, December 2013

“The problem is that you have centres that are HTR, and over time there are developments that make it less HTR. I would want periodic reviews of centres to see which ones should fall off or be added.”

Respondent, In-Depth Interview, December 2013

The third major theme from the KIIs was that there is an understanding that the ZHWRS does not possess any evidence of its results, and that this is a major constraint, especially with regard to attracting funding from central government or external donors. This also tallies with the findings from the ZHWRS Evaluation Report which was limited by the absence of M&E. There were strong and frequent assertions in the KIIs that the ZHWRS needs non-government funding in order to be saved or rescued.

“You see, I think the reporting or coordination...needs to be holistic, the disease burden, everything. If you are able to show people look we didn't have a doctor in Shangombo, but now we have. People should be able to connect the scheme to the health of the area. We should look at a whole picture. What are the indicators? As long as we don't have indicators to link it people will just be looking at something [that] they don't know what it means.”

Respondent, In-Depth Interview, December 2013

“[One]...other gap is the problem of funding, biggest problem on the scheme, some people saying management is weak; we have a lack of funds, if we had regular funding, and people will not think management is not doing its job. Where money is available it will be better.”

Respondent, In-Depth Interview, December 2013

The fourth theme was on flaws in the management of the ZHWRS, and the various disconnects between the entities, which are required to engage in it holistically.

“The scheme is a big project, but it has been looked at as a singular programme. I feel that it should be given more people in terms of management; you have a section that deals with loans, contractual issues, and database issues. The scheme is not part of the broader HRH framework meaning that training is independent of the scheme. Even if you are on the scheme you can apply, be approved and you can leave, and the administration wouldn’t know. We are not part of the channel. We only know at the end when we ask for the training report from the Department of Training at the MOH. Then we check the names against the database, and then when we find matching names and take them off.”

Respondent, In-Depth Interview, December 2013

“It should be a scheme that is all-embracing, so [one] shouldn’t have to hustle to go onto it. You shouldn’t have to hustle to go on the scheme.”

Respondent, In-Depth Interview, December 2013

The fifth major theme, linked to coordination issues on implementing the ZHWRS, was about the actual ownership of the ZHWRS. The main concern repeated in KIIs was that the ownership of the ZHWRS is presently situated at the MOH, which no longer has the mandate for the type of facility that the ZHWRS should zero-in on. (The mandate for RHCs and Level One hospitals now falls under MCDMCH.) Several respondents recognised that it is difficult to think of incentivising HWs in isolation especially where non-monetary incentives are concerned, because all key workers in rural and remote areas deserve the same retention package, and it is difficult for government to look at HWs without considering teachers, social welfare officers, and other public servants. Strategists suggested that the Cabinet Office ought to have a greater involvement in the retention initiative. In general respondents reported noting that there is a weak interest, understanding and buy-in to the ZHWRS, and there is no one who champions it, despite it being a very important initiative for Zambia.

“In my view what I lack is engagement of critical officers, Cabinet and then Ministry of Finance and National Planning [MoFNP]. We have meetings, on SADC³³, there are directors from HR and Ministers at that meeting actually, and who have committed to [international declarations such as the Abuja Agreement] declarations and have signed. But then the people who release the money are not there, and those who do conditions of service are not there, but everyone from health is there, but the others who feed into the sector are missing. It needs to be looked at broadly.”

Respondent, In-Depth Interview, December 2013

The sixth major theme was that the ZHWRS has not succeeded in attracting engagement and interaction from donors, despite there being strong donor support for HRH strengthening in-country. The ZHWRS therefore has lurched forward on an unsure financial footing. The culmination of these failings is leading to the sub-standard implementation of the ZHWRS, and renders it unviable in the longer-term unless these tendencies are reversed.

Donor perception is that the ZHWRS supports very few key HWs, and does not reach the targeted populations of donor interest. Donors have reported in KIIs that, during visits on the Joint Annual Review (JAR), it has been noted that the ZHWRS supports doctors in urban areas, and this is generally considered illogical. Some JAR delegates also noted that some HWs whom JAR delegates met were members of the ZHWRS, while others were not; this apparently random factor cannot be

³³ Southern African Development Community

easily comprehended. A recurring concern from donors, in regard to donor support for the ZHWRS, is that there is no clear evidence that the ZHWRS works.

There is also a lack of evidence for the present cost-effectiveness of the ZHWRS. As the ZHWRS is not linked to performance, it is not feasible to expect government or donors to fund high service allowance costs. Cooperating partners have observed that there are other national retention schemes, which score to their interests, such as the Department for International Development (DfID)-funded Community Health Assistants Programme through CHAI and the World Bank's RBF pilots. It is recommended that the ZHWRS explore opportunities to collaborate with such schemes and to consolidate efforts, and sustain gains that have already been made. As an over-arching theme, there is a real need to look at retention and motivation as a diverse theme in Zambia, and re-look at retention with more evidence.

