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Retention Enablers: Informing HIV Workforce Sustainability Planning

A Case Study from Uganda

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Introduction

Throughout sub-Saharan Africa, human resource challenges have hindered countries' efforts to achieve HIV epidemic control. To accelerate access to the services needed to realize the 95-95-95 goals¹, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and other donors, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), have invested in tens of thousands of health and social workers, from clinical to lay cadres, across a number of countries. PEPFAR and the GFATM have supplemented the budgets of governments both to hire additional, contracted staff and to amplify the reach and effectiveness of staff through overtime pay, support for outreach activities, motivational benefits, and skills development. Given the important role that these workers have played in HIV progress and the substantial level of investment made by donors to empower this workforce, it is vital that policymakers understand the factors and motivations that will enable successful transition and retention of donor-supported health workers locally in both the civil service and private sector.

Uganda offers a rich country experience. Following a massive recruitment of health workers at the primary care level—known as 'The Surge'—by the Government of Uganda (GOU) in 2012, PEPFAR recruited an additional 1,292 (2012) and 921 (2015) health workers across 87 focus districts to address remaining staffing gaps in hospitals and health volume Health Centers II. From the outset, the GOU and PEPFAR discussed transition and the GOU's commitment to absorbing the staff over time, which comprised of a mix of clinicians, clinical support staff, biostatisticians and medical records officers. The GOU issued guidance to districts to prioritize absorption of donor-supported staff into their budgets. With this direction and after seeing the added value of the health workers, several district and facility champions advocated for and incorporated donor-supported health workers into their annual budget plans. As a result, from May 2013 to December 2017, 695 of these PEPFAR-supported facility-based health workers applied for and were absorbed into public service while more than 500 left to find other employment and nearly 1000 remained to be transitioned. An accompanying case study -- Transition Enablers: Informing HIV Workforce Sustainability Planning-- examines the enabling factors that facilitated the transition of donor-supported health workers to local support. The USAID Human Resources for Health in 2030 (HRH2030) program conducted a cross-sectional study to better understand the factors and motivations that enabled the GOU to transition and retain health workers previously

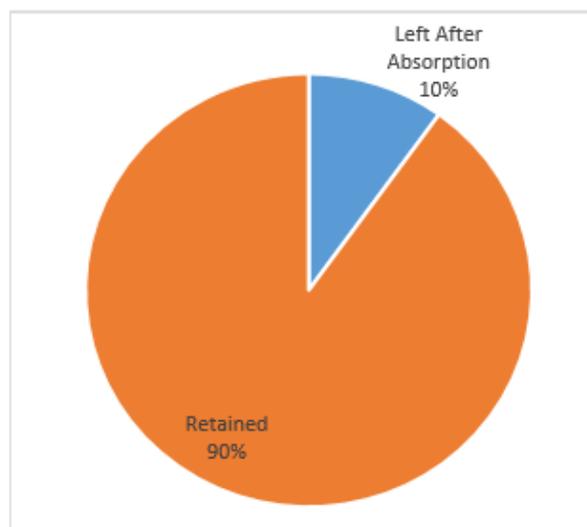
supported by PEPFAR. The study used existing databases to trace PEPFAR-supported health workers into the government system. It then analyzed the data for the 695 absorbed health workers, determined who remained in public service, and interviewed 75 previously PEPFAR-supported health workers in eight sample districts. For more about the study methodology, see Annex A. This particular case study focuses on retention – the extent to which PEPFAR-supported health workers who were absorbed into public service have remained in service and working on HIV services – and the implications of the Uganda experience for donors and governments in other countries.

What Did We Learn About PEPFAR-Supported Health Workers Who Where Absorbed into Public Service?

Retention is High at 90%, with 92% Remaining in the Same District

From May 2013 to December 2017, 695 PEPFAR-supported health workers across 87 PEPFAR-focus districts were absorbed into Uganda's public service. As of August 2018, 626 (90%) have been retained and only 69 (10%) have left GOU service (see Figure 1).

