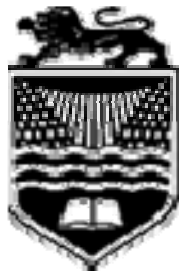


Survival and retention strategies for Malawian health professionals

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Executive summary

This paper was produced under the theme of work on Human Resources for Health in the Regional Network for Equity in Health in east and southern Africa (EQUINET) in co-operation with Health Systems Trust South Africa.

Malawi, like many southern African countries, is facing a critical human resources for health (HRH) crisis, preventing it from delivering acceptable quality health care services to its population. The reasons underlying the shortage of health professionals are multiple and include limited output from training institutions, high attrition rates resulting from migration and disease, and increased workloads because of HIV and AIDS.

Despite the increasing levels of migration of health professionals from Malawi which have caught international attention, many continue to serve their country. The challenges encountered by these health workers (which may eventually become push factors), and the coping or survival strategies that they utilise deserve attention if any meaningful solutions to retain health professionals in Malawi are to be developed.

Health professionals employ a range of survival strategies including:

- reliance on per diems/allowances from workshops and seminars
- saving on stipends from long-term training programs
- business activities
- working in places where the cost of living is perceived to be lower
- pilfering of drugs
- dual practice (working in both private and public sector),
- consultancy work
- being paid for work not done at one institution while working for another employer.

In order to retain health professionals in Malawi, we advocate for:

- debt relief and advocacy toward the IMF and World Bank to end restrictions on hiring and increasing remuneration for health workers;
- mandatory public sector employment after graduation from health training institutions;
- strengthening of the health professionals' association to enhance unionism and collective bargaining; and
- provision of free anti-retrovirals (ARVs) to health professionals.

1. Background

One of the biggest challenges facing African health systems is the shortage of human resources for health (HRH). This shortage has been exacerbated by the AIDS pandemic, which has not only increased attrition of health workers, but has also increased work loads as a result of increased morbidity in the general population. In addition, morbidity among health workers themselves leads to absenteeism, resulting in work overload for the remaining health professionals (Paradath et al, 2003).

The major formal health services provider in Malawi is the Ministry of Health (MoH), which provides approximately 60% of all services. The Christian Health Association of Malawi (CHAM) is responsible for the provision of about 37% of all services. Other providers include both private-for-profit and private not-for-profit, local government, the military and police health services and small clinics offering care for company employees and their families (Ministry of Health and Population, 1999).

The 'push factors' that lead to health workers leaving their posts in Africa, and the 'pull factors' operating in the recipient countries have been described elsewhere (Hagopian et al, 2004; Hagopian et al, 2005; Kline, 2003). While it is generally appreciated that remuneration packages and general work conditions in most health systems are inadequate (Hagopian et al, 2005), not all health workers leave. What are the factors that retain or could retain health workers in their posts? It is well recognised that the salaries/wages of health workers in many places in Africa may barely meet family living expenses. How are health workers surviving on such meagre wages? These are the questions that form the basis of this research. Hopefully the lessons learnt in Malawi may guide policy makers and health workers' associations in advocating for better working conditions for health workers here and in other African countries.

1.1 Training of health workers

Parastatal organisations and denominational training institutions provide training for most health workers in Malawi. Denominational nursing schools under CHAM train 77% of all nurses in Malawi. Malamulo College (a denominational institution) and the Malawi College of Health Sciences (parastatal) train clinical officers, medical assistants and laboratory technicians. The Malawi College of Health Sciences is the only institution for the training of dental technicians and therapists, radiographers and radiographers.

The College of Medicine trains medical doctors at undergraduate level, while the Kamuzu College of Nursing (KCN) trains degree-level nurses. Both institutions are constituent colleges of the University of Malawi (UNIMA). Although there are an increasing number of female students at the Malawi medical school, the medical profession is male-dominated (Muula et al, 2004). In addition, nurses are predominantly female (Muula et al, 2004b).