4. Five Strategies for Sustainability, Based on the Findings

Based on gaps which were identified in the situation analysis with regard to the selection of the districts and facilities in the ZHWRS, the ZHWRS Sustainability Strategy proposes for consideration criteria which use national health standard indicators to select what type of districts and facilities should be included in the ZHWRS from this point forward. These criteria hinge upon considering the well-recognised parameters, which are aligned with the MOH's goal to provide equitable access to cost effective quality health care, as close to the family as possible³⁴.

The ZHWRS Sustainability Strategy seeks to identify specific indicators, which will ensure that the ZHWRS addresses its main objectives of:

- Attracting and retaining medical professionals to the selected rural areas to provide clinical care to people in need.
- Increasing the number of health professional graduates, by increasing the number of tutors and lecturers so that the schools can increase student intakes.

The Sustainability Strategy is comprised of five specific strategies.

Strategy 1: Facility-based approach with new criteria for selection

This strategy proposes temporarily maintaining the financial incentives on a much reduced scale, based on qualifying HTR facilities, under radical new criteria for selection. This approach will permit the gradual phase-in of non-monetary incentives. This strategy will immediately reduce the present service costs and will facilitate the phasing out of allowances in favour of either non-monetary incentives or results-based incentives. This strategy will also permit time for a cost-benefit analysis and study of non-monetary incentives to take place.

The new criteria should be as follows:

Stage One – Criteria for selection of districts

- A. District Category:** The categorisation of districts into A, B, C and D categories will be considered as the first parameter in selecting which districts should qualify to be in the ZHWRS. The categorisation of the districts is based upon the analysis of the LCMS data and demographic, poverty, epidemiologic, and macroeconomic indicators.

Categories A to D reflect the descending order of urbanisation and levels of economic development. The ZHWRS Sustainability Strategy proposes maintaining the objective of the ZHWRS -- to retain staff in remote, rural and HTR areas. Forty-four of 77 remote rural and HTR areas are located in districts category C and D. Facilities in category A and B will be dropped from the scheme, unless they meet the criteria of being remote, rural and HTR.

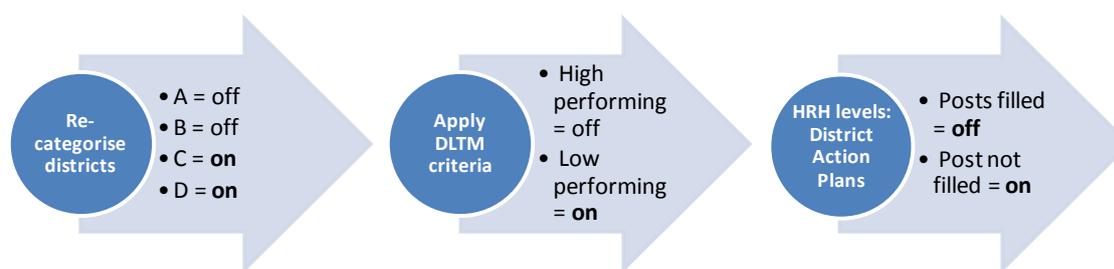
- B. District League Table Model:** At the second stage of establishing which districts can be eligible for the ZHWRS, the District League Table Model (DLTM) will be used. The DLTM is a known tool used to assess district performance by using selected health sector indicators. Districts are arranged in order of their performance in their province according to the League Table. The ZHWRS Sustainability Strategy proposes that the lowest performing districts should be included in the ZHWRS and the highest performing districts should be removed from the scheme. It is assumed that high performance does not indicate a staff attrition problem, and is rewarded under other HR management mechanisms.

³⁴ MOH, 2006.

C. Human Resources: The third parameter will be to give consideration to the level of HRH in the selected districts in categories C and D. Using the HRH data from the District Action Plans, districts should be selected based upon the established posts which have been filled/not-filled. The ZHWRS Sustainability Strategy proposes that this analysis should be done based on cadres which are presently eligible to be in the ZHWRS, i.e., Medical Officers, Medical Consultants, Medical Licentiates, Zambian Enrolled Nurses, Zambian Enrolled Midwives, Clinical Officers, Environmental Health Technologists, Lecturers and Tutors. Districts with the lowest proportion of filled positions will be selected to be in the ZHWRS.

A summary of the Stage One District Criteria is presented in Figure 5.

Figure 5. District Criteria



Stage Two - Criteria for selection of health facilities and training institutions

After completing the selection of districts (*Stage One*), the selection of health facilities and training institutions for the scheme would follow the specific steps below.