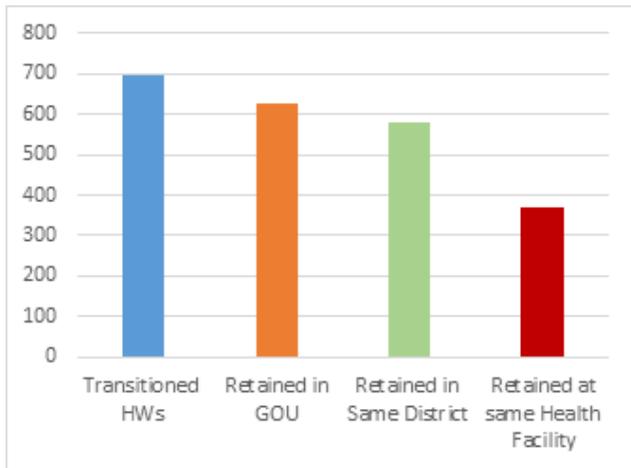
FIGURE 1: RETENTION RATE



These rates of retention are similar to analyses conducted by the Strengthening Human Resources for Health (SHRH)

program in its report “Impact of the 2012/2013 Massive Health Workforce Recruitment on Staffing and Service Delivery in Districts in Uganda” known as ‘The Surge’, which found 94% retention rates after three years.² However, while ‘The Surge’ led to extensive staff mobility, with 61.2% having come from other districts and only 38.8% having stayed in the same district of previous employment, 92% of the absorbed PEPFAR health workers were working in the same district as when they were employed with PEPFAR support, and 59% remained at the same health facility (Figure 2).

FIGURE 2: RETAINED AT THE SAME HEALTH FACILITY IN THE SAME DISTRICT (BY COUNT)



One contributing factor for this difference may be that PEPFAR-supported health workers come into public service with an appreciation for the work environment in public

health facilities, especially in rural areas and difficult posts, which facility managers felt explained the high levels of retention in place despite the dissatisfaction with these issues. In addition, PEPFAR partners reported that they intentionally recruited locally to encourage health workers to remain in the districts.

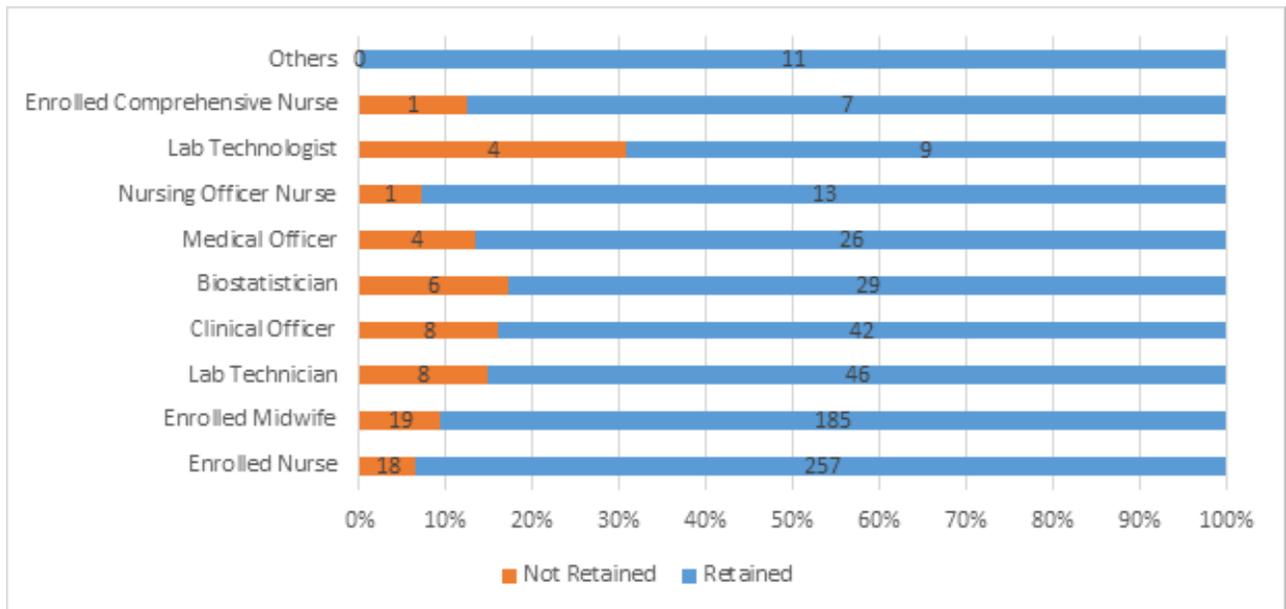
Retention Rate Varied Across Cadres

While enrolled nurses and midwives constituted the majority of those leaving service, they had among the highest retention rates by cadre (see Figure 3). Though small in numbers, lab technologists, biostatisticians, and clinical officers had the lowest retention rates. Stakeholders in Uganda reported that laboratory technologists were especially hard to retain because the market for their services was “hot.” Even when districts were able to recruit laboratory technologists, they hesitated to prioritize their absorption because they feared those cadres would leave soon anyway, and they did not want to waste the effort and resources. This is a concern as it will continue to perpetuate or even exacerbate vacancies in staff that may be deemed critical to HIV services, depending on the evolution of HIV epidemic control.