Clinical officers and medical assistants fall under the category of paramedical health workers. Clinical officers receive three years of training at the Malamulo or Malawi College of Health Sciences before a one-year clinical internship. Clinical officers are trained to do a selected list of surgical procedures including caesarean section deliveries. Medical assistants (MAs), on the other hand, receive two years of training and are not trained to conduct surgical operations. They do not undergo an internship programme and are mostly assigned to health centres. An MA can upgrade to a clinical officer by taking another 18 months of training, followed by an

internship programme. Most of the paramedical clinical officers providing anaesthetic and orthopaedic care in Malawi are upgraded from the MA cadre (Fenton, 1991; Fenton et al, 2003).

1.2 Distribution of health workers in Malawi

The public sector remains the major employer of professional health workers, followed by CHAM. The private for-profit health sector, although expanding, provides less than 3% of health services in Malawi. In 2003, Hornby and Ozcan reported that 69% and 31% of health workers were in the public sector and private sector (CHAM and for-profit) respectively. The private not-for-profit sector outside CHAM is almost non-existent. Information on the categories of health workers, numbers and distribution between urban vs. rural is presented in *Table 1* below.

Table 1: Distribution of health workers in Malawi by 2003

Category	In post 2003	% FTE in Public Sector	FTE by sector		Population per Worker
			Public vs.	*Private	
Specialist Physicians	29	62.07	18	11	403,345
Medical Officer	108	60.19	65	43	108,306
Clinical Officer	462	74.68	345	117	25,318
Medical Assistant	499	61.72	308	191	23,441
Dentist	4	80.00	3	1	2,924,250
Pharmacist	39	7.69	3	36	299,923
Registered Nurse	607	66.56	404	203	19,270
Pyschiatric and Community Nurses	327	93.88	307	20	35,771
Nurse/Midwife Techn.	2,160	53.94	1,165	995	4,415
Radiographer/Radiography Assistant	46	80.43	37	9	254,283
Lab Technician	260	51.16	66	63	90,674
Environmental Health Staff	129	97.69	254	6	44,988
Dentistry-related staff	174	89.66	156	18	67,224
Pharmacy-related staff	157	54.78	86	71	74,508
Other Managers	133	63.91	85	48	87,947
Snr. Allied staff	35	65.71	23	12	334,200
Allied professionals	55	81.82	45	10	212,673
Health Surveillance Assist.	4763	95.53	4,550	213	2,456
Skilled support staff	1511	64.20	970	541	7,742
Other support staff	8421	58.63	4,937	3,484	1,389
Totals	19,919	69.0	13,818	6,091	587

Note: FTE= Full Time Equivalent; *Private sector includes not-for-profit denominational services
Source: Hornby et al, 2003.

There has also been a growing demand for health professionals in non-governmental organisations (local, national and international) and research institutions (Kushner et al, 2004). These employers may provide higher, tax-free salaries and other benefits to health professionals, which can result in remuneration 10 to 15 times higher than that obtainable in the public health sector. Consequently, significant numbers of health workers have left the

public sector for the private sector, where remuneration is much better. Health workers can still work in a public institution, despite being employed by a private institution. Notable examples are clinical research projects that employ their own staff, who at the same time are responsible for the mainstream clinical care of patients.

Health professionals also work in the country's training institutions such as the College of Medicine, Kamuzu College of Nursing, Malamulo College of Health Sciences and the Malawi College of Health Sciences. Remuneration packages for employees of these training institutions are also generally higher than those of employees in the mainstream public health service.

1.3 Career progression within the public health sector

The major entry-level career categories for health professionals are technical assistant grade (with a two-year certificate), technical officer (three-year diploma) and the professional (PO) grade for those with at least a degree.

A medical doctor who completes his or her internship is free to join any employer, or to emigrate from Malawi, if desired. Many of those that continue working in the public health sector are sent to work as district health officers (DHOs). Normally, the DHO is at P8 Grade, one step ahead of the entry point of most graduates with a first degree into the public sector (professional officer grade, or PO grade). However, the entry grade for lawyers with a first degree is P7, in other words, one grade ahead of doctors. For a dentist (all of whom are trained abroad), there are no district level vacancies, as all are expected to be employed at central hospital level. As is the case with all degree holders, the entry point is at PO level. At P8 grade, in 2004, a medical doctor received about US\$ 300, all inclusive, per month. The MoH has the authority of promoting a medical doctor up to P5 grade, where remuneration is about US\$ 30 more than P8.