A. Selection of HTR health facilities: As we have seen, the ZHWRS has placed HWs in different levels of facilities, with exception of Level Three facilities. This occurred because the criteria of rural, remote or HTR areas have not been robustly followed. This section of the ZHWRS Sustainability Strategy proposes the criteria for selecting HTR facilities to be in the ZHWRS.

The ZHWRS Sustainability Strategy recommends that the first stage of selecting the facility ought to be to eliminate the Level Two hospitals, which are in districts in categories C and D. (There are no Level Three hospitals in these districts).

After eliminating these hospitals, the next parameter of selecting the facilities will be based on HR capacity. Using HRH data from the District Action Plans, the ZHWRS Sustainability Strategy proposes that facilities will be selected based on established posts which have been filled. Facilities with a low proportion of filled positions will be selected to be in the ZHWRS. The assumption is that the Level One facilities and health posts will have a high likelihood of remaining in the scheme.

The final parameter for selecting health facilities for ZHWRS inclusion will be their performance on standard key national health indicators from the Health Information Management System (HMIS), a strategy introduced for the first time in the history of the ZHWRS. The ZHWRS Sustainability Strategy proposes the following key health indicators for the basis of selection:

- i. Antenatal care coverage
- ii. Full immunisation coverage of children under one year
- iii. Facility deliveries attended by skilled personnel
- iv. Equipment at the facilities, number of beds, etc.
- v. Dataset report completeness

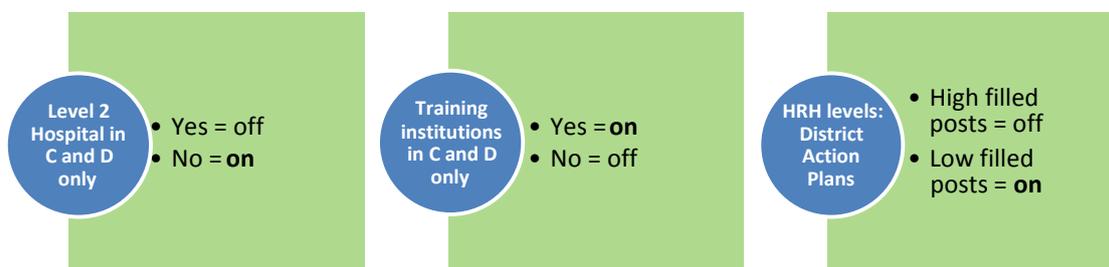
The facilities in the HTR areas with the lowest performance in these indicators, which is assumed to be related to inadequate HR staffing, will be prioritized for inclusion in the ZHWRS. Specific quantitative benchmarks for these indicators should be developed, based on what can be monitored through the HMIS or other existing monitoring systems.

These indicators can be reviewed annually to measure the value of ZHWRS in the selected facilities. Under the ZHWRS Sustainability Strategy, it is envisioned that the scheme should strengthen the capacity of any facility to provide health services up to standard, a departure from the scheme’s previous emphasis on monitoring placement of individual HWs in the ZHWRS as opposed to monitoring standards of service delivery. Based on the achievement in the above indicators, the ZHWRS Sustainability Strategy recommends that the facility graduate off the ZHWRS at some point. These indicators could not only be used as benchmarks for graduation, but also could eventually be used in the application of an RBF approach.

B. Selection of training institutions: As noted above, the second objective of the ZHWRS is to increase the number of health professional graduates by increasing the number of tutors and lecturers, so that schools can increase student intakes. The ZHWRS Sustainability Strategy asserts that retaining tutors and lecturers in already existing training institutions does not necessarily increase the number of graduates because there was not an increase in student intake in these schools. In addition to this failing, most of the schools are situated in districts in categories A and B (i.e., non HTR areas).

In order to achieve the second objective, the ZHWRS Sustainability Strategy proposes that only training institutions in categories C and D should be included in the ZHWRS, and opening new training institutions in these districts should be encouraged. This will hopefully further enhance the deployment and retention of staff in these areas after graduation.

Figure 6. Facility Criteria



Strategy 2: Introduce new retention incentives: Phase-in the use of facility-based non-monetary incentives, and forge linkages with RBF pilots

As discussed in *Section 3.1, Literature Review* (above), social and individual factors can “push” or “pull” a HW to or from a facility. Facility-based and non-monetary incentives are powerful ways of achieving the objectives of a retention scheme without creating recurring costs for the financing agency. Some of these types of non-monetary incentives are “transactional” in nature, namely providing something (such as a solar panel or water pump) that has a one-time cost. Other incentives are management-related and cost-neutral, such as ensuring that the facility’s supply chain system works so that health facilities receive the right amount of supplies at the right time in the right place.