Rural and Hard to Reach Districts Retained the Same Percentage as Urban Districts

While more health workers left service from rural districts owing to their larger numbers, there was still 90% rural retention – similar to urban districts with a 91% retention rate. Even hard-to-reach districts retained 90% of their health

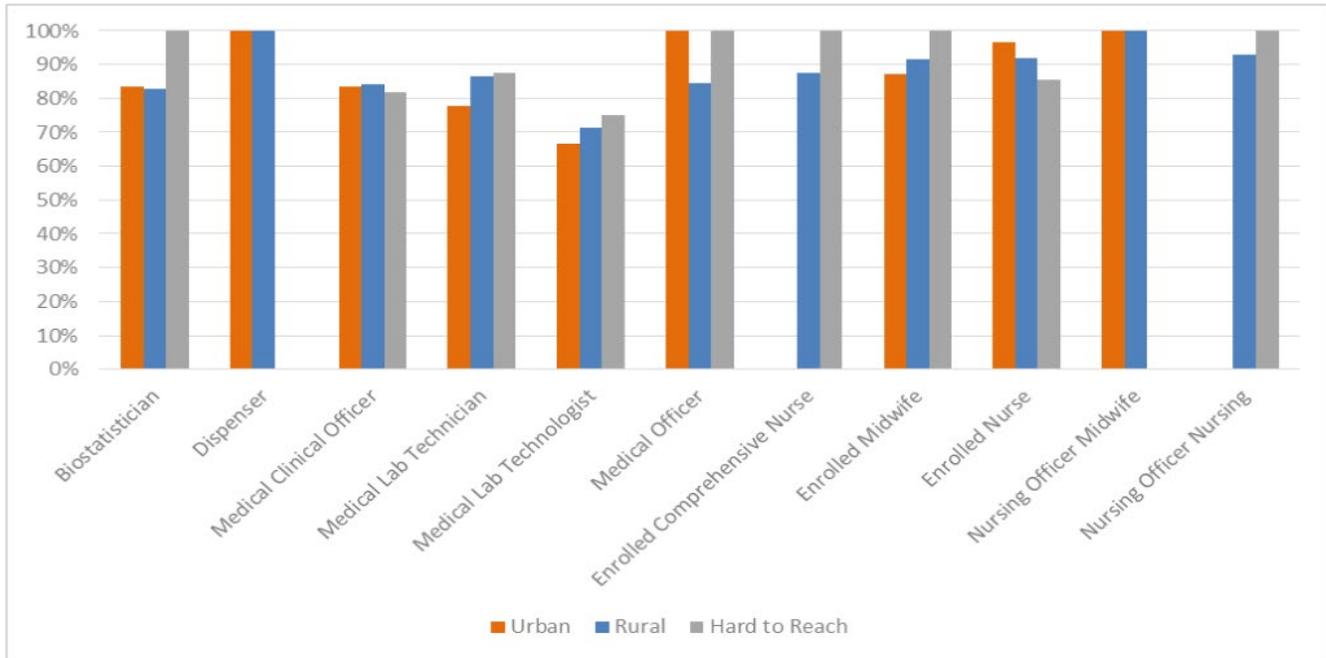
FIGURE 3: RETENTION RATES BY CADRE



workers. For most cadres, the retention rate by cadre between rural and urban districts was similar. Rural areas faced worse retention rates for medical officers (85% v. 100%) and enrolled nurses (92% v 97%) but fared better with their medical lab technicians and technologists (Figure 4).

only recall a few who declined an offer to be absorbed or left after being absorbed. According to interviewees many of those who left PEPFAR service prior to absorption were considered poor performers, had taken unapproved leave, or

FIGURE 4: RETENTION RATES BY CADRE AND DISTRICT TYPE



Large Majority (82%) Continue Working in HIV Services

Among the 75 previously PEPFAR-supported health workers interviewed as part of this study, 61.3% of absorbed health workers rated their continued involvement in the provision of HIV services as full-time, followed by 21.3% who rated their involvement as part-time. Only 17.3% reported that they were no longer involved in the provision of HIV services. Two-thirds of clinical officers and doctors reported that they worked full-time on HIV-related services and the remaining 33% said they were part-time. While more than 60% nurses and midwives stated their full-time was spent on HIV services, 15% and 20% respectively reported that they were not involved in HIV service delivery at all. Half of the laboratory staff, however, reported no HIV engagement; with a quarter stating that they engaged in HIV-related services full-time and a quarter part-time.

