

CPD as a strategy for retention of health workers in sub-Saharan Africa

In-service training and support is increasingly being recognised as a crucial component in enabling career progression. Professor Kayode Odusote reports.

For the past 50 years or more, post-independence sub-Saharan Africa (SSA) has made efforts to train health professionals to meet its healthcare system, which was expanding beyond the coverage that it inherited from the colonial era. These efforts were supplemented by nationals trained abroad who returned home in the early days. The structural adjustment programmes of the World Bank and International Monetary Fund put a freeze on investment in education, recruitment of new staff and infrastructural development, as well as capped increases in salaries and emoluments. The infrastructure and quality of service at both training institutions and healthcare facilities deteriorated.

By 2004, the human resources for health (HRH) situation in SSA had deteriorated to crisis level. The countries not only do not have enough numbers to achieve the Millennium Development Goals (MDGs) but they neither have the capacity to scale-up production nor the resources to motivate and retain those they spent their meagre resources to train. The situation led to the introduction of strategies to attract and retain health workers. The problem is multi-faceted and complex, therefore the solution cannot be a 'one cap fits all' single strategy. Those that have been effective have combined financial and non-financial incentives. Of the non-financial incentives, not enough emphasis has been put on continuing professional development (CPD), which significantly impacts on career progression, salary grading, and self-esteem of the health professionals.

Magnitude of the crisis

The HRH situation in sub-Saharan Africa is characterised by:

- inadequate number of health workers;
- maldistribution of those available;
- inappropriate mix of health professionals;
- low productivity associated with poor motivation and poor working conditions.

It is ironic that there are countries in SSA that

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have large numbers of unemployed medical and nursing graduates due to the structural adjustment programme.

The World Health Organization (WHO) estimates that 36 of the 46 SSA countries have a density of healthcare professionals (doctors, nurses, and midwives) below the threshold required to provide high healthcare coverage.¹ About 1 million additional health workers are needed to achieve the health-related MDGs by 2015. This stock of health workers is a balance between production and attrition. Whilst deaths and retirement are ongoing causes of attrition, migration (mostly external) has become a major factor in the available stock of health workers. A recent study showed that a significant proportion of doctors (28%) and nurses (11%) born in SSA were working in developed countries in 2000.² The numbers do not include those who were not registered to practise.

Factors favouring migration

The factors that favour migration from developing countries to high-income developed countries are classified into 'pull' and 'push' factors. 'Pull' factors are conditions in the recipient countries that attract migrant workers and these include:

- Better remunerations and better living conditions.
- Well maintained high-tech facilities.
- Easier system of post-graduate education.
- Safer environment.
- Prestige.



Universal understanding: in-service training is crucial

'Push' factors are conditions in the home country that are associated with job dissatisfaction and the urge to migrate. These include:

- Poor remuneration.
- Poor standard of living.
- Insufficient opportunities for post-graduate education.
- Poor working conditions.
- Socio-political instability.
- Poor management.

Some of the 'push' factors contribute significantly to the reluctance of health workers to work in rural areas and internal migration from the rural areas to urban areas or to other professions. These factors interplay in a complex fashion that is dependent on the professional category and location. In addition, there is the culture of migration³ and active export of health professionals in others. External migration is facilitated by the growing demand for health workers in developed countries due to demographic changes and active recruitment from developing countries.

Strategies for motivation and retention

Owing to the complex and multi-faceted nature of migration, the impact of strategies for motivation and retention of staff has varied. Strategies that address a single factor tend to have least success. Common themes in most incentive packages are:⁴

- financial (salaries and allowances);
- career development;
- continuing education;
- personal recognition.

This is because the core issues that need to be addressed by the incentive packages can be summarised into three categories:

1. Financial issues.
2. Career development.
3. Management issues.

Dissatisfaction with salaries and allowances are demotivating and this is an issue that can never be completely satisfied. Therefore, any incentive package that is likely to have an impact must combine financial (and material) with non-financial incentives.

In developing countries, career development in the health profession is tied to higher qualification and assures better remuneration and prestige. A specialist medical graduate has a more rapid climb in the career ladder and achieves higher status. A qualified nurse is not likely to get an administrative position and a faster rise in status. The qualification limits the career growth and additional qualification is required to progress to the next level in status and remuneration. Hence opportunities for acquiring higher qualifications are very important for young health professionals, especially doctors and nurses, who form the bulk of healthcare providers.

Management issues, by themselves, are not factors in the migration of health workers but the non-application of appropriate management strategies and tools. Most managers are senior health professionals who have been promoted to these positions without additional training to cope with the complexities of management, especially management of human resources.

Continuing professional development and retention

For the purpose of this discussion, continuing professional development (CPD) is described as any activity that would increase the professional competence of a qualified professional. Two major types of CPD activities that would be considered viz:

1. Formal CPD leading to the award of a recognised qualification.
2. In-service CPD, which are short-course to improve competence and performance.

Informal self-directed CPD is important for life-long learning and continuing professional development but would not be considered.