For clinical officers, laboratory and dental technician and diploma nurses, the entry level into public service is the technical officer level. A technical officer may be promoted to senior technical officer and then to chief technical officer (CTO). The CTO is at the same level as a PO, and this is usually the topmost position for any diploma holder.

An enrolled nurse enters at TA (technical assistant) level, which is the lowest grade for any certificate holder. A TA nurse or medical assistant can be promoted, with training, by obtaining a diploma. He or she has to undergo upgrading training for a period of 18 months.

1.4 Shortages of health care professionals in Malawi

Malawi's shortage of health care professionals is caused by several factors:

- *Inadequate numbers of health professionals produced by training institutions:* Since its opening in 1991, Malawi's medical school has produced an average of 17 doctors annually. Although the school has helped to increase the number of doctors in the country, an annual output of about 17 is unlikely to make a significant dent in the national requirement shortfall. From 2003 however, the annual intake at the College of Medicine was increased to over 40 students and currently has been further increased to about 60. About 40 to 50 nurses graduate with diplomas and degrees at the Kamuzu College of Nursing (KCN) every year, although there are many years when output is lower. Training for clinical officers, laboratory technicians and medical assistants is

hampered by the closure of training schools due to limited financial resources. For instance, the Malamulo College of Health Sciences was closed for the latter part of 2004 because of a lack of funds. The possibility of increasing output from training institutions is curtailed by a shortage of tutors, many of whom have either emigrated or moved to non-training private-sector jobs.

- *Migration of health professionals:* Many health professionals leave the public sector for the private sector and NGOs, while others leave Malawi to go abroad. Some leave the health profession to work in other professions. Since 1999 between 80 and 120 nurses have left Malawi for work abroad each year. The situation regarding doctors is just starting to be appreciated, although currently there is a net migration of doctors from abroad into Malawi (Muula, unpublished data). Of the 200 graduates of the College of Medicine (1991 to 2003), 53 have gone abroad, mostly for further training. Whether they will return or not is unknown. In 2003, out of 252 doctors working in Malawi, only 90 (35.7%) were Malawian nationals. There is currently no data available for the other cadres.
- *Attrition due to death and ill-health:* In any profession, allowances must be made for natural loss due to death and illness. However, it would appear that there is an accelerated loss of health human resources in Malawi. The MoH has attributed this loss to the HIV and AIDS pandemic (Ministry of Health and Population, 1999). Kober and Van Damme (2004) reported that the number of deaths among nurses in Malawi is about 40% of the average annual output from training schools. The tuberculosis burden among health workers is especially high (Harries et al, 1999; Harries et al, 2002).

1.5 Policy decisions to improve the human resources shortages

The government of Malawi has put a number of measures in place in an attempt to address the human resources deficits within the health sector:

- *Introducing and training new cadres of staff.* In 2003, the MoH introduced the nurse auxiliary cadre. Nursing auxiliaries (NAs) are trained on the job for one year before being certified by the government to practise. However, the Nurses and Midwives' Council of Malawi (NMCM) currently does not recognise this cadre, and nursing auxiliaries are not allowed to register with NMCM. The Council's position was that recognising the NAs would distract attention from the need to improve the work conditions of full-trained nurses, and the quality of care would reduce.
- *Increasing enrolment in training schools:* All training institutions in the health profession receive a large part of their funding from government, including the denominational training institutions through CHAM. Between 2002 and 2005, funding to these institutions was increased to enable higher enrolment levels. Some of the funding comes from the Highly Indebted Poor Countries (HIPC) programme. The over-reliance on government support for funding also means that the government must disburse the money in good time, otherwise the training institutions are unlikely to meet their running costs. It is noteworthy that, while other colleges at the University of Malawi have closed because of a lack of finances, the College of Medicine has never closed for this reason. This has been possible due to government mostly honouring its commitment and the COM's own fundraising initiatives, mostly through research grant administration fees.
- *Improving the remuneration of health workers:* The government has established the Health Services Commission with powers to determine the remuneration of health workers. The MoH also supplements health professionals' remuneration through salary supplementation/allowances, mostly funded by donors. By 2004, DfID and the

Norwegian Agency for Development (NORAD) had committed over US\$300 million for the salary supplementation. Implementation had started by April 2005.