Similarly, modern management techniques go a long way in ensuring job satisfaction, and these are free. Simple management styles, such as giving feedback, praise, and encouragement and being diligent with formal appraisal systems are important motivators. All human beings deserve to be appreciated and treated with respect. Proper job descriptions and terms of reference are important for employees to feel secure in their roles and responsibilities. These are actions which are cost-neutral but can highly motivate staff. Likewise, if task shifting can be put in place to relieve busy HWs from cumbersome administrative duties or non-essential duties, HWs will feel less burn-out.

The ZHWRS Sustainability Strategy proposes civil society engagement through traditional leaders and other community leaders and representatives, such as Neighbourhood Health Committees, in order to get the community to support the health facility; and, where possible provide voluntary support to HWs. In return, HWs should be encouraged by supervisors and the HR Directorate to treat patients with compassion and respect, thus elevating the HWs’ reputation in the community. Performance-based awards can be offered to health facilities, which outperform themselves in terms of social recognition.

Other recommendations include conducting the first official Zambian study of non-monetary stimuli for public sector workers, and scoping opportunities to merge the ZHWRS with RBF pilots and other donor funded initiatives.

A list of possible non-monetary incentives can be found in Box 2 below, compiled and based on findings reviewed throughout the development of this Sustainability Strategy (e.g., literature review, key informants, stakeholder inputs, etc.)

BOX 2: RECOMMENDED POSSIBLE OPTIONS FOR NON-MONETARY INCENTIVES Related TO THE ZHWRS COMMUNITY FACTORS

- Child schooling opportunities: Lobby for schools to be built through the Constituency Development Fund in its catchment areas
- Lobby for improvement of rural infrastructure (e.g., housing, roads, phone networks, water supplies, radio communication, etc.)
- Lobby Chiefs to allocate land to HWs so that they can participate in farming.
- MOH and MCDMCH to forge linkages with other development programmes (e.g., hydro-power)

Facility infrastructure improvements, including improvements to staff housing:

- Provide solar panel installations at facilities and staff houses in HTR areas
- Provide water pumps
- Carry out renovations to the facilities
- Enhance hygiene factors, health and safety, occupational safety processes, and ergonomics (prevent discontent and negative feelings because of the work environment)

Health systems factors:

- Ensure supervision of facilities' supply chains so that essential supplies are available (e.g., gloves and soap, sterilizing equipment and scrubs/uniforms)
- Promote task shifting between staff in the establishment (reduction of time to be spent on administrative tasks)
- Encourage greater partnership with civil society organisations to provide greater harmonisation between the formal health sector and civil society
- Support the greater meaningful inclusion of non-formal HWs (CHWs, Treatment Support Workers, Alangizi, other civil society entities)
- Foster linkages with mentorship programmes like *Saving Mothers Giving Life* and the Community Health Assistants programme

Management factors:

- Improve management supervision and continuing professional development:
 - i. Ensure job descriptions are in place
 - ii. Provide clear supervision
 - iii. Ensure that performance appraisal reviews take place
 - iv. Provide decentralised in-service training/on-the-job training
 - v. Enhance the image/status recognition of nurses (vocation)
- Ensure placement of qualified district administrators (to prevent HW from taking on administrative work)
- Provide recognition: Raise the profile of HWs and make them community "heroes"
 - i. Supervisors should work with HWs on demonstrating appropriate professional attitudes, duty of care, stigma and discrimination, and link with the Neighbourhood Health Committees to achieve this goal
 - ii. Special awards, civic movement and social recognition (such as Labour Day awards), and physical visits by senior line managers from the province or centre
 - iii. Social and team-building activities

Strategy 3: Attach output and outcome indicators to the ZHWRS to link them to facility-based indicators in the HMIS

The action of “measuring-up” the ZHWRS in terms of health outcomes should result in a transformational shift in appreciation of the value of the initiative and its value for money in terms of return on social investment.

This strategy recommends the following actions presented in Box 3.

Box 3. Recommended actions to strengthen the ZHWRS M&E system

- Conduct a value-for-money analysis with immediate effect
- Develop ZHWRS Research Protocol and conduct research to propose a performance-based M&E mechanism for the ZHWRS
- Create an M&E plan, including the plan for the monitoring of outcome indicators by mid-term
- Implement the M&E plan
- Carry out a mid-term evaluation of the ZHWRS Sustainability Strategy
- Document the evidence the effectiveness of the scheme through written policy briefs

Strategy 4: Re-assign the ownership of the ZHWRS: Improve buy-in and recognition of the ZHWRS through advocacy efforts and resource mobilisation to attract funding

The ZHWRS Sustainability Strategy proposes that it is necessary to consider clarifying which agency will own the intervention, and then ensure that representatives from that agency are invited to and attend all stakeholder meetings pertaining to the management and evaluation of the ZHWRS. The ZHWRS Sustainability Strategy proposes that ownership of the ZHWRS be transferred out of the MOH and into joint ownership by the Cabinet Office and the MCDMCH, based on the new criteria for facility selection.