Contract Period Helped to Target the Best Performers for Absorption

PEPFAR-supported health workers were viewed as highly productive and valued workers. While many PEPFAR-supported staff left before absorption, stakeholders could

failed to report to work regularly or on time. When it came time for transition and positions opened, these health workers were not recommended for absorption. The contract period was viewed as an opportunity to test the health workers' skills and work habits and integrate them to the health system. In fact, many supervisors were critical in advocating for their absorption and supporting the health workers in applying where necessary or with funds and food if there was a gap in pay to ensure they remained at their post.

“What has made me stay in government is to obtain more experience because I am handling many patients, so many cases compared to the private wing because sometimes we see few patients and become inexperienced. ... I have received so many trainings in terms of TB and ... it has helped me improve in the knowledge gap and I have come across so many cases which I didn't encounter when I was intrining.” (FGD HW Iganga)

Contrary to commonly held perceptions of public service, a few health workers expressed a preference for public service because, relative to their work experience in for-profit clinics, working in public facilities offered a more challenging and diverse work experience which enabled them to optimize their competencies. Nonetheless, some stakeholders expressed concern about lagging productivity after health workers ceased filling out timesheets for IPs and wished they were held to the same standards after absorption.

Many Rising to Leadership and Mentor Positions

In the eight sample districts, especially in Iganga, Sheema, Nwoya, and Kasese districts, absorbed-PEPFAR health workers had taken up leadership roles. For example, a medical officer absorbed within the Nwoya District Service Commission in 2015 had risen to the position of Medical Superintendent of Anaka Hospital, and in Iganga, a laboratory technician had been promoted to the position of head of laboratory service of Iganga District Hospital. Several previously PEPFAR-supported health workers were the heads of ART, EMCT and TB clinics in health facilities in which they were absorbed, while laboratory staff were selected as district focal persons for viral load monitoring and HIV testing and were involved in supporting supervision for laboratory services at lower level facilities.

What Motivates Health Workers to Stay?

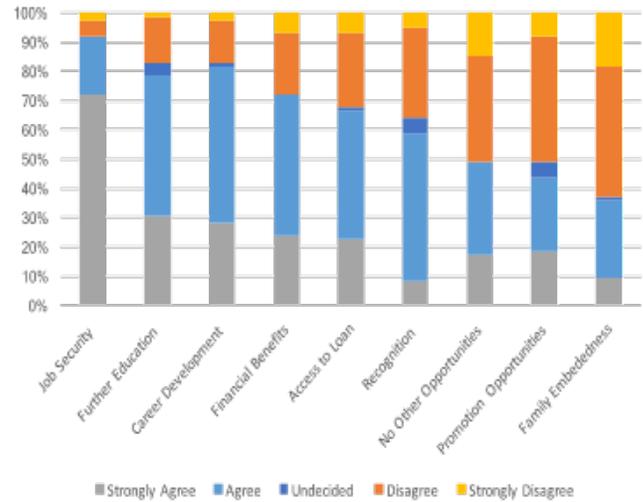
Job Security Main Reason Cited for Retention

The 75 previously PEPFAR-supported health workers interviewed as part of this study cited (1) job security, (2) opportunities for further training and education, (3) career development, and (4) compensation as the main factors enabling their retention to date (see Figure 5). Seventy-five percent (75%) of those interviewed strongly agreed that job security influenced their decision to stay and continue with public service. Given that job security was cited as a leading reason why health workers sought and remained in public service, it is likely that attrition rates will remain low, so long as the government can address major areas of dissatisfaction.

Motivated by Professional and Career Advancement

More than three-quarters of the 75 previously PEPFAR-

FIGURE 5: MOTIVATIONS FOR REMAINING



supported health workers interviewed as part of this study reported being attracted to remaining in government service due to opportunities of advancing in their careers given the clear and established structures for promotion and growth in local government service. More than 80% stated that it influenced their decision to remain. From the sample cohort, 86.7% retained their same position, 10.7% had already been promoted and 2.7% had been demoted.