Formal CPD

In the 21st century, specialisation has become the norm rather than an exception in medical practice. There is no longer a general practitioner with basic medical qualification in high-income countries and the trend is spreading all over the world. In some developing countries, general medical practice has evolved into a specialty of doctors with skills and competencies to man secondary healthcare facilities. Therefore, every medical graduate aspires to specialise not only for attaining personal professional goals but also better career development and enhanced remuneration.

The same situation is emerging in the nursing profession. In most English-speaking countries in Africa, a female nurse needs to acquire additional qualifications as a midwife, whilst male nurses require a specialised qualification to advance in their career. In many French-speaking countries, the additional specialisation is a requirement to scale the barrier of career stagnation. Therefore, personal professional growth of health professionals must be taken into consideration to avoid losing a significant proportion of them either to internal or external migration.

In-service CPD

The vertical (donor-driven) programmes have shown the importance of in-service training to improve the competence of health workers. The additional competence gives the health worker confidence and opportunities for

Support in practice: an example from Ghana

In 1991, the Carnegie Foundation gave a grant to the University of Ghana to commence postgraduate training of obstetricians and gynaecologists. The grant was to provide educational resources and materials for the trainees, training of trainers for effective supervision and mentorship, and support for 3 months attachment in an institution in the North. The grant was renewed in 1994 and a final grant given in 1997. By the end of the period of the grant in 2000, about 30 specialists had been trained. All of them are still practising in the country today and five of them have become Professors. They have continued the training in the major teaching hospitals of Ghana. The training programme is now supported fully by the Ghana government within the limits of the resources of the country.

higher responsibilities and challenges, which are fulfilling. One area where in-service CPD would enhance retention of staff is in management, especially human resources management. In-service training of all who find themselves in management position is essential both for the performance of the facility and motivation of the staff.

Proposed strategies for CPD for retention

No strategy for retention of health workers would succeed without the political will and financial backing from government with full support of its Development Partners.

Residency Training is a training format where the trainee learns on the job in an accredited institution guided by a curriculum. The format ensures that the trainee, who is in employment, is available to offer service throughout the period of the training. The West African College of Physicians and the West African College of Surgeons were established in 1975 and have accredited institutions for training medical graduates in different specialties, mostly in Nigeria and Ghana. Table 1 shows the average number of trainees that have sat the examinations of the Colleges over the past 10 years. Assuming that only half of those in training sit for the examinations in any 1 year, then for each year at least twice as many doctors are in the region, learning and offering service. Without this training programme, most of them would be out of the region seeking specialist qualifications and may never return. It is estimated that about 80% of medical specialists in practice in Nigeria and Ghana today are products of this training programme and about 80% of the products of the programme are still practising in the region.

A similar residency programme can be established for the training of specialised nurses and pharmacists so that many of them can offer service whilst in training and eventually remain in the region.

Learning from the experience of Cuba, every District Hospital can be upgraded to be part of the network of training Institutions for a residency programme. This ensures that the quality of health service provided by the District Hospital is improved and health workers are available.

In-Service CPD should be developed to meet identified needs in each service of each facility. This should be part of regular management of the Human Resources of all facilities. In a sector, where new knowledge is available with exponential rapidity, it should be part of regular management activities. 'Hotel' training should be discouraged except for the training of trainers. All in-service training should be facility-based and training of teams not individuals.

Training in management is essential for any health professional who is required to perform a management role. Including course management on the basic training of health professionals has been proposed over the years and has been implemented by some medical schools. This does not replace the need for training of health professionals when they have to take on this additional role.

Distance learning is a methodology that is available

Table 1 (a & b): Average number of trainee resident doctors that registered for the different parts of the examinations of the West African College of Surgeons (WACS) and the West African College of Physicians (WACP) over a 10-year period.

(a)

AVERAGE ANNUAL REGISTRATION FOR EXAMINATIONS OF WACS (2000 - 2009)				
	PRIMARY	PART ONE	PART TWO	TOTAL
2000	622	203	109	933
2001	735	217	114	1,066
2002	652	233	118	1,003
2003	551	316	121	987
2004	467	375	141	982
2005	500	372	146	1,018
2006	684	375	184	1,242
2007	812	368	193	1,372
2008	985	467	225	1,677
2009	1,013	513	226	1,752

(b)

AVERAGE ANNUAL REGISTRATION FOR THE EXAMINATIONS OF WACP (2000 - 2009)				
	PRIMARY	PART ONE	PART TWO	TOTAL
2000	319	115	49	483
2001	380	152	52	584
2002	364	201	44	609
2003	378	253	45	676
2004	366	253	53	672
2005	359	243	62	664
2006	654	294	37	985
2007	821	307	78	1,206
2008	867	454	74	1,395
2009	931	483	118	1,532

to all with advances in information and communication technology. It provides access to the best learning materials and trainers from everywhere. With mobile e-learning, availability of a computer and internet service is no longer a limitation. Distance learning should be adopted for both formal and in-service CPD.

Conclusion

The HRH crisis in developing countries, especially in SSA, requires urgent action in order to have adequate health workers for the achievement of the MDGs. Production of additional health workers is a solution that takes time to have adequate impact. Current efforts by government and partners to retain the available staff must take into account the complexity of the factors that lead to internal and external migration. Financial incentives are important in reducing the demotivation. Complementing this with continuing professional development would synergistically lead to retention of highly qualified health workers.

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