Due to the need for a multi-sectoral approach, it is expected that there would be many government agencies involved in financing different aspects of the Sustainability Strategy and similar retention strategies for other public sector employees. Even though the MOH and MCDMCH are committed to the retention strategy, it might not be financially sustainable without the agreement of other agencies³⁵. In a case such as this, it becomes even more paramount for the owner of the ZHWRS to demonstrate the impact of the intervention to facilitate cross-government engagement. Funding partners may opt for either basket funding to the entire strategy or supporting objectives around a particular objective or theme.

The development of a business plan for the ZHWRS, with clear and measurable health development targets, will facilitate the attraction of other co-funding agencies. The ZHWRS Sustainability Strategy recommends a need to address options for resource mobilisation and a value-for-money analysis. The ZHWRS is under-budgeted for in 2014, indicating a shift in policy towards it in its present form.

³⁵ Pascal Zurn et al. (2011). “A technical framework for costing health workforce retention schemes in remote and rural areas.” Human Resources for Health. <<http://www.human-resources-health.com/content/9/1/8>>

Specific recommended actions are described in Box 4. In order to be successful, the ZHWRS Sustainability Strategy will need to be launched and promoted through a series of pre-launch activities.

Box 4. Recommended actions to improve buy-in and recognition of the ZHWRS

Strengthen cross-government engagement:

- Shift principal ownership of the ZHWRS to the Cabinet Office and MCDMCH (based on the new facility-based criteria of Strategy One)
- Reverse the lack of engagement of critical officers from Cabinet and MoFNP by scheduling meetings with flexibility to meet when key people are available
- Map the interests of critical officers from the Cabinet and MoFNP, and find strategies for promoting the ZHWRS within identified interests
- Encourage the greater engagement of sectors in meetings that feed into health in order to draw officers to honour the binding international declarations that have been signed (e.g., SADC meetings and the Abuja Declaration)
- Engage critical officers, from Cabinet and MoFNP, in key stakeholder meetings
- Carry out cross-sector advocacy for infrastructure development in catchment areas of health facilities on the scheme

Develop a resource mobilization plan:

- Devise a five-year business plan for the ZHWRS
- Cost the ZHWRS Sustainability Strategy as part of the business plan
- Make a resource mobilisation plan, with a mapping of range of potential donors (e.g., cooperating partners, and private sector) based on the ZHWRS budget 2013-2018

Create advocacy channels:

- Launch the ZHWRS Sustainability Strategy
- Create tools for advocacy: policy briefs, fact sheets, campaigns
- Disseminate promotional messages to public via media channels

Strategy 5: Build capacity in the operation of the ZHWRS, and link the ZHWRS to the National Decentralisation Plan.

- A. Building the operational capacity of the ZHWRS:** As of December 2009, the HRMOs had been employed in various district hospitals and district-level institutions, and most HRMOs had been trained to manage HR affairs as well as administer the ZHWRS at their stations. One vital obstacle to the management of the ZHWRS has been that since 2010, most HRMOs have been transferred to other stations, either within MOH or to other ministries. Replacement HRMOs were provided with little or no orientation on how the ZHWRS is administered. In some cases there was no replacement HRMO at all. This led to clinicians or untrained staff running HR affairs.

The gap in district-level trained staff has resulted in diminished administrative oversight regarding the ZHWRS functions, and has led to over-spending and inefficiencies. Data on staff attrition (e.g., due to transfers, deaths, leaves of absence, and study leave) were often unreported. Cases occurred where HWs, who were no longer eligible to be in the ZHWRS, continued to receive financial allowances. Other critical cases included overpayment or underpayment of retention allowance; failure of enrolment following submission of retention scheme enrolment forms; follow-up of unpaid gratuity only after successful completion of the contract period; lack of timely response to requests for loans and house renovation grants; and failure by the MOH to recover monies. It has also been noted that contracts which are brought to the district hub are often incorrectly completed, thereby rendering them invalid and rejected. This means that eligible HWs, lacking guidance on how to fill the application, have been excluded from the ZHWRS, and this has led to feelings of demotivation and disgruntlement. There have also been several documented instances of HRMOs tendering applications of cadres who qualify, but who are stationed at facilities which do not qualify.

Based on the above examples, it can be inferred that the administrators in the districts are unaware of the ZHWRS guidelines. This has become costly in terms of money and time, and has posed many challenges in the general administration of the scheme and the perception of equity and valence amongst HWs; from some HWs' perspective, it can seem to be quite random who is accepted onto the ZHWRS and who is not. This is a huge risk to the ZHWRS and actively demotivates HWs.