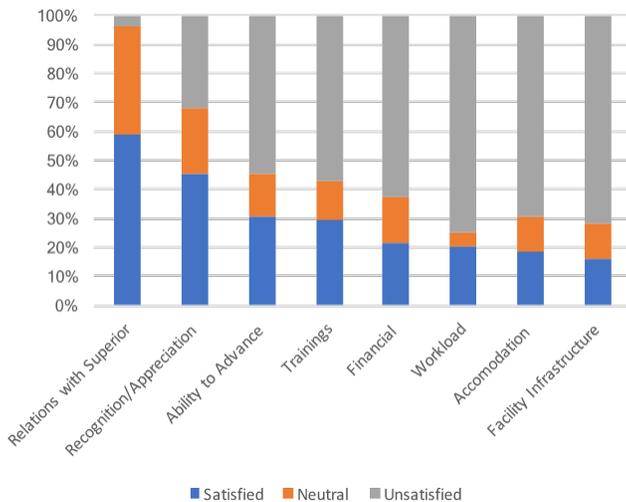
“Even for us, being employed in civil service, it is a motivation factor. Being somehow permanent. Because when you are on contract, they can say ‘the contract is not going to be renewed.’ So, if there is something worth fighting for, it is being fully recruited and appointed in government service.” (KII, District Official, Sheema)

Workplace Concerns are Potential Threat to Retention

Nonetheless, dissatisfaction with the work environment in government health facilities has demotivated health workers and may threaten long-term retention in government service. When the 75 previously PEPFAR-supported health workers interviewed as part of this study were asked about satisfaction levels while working as a public servant, heavy workloads (75%), poor facility infrastructure (74%) and lack of access to accommodation (69%) caused the most dissatisfaction (Figure 6). While retention is currently high, many health workers in the sample cohort highlighted workplace factors as concerns and potential threats to retention. Frustration with routine stock-outs of commodities, supplies, and electricity was raised frequently

during FGDs, as health workers felt they could not provide the needed services. For example, lab technicians mentioned that they had to use solar power which would turn off at night or due to weather and affect their tests and midwives noted they could not deliver in the dark. Female health workers who had to man the late-night shifts, in particular, expressed concern with the lack of security and light. They feared opening doors to potential patients when they did not have any light in to assess whether the person was a real patient or a potential threat.

FIGURE 6: LEVELS OF SATISFACTION



What Does this Mean for Donors and Governments in Other Countries?

Efforts made by donors and governments to transition donor-supported staff into public service is an optimal strategy for ensuring that the HIV health workforce continues to be highly engaged in HIV epidemic control, even after donor financing has receded. (See the case study from Uganda on Transition Enablers to learn more about the lessons from Uganda on how to facilitate absorption of donor-supported workers to public service.)

While governments may not always be able to match private sector pay, public service is seen as attractive for the longevity it provides and the additional benefits that come with stable income. However, challenges to long-term retention remain if the government fails to invest sufficiently in the health workers and the health system more generally. Health workers who remain demonstrate commitment to the work but feel demotivated when the infrastructure and

supplies are inadequate to adequately perform services. In addition, health workers want to develop skills and their career and may seek out other opportunities if they do not feel the government is investing in them.

Below are recommendations based on the Uganda experience for donors and governments in other countries that are contemplating how to sustain the donor investment in human resource, as financing and oversight is shifted to domestic partners.

I. Advanced Planning Supports Retention

Donors and the government should plan from the outset that any health workers hired with the expectation of absorption should be hired according to government standards and salaries. Health worker salaries should be aligned with the official government pay scales and the short-term contracts should be treated as probationary periods. Even though health workers may accept a decrease in salary to enter government service and access the associated benefits, they are more likely to remain if their salaries remain consistent before and after absorption. If the transition period takes place in phases over several years, some health workers may prefer the higher salaries and continuously seek out new contracts rather than remain in the government position. Furthermore, if the donor-supported staff are paid more than their government counterparts, including their supervisors, it can foster bad blood between the donor-supported staff and the rest of the health team. In Uganda, PEPFAR hired health workers at the onset with an explicit objective to transition these positions to the GOU and to maximize the extent to which PEPFAR-supported health workers would be absorbed. By harmonizing salaries to official establishment lists ahead of time, most health workers were not faced with the dilemma of whether to accept lower pay to work for the GOU or try to seek other project work to keep the higher salary.