- *Temporary re-employment of retired health workers:* In the public health system, workers retire at the age of 55. Workers who are younger than 55 may choose to retire after 20 years of service. The MoH employs retired health professionals. As many of these retirees desire to work in underserved areas, this practice contributes to improved service delivery in these areas.

2. Research aims and methodology

The broad objective of this paper is to contribute to the retention of health workers in Malawi by providing an enhanced understanding of health workers' coping strategies, together with the identification of possible strategies that could impact on their retention.

The specific objectives were to:

- determine the sources of income for health professionals in both private and public services in Malawi (other than formal wages, or pay salaries);
- identify the working practices of health professionals in Malawi that may influence their retention in the country;
- determine the attitudes of health professionals towards various forms of out-of-formal-employment incomes;
- identify possible strategies that could contribute to retention of staff and have a positive impact on the problem of the brain drain in Malawi; and
- contribute to national and regional debates by presenting the findings of this study to a dissemination conference, to Parliament, to health workers and to the general public as a lobby tool. (This would enable stakeholders understand the working environments and situation of health workers and therefore help to identify gaps in working policies and advocacy, and identify areas for policy change.)

This study used literature searches (published and unpublished) on human resources in health, focus group discussions, and in-depth key informant interviews. The study participants included health workers and administrators working at health centres – at both district and central levels. A total of 35 nurses, 15 doctors, 25 clinical officers, 15 medical assistants, 40 technical support staff and 15 administrators and policy makers were interviewed.

3. Findings

As mentioned earlier, the aim of this study is to obtain in-depth information regarding the challenges faced by health professionals in Malawi and to identify their coping mechanisms. Potential strategies for improving retention of health professionals were also explored.

3.1 Challenges faced by health professionals

Challenges fall into those that impact on work status and remuneration, working conditions, opportunities for further training/advancement and unfair recruiting practices.

3.1.1 Inequitable salaries and a lack of recognition of experience

When the College of Medicine's first graduates completed their internships in 1994, all of them were sent to districts to work as district health officers (DHOs). This was the first group of Malawian doctors to be deployed to districts at any one time. Newly qualified doctors continue to be posted as DHOs once they have completed their internships. However, this practice creates a situation where much more experienced DHOs who have worked for several years may be at the same grade as those who are entering the health sector for the first time, with no experience. They are also remunerated at the same grade and given the same privileges. As a CHAM doctor interviewed said: "I have served as a DHO for many years. Someone has just come in from internship. We are at the same grade. What is that?"

Nurses feel that they are marginalised by the MoH and other employers in favour of medical doctors, clinical officers and medical assistants. For instance, doctors within CHAM units are eligible for salary supplementation, which may be in excess of US\$300 each month, and yet the nurses receive no such privileges.

While DHOs are mostly doctors and, in some cases, clinical officers, it seems that no nurse – even one with a degree – can become a DHO. This inevitably results in discontent among nurses with degrees, who end up being subordinates to clinical officers and medical assistants with a junior qualification and/or less experience. For instance, a newly graduated medical assistant (MA) sent to a health centre may find herself or himself in charge of that health centre and responsible for all its supplies and operations, including supervising the nurse (in some cases a registered nurse), who may have been at the health facility for many years already.

As one nurse said: "*What is painful is that even myself as a degree nurse must work under a medical assistant who has a mere two-year certificate.*"

These situations may breed frustration and resentment towards the health care system.

3.1.2 Overwhelming responsibilities

A significant number of health professionals find themselves taking up enormous responsibilities that are beyond what their training and/or experience has equipped them for. In the case of doctors who complete their internships and desire to continue working in the public health sector, many are sent to work as DHOs and are expected to provide both clinical and administrative leadership for an entire district, with little relevant experience to guide them through such challenging situations.

The situation is little different for registered nurses (degree nurses) who are sent to district hospitals. They are likely to be appointed as ward sisters-in-charge, acting matrons or, in some cases, even matrons, working as the district nursing officer. While health professionals

are trained at KCN to take up such responsibilities at the appropriate time after having acquired the requisite experience, the urgency to take on these responsibilities without first having gained experience can easily lead to frustration and burn out.