In addition, as a result of poor administrative management of the scheme at district level, high numbers of scheme members abandon their work stations to make frequent visits to the district or provincial offices or to MOH headquarters in Lusaka, to enquire on matters regarding their membership in the ZHWRS. This leads to the HR staff to spend more time attending to queries as opposed to carrying out the technical work, and results in fewer days that ZHWRS members are providing healthcare services at their assigned health facility.

In order to ensure the effective implementation of the strategy, consideration will be given to enhancing the capacities of coordinating structures. At provincial and district levels, the strategy will be coordinated through the respective HRMOs, who will require re-training in the ZHWRS. Consideration should be given to making an operational plan for the ZHWRS and generating specific annual work plans. Capacity building could be considered for all necessary staff whose mandate will be to support the application of the ZHWRS, and job descriptions should be streamlined and coordinated to include responsibilities pertaining to the ZHWRS. Provision could be considered to incorporate the ZHWRS into the agendas of regular HR related meetings. Regular re-training of HRMOs could be considered.

In order for the ZHWRS to be effective, the harmonisation of all the currently fragmented communication and management activities and systems will have to be considered, preferably under one unit or task force, comprising of qualified individuals who are mandated to work on the efficient running of the ZHWRS.

B. *Linking the ZHWRS Sustainability Strategy to the National Decentralisation Plan:* The development of the ZHWRS Sustainability Strategy may also be considered as an opportunity to link to the National Decentralisation Plan in order to harmonise its administration. The National Decentralisation Plan advocates devolution as the guiding governance principle where the district is the main focus of development and service delivery. Accordingly, the National Decentralisation Plan provides for strengthening local government through reactivation of mandates at this level, as well as the transfer of additional responsibilities.

The National Decentralisation Plan empowers local communities by devolving decision-making authority, functions and resources from the centre to the lowest level, with matching financial resources in order to improve efficiency and effectiveness in the delivery of services. This plan is consistent with the new criteria of the ZHWRS Sustainability Strategy. Under devolution, all design and implementation mechanisms need to ensure a “bottom-up” flow of integrated development planning and budgeting from the district to Central Government, and not vice-versa as it has been historically with the ZHWRS.

The tenets of the enhancement of political and administrative authority in order to effectively and efficiently deliver services to the lowest level (i.e., promoting accountability and transparency in the management and utilisation of resources; developing the capacity of Local Councils and communities in development planning; and financing, coordinating, and managing the delivery of services in their areas) all resonate with the ZHWRS Sustainability Strategy.

These objectives speak to the themes of building capacity in the administration of the ZHWRS and of harmonising the regulatory interventions, management, communication, and collection and storage of information in the ZHWRS. The ZHWRS Sustainability Strategy seeks to promote the need for the enhancement of district-level management, specifically through HRMOs and District Medical Offices, and seeks to engage the involvement of Local Councils in health service delivery. The role of elected councils is cardinal to devolved functions, as services provided at this level primarily determine the quality of citizens’ lives as enshrined in instruments such as the Sixth National Development Plan. As such, the district will increasingly become the focus of development activities and service delivery. It is important that district councils receive orientation on the ZHWRS and take ownership of it.

The linkage between the National Decentralisation Plan and the ZHWRS Sustainability Strategy also supports consideration of engaging the Constituency Development Fund to lobby for funding for schools and the provision of off-road vehicles to remote districts. It also supports the desired consideration for the greater involvement of Neighbourhood Health Committees with the ZHWRS in order to achieve the goal of raising the profile of HWs and other essential public sector workers in their communities.

The use of non-monetary incentives in the ZHWRS Sustainability Strategy seeks to build capacity for development and maintenance of infrastructure at local level, as does the National Decentralisation Plan, which provides a legal and institutional framework to promote autonomy in decision-making at local level. The future of the ZHWRS Sustainability Strategy must be married into the districts’ integrated budgets for district development and management.

Strategy Five recommends the following actions presented in Box 5.

Box 5. Recommendations for building district-level capacity to administer the ZHWRS

Strengthen ZHWRS planning at district level:

- Make an operational plan for the timeframe of the Sustainability Strategy
- Cost the operational plan for the timeframe of the Sustainability Strategy
- Create a capacity-building plan which incorporates recommendations specific to the administration and management of the ZHWRS and made in the 2012 Verification Report and 2013 Evaluation

Training and coordination:

- Re-train HRMOs
- Hold regular (quarterly) ZHWRS team meetings at district level to provide orientation, review and updates to be conducted with District HRMOs
- Hold an annual central meeting with representatives from all the districts

Improved district HRMOs' access to information:

- Provide laptops and modems to district HRMOs for communication purposes
- Empower district HRMOs: provide information on the payment schedule
- Explore what improvements to the communication flow can be achieved through SMS technology using simple smartphones
- Link the ZHWRS to the roll-out of the HRIS at MCDMCH
 - Specifically monitor training and promotions of HWs on the ZHWRS and ensure that managers expose them to opportunities for training and career development
 - Ensure that each facility in the ZHWRS is cross-matched on the HRIS, and eligible cadres at the facility are identified

Devolve responsibility:

- Shorten periods for processing the administration of applications: decentralise the application function to the Provincial Health Office
- Make HRMOs responsible for the ZHWRS (write into the HRMO job description)
- HRMOs should conduct regular data validation and updating of the ZHWRS database; conduct "spot-check" verification exercises to the facilities in the scheme
- Expedite the entry of new graduates into work to HTR areas (using up-to-date information of district-specific needs)
- Improve communication between districts and the Directorates of HRH at MOH and MCDMCH
- Sensitise Local Councils on the ZHWRS and how it pertains to their districts

5. Conclusion

Zambia still struggles to retain its HWs in HTR areas. The present retention system only encourages health providers to devote energy to securing funds (for themselves) and justify inputs, rather than focusing on making improvements in efficiency or quality of care³⁶. The immediate sustainability goal for the ZHWRS is to revise the baseline for facilities enrolled in the ZHWRS with new criteria, and to reduce the present recurring financial costs of the ZHWRS by phasing-out monetary allowances. The mid-term goal is to introduce monitoring of the ZHWRS against national indicators for the HMIS. The long-term goal is to support eligible facilities with non-monetary incentives, and performance-based financing initiatives, until rural development indicators have shown that the facility is sufficiently developed to graduate off of the ZHWRS.

It must be envisioned that the future ZHWRS will cost less. Facility-based non-monetary incentives will have demonstratively replaced the use of individual financial allowances. The ZHWRS Sustainability Strategy holds that it is important to consider that facility-based membership in the ZHWRS is a time-bound, non-permanent arrangement with strict criteria for acceptance and graduation. As national development accelerates in terms of improved rural infrastructure, electrification of rural areas, and reduced morbidity and mortality rates, facilities will no longer require the ZHWRS, and its legacy will be improved community relations between facilities, staff and the community, leading to improved health-seeking behaviour from patients and better health outcomes.

³⁶ Morgan, Lindsay. Performance Incentives in Global Health: Potential and Pitfalls. World Bank, p. 2.

6. Recommendations

Based on the findings and the conclusion of this study, the following are the recommendations for the implementation of the proposed strategies. It is hoped that the proposals in the ZHWRS Sustainability Strategy will be adopted by the MOH and MCDMCH at the level of the respective Directors. The strategies can be implemented through the HRH TWG. The ZHWRS Sustainability Strategy can be presented to the Sector Advisory Group for consideration during planning processes and presented at the cooperating partners' health meeting. It is hoped that interest in this strategy will gain momentum, and that stakeholders involved in retention planning for HWs in Zambia will take the strategy into consideration.

The ZHWRS Sustainability Strategy recommendations are the following:

1. Apply the new criteria for selection of facilities in Strategy One with immediate effect.
2. Create a cost-benefit analysis and an evidence base on non-monetary incentives, in order to establish the opportunity costs of motivating HWs to work in the HTR areas of Zambia versus their not being there.
3. The ownership and operation of the ZHWRS should shift from the MOH to the Cabinet Office and the MDMCH.
4. Research is needed on how to merge the ZHWRS into other existing HRH strengthening initiatives; particularly recommended is RBF.
5. Opportunities to decentralise the function of the ZHWRS should be seized upon, and an operational plan for the ZHWRS Sustainability Strategy needs to be created and budgeted.
6. The ZHWRS Sustainability Strategy should not be time-bound to five years' duration, but should link to the duration of future national health policy and Vision 2030.
7. The existing ZHWRS Guidelines should be reviewed.