“Remember these districts some of them are not the best to work in; they are up country... You can imagine people who came from colleges where they had electricity, internet services, flush toilets, and then you go to work and serve in an area where they use pit latrines... That is person that has really shown commitment in this area I will serve.” (KII, Mubende DHO)

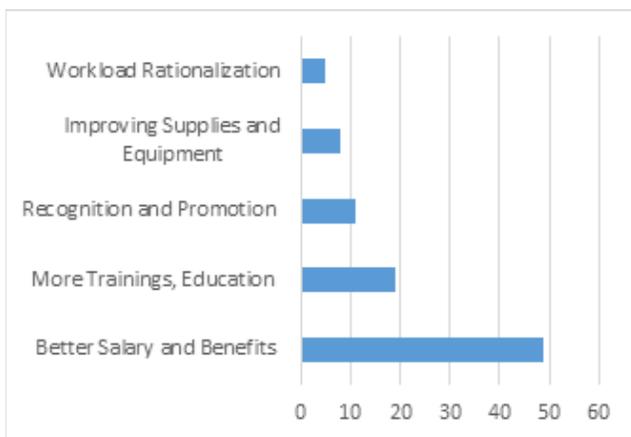
In addition, because the PEPFAR-supported staff were hired using government systems and integrated into the facility’s

overall hierarchy, health workers had an opportunity to be inducted and initiated into government systems and work environments. Facility managers oversaw the PEPFAR-supported staff and could recommend for absorption those who had contributed and were most likely to stay. At absorption, health workers were familiar with the work environment in government including the constraints that are common in public health facilities like shortage of supplies and heavy workloads which probably explains the high levels of retention despite the dissatisfaction with these issues.

2. Create Locally Relevant Retention Strategies and Plans

Creating a retention plan that fosters dialogue between facilities and their staff and helps to identify locally relevant challenges and potential solutions will be important for continuing to realize the benefits of high retention of these motivated workers into the future. National governments, districts, and facilities should develop targeted retention strategies or plans for all health workers as part of a concerted effort to understand the concerns and challenges facing their staff and actions that could mitigate them or increase satisfaction with their work. Some strategies may be more national in nature, such as ensuring adequate supplies while others may be specific to facilities. For example, while salary enhancements and provision of accommodation was the most cited strategy suggested by health workers in this study for promoting retention after transition (Figure 7), regular trainings and study leave was another frequent request and health workers spent more time in discussions highlighting challenges with supplies, training, and workload rationalization.

FIGURE 7: REQUESTS FOR LONG TERM RETENTION



3. Recruit Locally When Possible

If possible, health workers should be recruited from their own communities especially in hard-to-reach areas. This can be facilitated by focusing advertising locally rather than only through a central mechanism or at the major urban schools. Health workers from the community are more likely to remain in districts where they are familiar and have family than seek out employment elsewhere. In addition, local hires are more likely to be satisfied with the pay as they can save on food, transportation, and accommodation. Further, commutes can be long and expensive which can lead health workers to be late and miss work especially when the weather makes roads difficult. Ugandan stakeholders felt that local hires were more likely to stay for longer than those from other districts, and health workers reported a heightened sense of responsibility for their local communities. One IP noted that they stopped advertising centrally and focused their efforts locally. Nonetheless, the contract period can give health workers and their supervisors the chance to get familiar with the area and evaluate whether they can succeed in the environment especially if they are provided local accommodation to live in and get to know the community. Stakeholders noted that many recruited health workers were young and during the contract period, met and started families in the districts where they worked and wanted to stay.

4. Design Targeted Strategies to Retain Scarce Cadres

Scarce cadres, such as pharmacists, medical officers and laboratory technologists, can be difficult to recruit and hold on to at government salaries, especially where there is a robust private sector. It may be necessary to develop a different plan for cadres that the government has not traditionally been able to recruit. While it may be that salaries need to be increased, other options could include part-time work that allows them to work in the private sector at the same time or providing time and opportunities for research and study leave. Districts could institute a rotation that allows health workers to commit to shorter timeframes at a facility and fill in their post when they take study leave. In addition, they can target training to existing laboratory technicians with less education with the commitment that they return. However, the government will need to ensure that there is space in the establishment list for the advanced degree. Also, governments should not recruit cadres for facilities that do not have the equipment or means to utilize them. It may be tempting to hire higher level cadres for certain facilities, but the capacity of the facility to take advantage of the skill set should be evaluated first. For example, in Uganda, one

stakeholder reported that they had a medical officer at a facility but no anesthesiologist to support operations, which led the medical officer to leave, as he felt underutilized.