However, it is also difficult to envisage what other roles could be offered to nurses, given that many of the health professionals they find at their site are junior to them in qualifications (although possibly with more experience). To make matters worse, invitations to workshops, seminars and conferences, and therefore opportunities to access allowances/per diems usually goes to these senior cadres. The new nurses with degrees may therefore feel pressured to attend to all these meetings, thereby leading to burn out.

3.1.3 Lack of stimulating interaction in the workplace

Many health workers in the public sector in Malawi are working in isolation. It is common to have the only doctor in a particular district as the DHO, and many districts have the only laboratory technician or radiographer, with no other employees in the same profession. There are only a few registered nurses in each district, and the situation is similar for other cadres. In many cases this professional isolation implies an environment that is not challenging due to a lack of peer support and sharing of ideas, resulting in frustration because of the lack of professional interaction. The lack of an academically and professionally challenging environment is exacerbated by the absence of any requirement for continued professional development (CPD) or professional medical education (CME). There is no requirement for continued professional development as a necessity for re-registration by the regulatory bodies.

3.1.4 Inadequate supervision

Supervision is perceived to be a motivating factor by health workers. Workers reported they were either poorly or inadequately supervised or were not supervised at all. Supervisors reported that a lack of resources and especially transport, coupled with other commitments and responsibilities, prevented them from making supervisory visits. In some cases, supervisors lacked the requisite training and experience, so they had a poor understanding and appreciation of the importance of supervision. For fear of exposing their shortcomings, some supervisors did no supervision at all. Lack of supervision resulted in workers feeling unappreciated, demotivated and frustrated, and was an acknowledged push factor.

3.1.5 Impact of HIV and AIDS

There was a general perception among health professionals that they were at an increased risk of occupational exposure to HIV and other infectious diseases, such as tuberculosis. Although almost all health facilities had a focal person responsible for universal precautions against hospital-acquired infections, the availability of supplies such as disinfectants was not universally guaranteed.

Apart from occupational exposure to HIV, it is likely that a significant number of health workers are already infected with HIV, although HIV prevalence figures among health workers in Malawi are not available. In 1999, the Health Sector Human Resources Plan reported the following losses due to death: registered nurses (2.7%), clinical officers (2.1%), medical assistants (2.1%), all enrolled nurses/midwives (1.9%) (Ministry of Health and Population, 1999). Although the Health Sector Human Resources Plan did not indicate the distribution of causes of deaths among the various health cadres, AIDS is likely to be an important factor. In 2004, Shisana et al reported that HIV prevalence among health workers in South Africa was 15.7%, with younger health workers (18–35 years) having a much higher prevalence of 20%.

Tuberculosis infection rates among health workers in Malawi is higher than the general community (Harries et al, 1999).

The heavy work load, coupled with the perception of an increased risk of getting an infection (for example, HIV or tuberculosis), means that some health professional have changed from clinical to other duties, or have left the health profession altogether.

3.1.6 Access to further training

Many health professionals value access to further training. Employment as a junior faculty member within a university department (at the Kamuzu College of Nursing and the College of Medicine) almost always guarantees the opportunity to obtain a postgraduate qualification, either from the institution itself or from another institution. Sponsoring agencies and government are more likely to support postgraduate training for a university employee than for a health professional working in a non-educational institution. Therefore, health workers who wish to obtain higher qualifications are attracted to working in the training institutions.

Tutors in health training colleges are normally employed when they have three-year diplomas and so have an opportunity to obtain advanced or higher diplomas, as well as degrees. However, in the case of Malamulo College and the Malawi College of Health Sciences, one of the challenges is the fact that many of these degrees obtained by tutors are not in mainstream clinical training but rather in areas like health education. Such qualifications are mostly good for a teaching position but little recognised by the public sector to facilitate advancement in mainstream clinical jobs.

Previously, with limited numbers of health professionals competing for training posts, the public health sector was competitive in so far as it provided or facilitated training fellowships/ scholarships. While this continues to occur, there are many more health professionals requiring such training and demand can hardly be met.