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Annex: Interview Questions

<p>Introduction Key Components:</p> <ul style="list-style-type: none"> • Thank you • Name • Purpose • Confidentiality • Duration • How interview will be conducted • Opportunity for questions • Signature of consent on face sheet 	<p>I want to thank you for taking the time to meet with me today. My name is... (letter of introduction), and I would like to talk to you about your knowledge and experience of the Zambia Health Workers Retention Scheme, or the ZHWRS in its abbreviated form, or the “Scheme”. Specifically, as one of the components of this evaluation, we would like to find out what is the way forward for the ZHWRS in terms of sustainability? How best it can be managed, in what form, how it can be equitable, and what it can look like scaled-up. We would like to find out what non-financial alternatives there are in the region, and locally, and how they can be improved upon and sustained.</p> <p>The interview should take less than an hour. I will be recording the session because I don’t want to miss any of your comments, and though I will be taking some notes during the session, I can’t manage to be fast enough to write all of it down.</p> <p>All responses will be kept confidential. This means that your responses will only be shared with the research team members, and we will ensure that any information we include in the Sustainability Strategy does not identify you as a respondent. We don’t have to talk about anything you don’t want to, and you may end the interview at any time.</p> <p>Do you have any questions about what I have just explained?</p> <p>Are you willing to participate in this interview?</p> <p>Interviewee _____</p> <p>Witness _____</p> <p>Date _____</p>	<p>Notes:</p>
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<p>Questions:</p> <ul style="list-style-type: none"> • No more than 15 open ended questions • Always ask factual before opinion • Probe as necessary 	<p>Four themes</p> <p>Theme 1: guidelines/ the lapses and gaps/areas for review</p> <p>What do you think of the ZHWRS scale-up guidelines?</p> <ol style="list-style-type: none"> 1. What do you think are sustainable points in the ZHWRS guidelines that should be retained? 2. Are there any gaps in the ZHWRS guidelines? 3. What would you change in the ZHWRS guidelines? 4. Would you give me an example? 5. Can you elaborate on that idea? 6. Would you explain that further? 7. Is there anything else? 8. Can you help me understand that better? 9. What facility-based initiatives are suggested in the guidelines? 10. Is there any evidence of these facility-based guidelines working? 11. Which other initiatives could be strengthened, and why? 12. Is there equality in the application of the ZHWRS guidelines? 13. How is equality evidenced/not evidenced? Would you give me an example? <p>Theme 2: Non-financial incentives</p> <ol style="list-style-type: none"> 1. What non-monetary incentives are you aware of in Zambia; which of these are proven to retain health workers? 2. Would you give examples of non-monetary incentives that are appropriate for the rural areas? And non-monetary incentives that are appropriate for the urban areas? 3. Do you have any examples of successful non-monetary incentives that are used in any other context in Zambia/or in other countries? 4. Would you give me an example? 5. Can you elaborate on that idea? 	<p>Notes:</p>
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6. Would you explain that further?
7. Why do you think this incentive could work taking into account the local context?
8. Is there anything else?
9. Can you help me understand that better?
10. What capital items ought to be prioritised in order to make HWs attracted to a facility?
11. How could non-monetary incentives be “bundled”, and kept to a minimum and cost?

Theme 3: Financing options

1. Do you think that the present monetary incentives in the scheme are sustainable?
2. Which incentives do you think are sustainable, and why do you say so?
3. How many other schemes is the MoFNP financing?
4. Of those different schemes, which ones are working? (Probing: how is it being implemented, who are the stakeholders, what is the payment schedule, and payment system?)
5. Which schemes have challenges? Why is this?
6. Who are the funders?
7. How is the scheme paid?
8. Which challenges are faced in financing the ZHWRS as it is?
9. Why are funds for the ZHWRS not always released on time from MoFNP?
10. Are the monies for the ZHWRS coded and budgeted in the national annual budget?
11. How does MoFNP know what to budget for the ZHWRS?
12. How should MoFNP know what to budget for the ZHWRS?
13. Who does the budgeting for the ZHWRS?
14. Is it the same process as for the other Schemes which are financed by the MoFNP?
15. Would you explain that further?
16. What can be done to address the issue of outstanding “liability” to HWs on the ZHWRS?
17. (For donors) What different kind of support is the donor giving to HSUSTAINABILITY

STRATEGY in Zambia?

18. (For donors) How long is the support committed for?
19. (For donors) Could such support be directed to the ZHWRS?
20. Under which conditions?

Theme 4: Management, administration, and decentralisation of the scheme

1. What criteria should be used for a facility to be put on the ZHWRS?
2. Should all the present cadres of Health Worker be maintained on the ZHWRS? Or should any particular cadre be added, or removed, from the Scheme?
3. Should the categories of locations stay the same be maintained?
4. How can management of the Scheme serve as an incentive to HWs?
5. Would you give me an example?
6. Can you elaborate on that idea?
7. How could the Scheme be decentralised?
8. How can decentralisation of the Scheme strengthen its equitability?
9. How can decentralisation of the Scheme make it more economical?
10. What can be done to provide greater accountability for the Scheme?
11. Which management tools should be implemented to improve the management of the Scheme?
12. How can inadequate conditions of service be addressed?
13. How can poor working conditions be addressed?
14. How can poor performance management be addressed?
15. How can inadequate education and training be addressed?
16. How can poor living conditions be addressed?
17. What channels of communication need to be in place?
18. How should the financial incentives be paid?

Closing Key Components:

- Additional comments
- Next steps
- Thank you

Is there anything else you would like to add?

I'll be analysing the information you and others gave me and submitting a draft report to MOH and ZISSP in one month. I'd be happy to send you a copy to review at that time, if you are interested.

Thank you for your time.