5. Don't Ignore Transition Logistics, Especially Payroll

The transition experience – what health workers experience as they move from donor contracts to public service -- can have short- and long-term ramifications on the ability of the government to retain health workers, and therefore, should be prioritized (see Uganda Case Study on Transition Enablers for more details). Salary delays during absorption can be devastating to health workers and lead some to seek employment elsewhere. Districts, facilities, and implementing partners should work closely together to ensure that there is no gap in payment between the end of the contract and absorption and develop a process for addressing complaints. For example, in Uganda's Sheema and Iganga Districts, a few health workers noted that they were not paid for months after being absorbed. In most cases, they were paid all or partial arrears, but during this time, they worked for free. One health worker speculated that the delay was because the government thought they might be double paying them. Even after they received salary from government, the Principle Nursing Officer in Tororo believed that some health workers still believed that they were being paid by PEPFAR and not the government.

6. Manage Expectations Around Changes in Benefits, Which Matter to Health Workers

“We suffered because our salary was not paid for around five months, they didn't pay it... Some of us starved. Others were about to leave.” (FGD, Sheema)

It is important to clearly communicate with donor-supported health workers when they are considering opportunities for absorption into public service about what they will receive, not only in terms of salary but also benefits, as they transition from contracted staff to government staff. Donor-supported staff often receive different types of benefits post-absorption, which can result in abrupt and unforeseen changes in the health worker experience and foster dissatisfaction. For example, in Uganda, some implementing partners had been providing in-kind benefits, such as food allowances and accommodation, which were not provided under public service; rather, public servants tended to receive greater

monetary benefits (e.g. pension). Even though more than 50% of the PEPFAR-absorbed health workers reported receiving the same or more benefits (in terms of amount) after transition, the types of benefits and allowances mattered. Health workers, especially those stationed away from home districts, expressed frustration at the lack of accessible food options while working and accommodation was one factor that health workers repeatedly noted had gotten worse under government service. During a focus group discussion in Sheema, all health workers stated in unison that accommodation was the main challenge in transitioning.

“I feel good working for the government because I love providing services for the people but one bad thing about the government is inconsistent supply of supplies and commodities that we need to provide a good service to the community.” (FGD, Iganga)

“[The lack of supply of medicines and other health supplies] demotivates, if those things are not there, and you start asking the client to go and purchase those things from private clinics or pharmacies... it's not good, it's very demotivating.” (FGD, Apac)

7. Continue to Follow Up with Absorbed Staff and Provide Targetted Support

Donors should consider a transition period where their implementing partners continue to follow up with absorbed staff during their first year. They can help troubleshoot issues and provide targeted technical assistance to districts if they identify a widespread or fundamental problem. For example, in Uganda, PEPFAR-absorbed health workers wished that the PEPFAR partners had remained in communication with them. They felt that they could express concerns more easily without fear of reprisals. For example, in a couple of areas, health workers reported delays in pay but felt powerless to address their concerns with the government and felt the implementing partners could have played a facilitating role. They wished they still had the ability to speak to the implementing partners about their situation as they were seen as more responsive.

8. Ensure Health Infrastructure and Supplies Are Adequate

Investing in health facility infrastructure, including accommodation and health supplies, may be more important than investments in individuals' salary and monetary benefits.

Health workers cannot perform their jobs if they do not have access to the proper supplies and drugs or if electricity and clean water are lacking. In Uganda, while retention is currently high, many PEPFAR-absorbed health workers highlighted workplace factors as concerns and potential threats to retention of health workers.

9. Prioritize Investments in Health Workers' Long-Term Professional Development

The government should prioritize investments in health workers' long-term professional development through trainings, quality supervision, opportunities for new experiences, and/or promotions for good performers. Post-transition, donors also should continue to invest in the professional development of health workers, working through the government and other local partners. In Uganda, after job security and more than financial benefits, professional development was cited as the second leading influencer for wanting to join and remain in public service. Overall, employment in public service was associated with gaining new skills and additional academic qualifications that would enhance opportunities for securing new positions in government through promotion and ultimately better pay. PEPFAR-absorbed health workers opted for and remained in government service because they hoped for more opportunities for in-service training in the form of seminars and workshops, and to increase their access to study scholarships and study leave for offsite trainings. Nonetheless, many health workers felt that the training promises had not necessarily been met and were frustrated that new staff were not given more opportunities for training.

Conclusion

The case study of PEPFAR-supported HRH in Uganda demonstrated that multi-stakeholder planning from the beginning can facilitate the process for absorption of donor-supported staff into public service while ensuring that those who are absorbed are retained.

The contract period is an opportunity to test the health workers' skills and work habits and integrate them to the health system. It should be expected that not all health workers will be absorbed. Those who remain through their contract and are recommended for absorption generally are eager to accept and gain the benefit of job security and may even be willing to take a small salary cut. However, challenges to long-term retention remain if the government fails to invest sufficiently in the health workers and the health system

more generally. Health workers who remain demonstrated commitment to the work but feel demotivated when the infrastructure and supplies are inadequate to adequately perform services. In addition, health workers want to develop skills and their career and may seek out other opportunities if they do not feel the government is investing in them. Creating a training and retention plan can foster a dialogue between facilities and their staff and help to identify challenges and potential solutions to retention into the future. Donors can continue to bolster retention by continuing to follow up with former staff for a transition period after absorption, financing trainings especially for new workers, and working with the government to create a conducive environment that supports health workers deliver services.

Annex A. Methodology

Approach

This cross-sectional case study used both quantitative and qualitative methods for data collection to complement each other in answering the study questions. The retrospective quantitative component of the study (Component 1) drew on data from the MOH's human resource information system (HRIS), as well as databases at IntraHealth International and other PEPFAR Implementing Partners, and from district level HIV service delivery databases, to identify health workers who were recruited under PEPFAR and later transitioned from PEPFAR to GOU system, and determine whether they remain in service with the GOU. For this component, the study team matched names across the PEPFAR Implementing Partners database to trace them to the MOU HRIS system to identify those health workers who had been absorbed. The study team identified 695 health workers absorbed by the GOU between 2012 and 2017 across the country.

Quantitative analyses were conducted on the full 695 absorbed health workers. Then the team determined whether any absorbed health workers had left the MOH and were no longer listed in HRIS as part of the workforce to calculate the percentage of staff retained. While the databases did not include information on whether health workers were offered the opportunity to transition but opted against it, effort was made to identify a few health workers who elected not to transition to understand their motivations.

The mixed-methods component of the study (Component 2) involved collecting primary qualitative and quantitative data among health workers absorbed from PEPFAR to GOU support, policy makers and health service managers involved in the health workers transition in a sample of seven selected districts and Kampala City. Participants included absorbed health workers at health facility level, health workers who elected not to transition, and district and health facility managers. At national level, KIIs were conducted with officials from the MOH, PEPFAR, IntraHealth and other PEPFAR Implementing Partners who were involved in planning and implementation of health worker absorption.

Sample Selection

The sample districts, Shema, Iganga, Tororo, Kasese, Mubende, Nwoya, Apac and Napac, were selected based on the number of health workers absorbed, a mix of urban, rural, and hard to reach and HIV prevalence. They represented eight of the top 11 districts for number of absorbed health workers. Using data from HRIS, absorbed health workers were identified and a proportionate

random sample selected and invited to participate in the study. The eight selected districts (selection criteria for these districts is detailed in Table 1) had a total of 174 transitioned health workers, including those who have since left GOU service. Of these, 75 were purposively selected by cadre of health worker for semi-structured interviews or one of four FGDs of 6-8 health workers each. Within the sample districts, only eight had left GOU service and the study team interviewed four of them. In addition, the study team interviewed 16 health facility and District level officials from the department of health and human resource management and 14 national level key informants including officials from the Ministry of Health, Ministry of Finance and Economic Planning (MoFEP), Ministry of Public Service (MoPS), IntraHealth International, Implementing Partners (IPs), PEPFAR, USAID, and CDC.

Limitations

While the case study drew out a rich set of insights and lessons learned especially from the qualitative component, the case study had a few limitations that hindered the quantitative assessment. Because that the study required ethics approval, the study design and sample selection had to be determined at the outset and was based on the number of health workers transitioned. Because the data on health workers hired under PEPFAR or by the GOU were in separate databases, the number of retained workers was not easily available at the outset. As a result, the study questions and sample districts were determined prior to having this information. With different data, a sample selection based on a variety of retention rates may have yielded other lessons. In addition, given that many health workers were only absorbed in the last couple of years, most health workers still remained in their posts. With only a few health workers leaving after absorption, the factors motivating them to leave were highly personal. It may not have been sufficient time to understand whether retention is a significant problem and what factors will enable or hinder retention over time. Finally, the Uganda experience was limited to retention in the public sector as few had been absorbed into the private sector.



An HIV counselor tests a client in Lagos, Nigeria. Photo Credit: URC, 2016.

Program Partners

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- Palladium
- ThinkWell
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About HRH2030

HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.

Global Program Objectives

1. **Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.
2. **Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.
3. **Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.
4. **Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.



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