Unfortunately, it would seem also that blocks are occurring at MoH headquarters and that some do not support the provision of postgraduate qualification to MoH employees. A case in point would be the handling of World Health Organisation's training fellowship from the WHO's Malawi office. Malawi should receive up to 20 WHO-funded training fellowships every two years from the WHO Malawi office. Despite the availability of this facility, the MoH has dragged its feet since 2002, impeding the ability of Malawian health workers to benefit from such opportunities, and thereby removing a reason to remain within the public health sector.

Since 2005, the College of Medicine has offered a specialist degree course in several of the core clinical specialties of internal medicine, surgery, obstetrics and gynaecology and surgery. Graduate public-health training was started much earlier, in 2003. However this training in the clinical specialist programs is currently only available to employees of the MoH and the College of Medicine. Private sector employees are not eligible. This may be an incentive for doctors to work in the public sector. However, for those in the private sector, the only opportunity for training is available outside the country.

3.1.7 Limited career recognition

Access to further training can be a motivating factor assisting in the retention of health professionals. However, when a health professional acquires additional qualifications, he or she requires appropriate recognition for this achievement. In several instances, the MoH does

not seem to accord this expected recognition to a staff member. Frustration and resentment set in and the health professional may leave.

For example, several DHOs, who left to obtain post-graduate qualifications abroad in public health/ epidemiology, returned to the country expecting promotion to higher MoH positions. When this did not happen, a few stayed on leave for several months while they negotiated with the MoH for their posting, while others resigned.

The MoH is not solely responsible for the lack of recognition for its staff since it can only promote its staff to P5 grade, a level already attained by several DHOs. Promotions above this grade are the prerogative of the office of the president, in other words political appointments.

A further problem is that posts may not be available for employees who have upgraded themselves. Currently, the civil service posts are established centrally, with significant guidance from the Department of Human Resources (DoHR) of the central government. The DoHR receives many requests from all government departments for creation of new posts. It must consider both the short-term and long-term financial implications of creating new posts. In many cases, new posts cannot be created and a health worker who has acquired further training may have to wait until someone leaves a position in the civil service, which he or she can apply for.

3.1.8 Lack of transparency in the recruitment of staff

There was a perceived lack of transparency in the recruitment of health professionals. Health professionals reported that even in some public institutions there were no public advertisements for posts but rather a process of headhunting occurred. A doctor reported: "What you first hear is that there is a vacancy and so and so has been earmarked for such a post. At first, you think it is not true. Let me apply for the post. You are not successful but to your surprise, the candidate whom people said would take the post is the successful one. Now I don't think I can apply for a job there anymore."

Even when the advertisements are placed, there is still an expectation that an individual has been earmarked for the post. This suspicion was reported as often proven correct with the identified individual being recruited. Among the reasons given for the absence of public advertisements by the employing institutions was the lack of money for adverts and the reasoning that "even if you advertise, people will still not apply for the post."

Whatever the reasons behind such a practice, some health professionals indicated that such practices are demotivating. Many just remain in the public service in order to gain work experience before moving on (Ferrinho et al, 1998).

3.1.9 Discriminatory remuneration

Respondents were frustrated with receiving much lower remuneration packages than expatriate technical support staff who, in some cases, may have the same or even a lesser qualifications and experience. Respondents noted that they could understand "reasonable" differences in remuneration between national and expatriate staff "up to a degree but not to a level where one is tempted to think that nationality matters".

3.2 Survival strategies for health workers

Health workers have adopted various strategies, ranging from legal to unethical and criminal behaviours, in order to survive poor conditions and low pay. A number of strategies require the health worker to take on additional responsibilities either in or outside the health sector, while others require varying degrees of personal denial. Several of these coping strategies occur as a result of inefficiencies within the health system while some are only possible because of poor governance. The survival strategies have two purposes:

- increasing income; and
- minimising expenditure.

3.2.1 Increasing income

Health workers may increase their income in the following twelve ways:

- working closer to home villages;
- stealing drugs;
- undergoing short-term and long-term training;
- receiving allowances/per diems from meetings;
- doing locum/part-time duties;
- changing their workstations;
- doing over-time work at a public health facility;
- treating private patients during official work hours;
- receiving double salaries and supplementation;
- receiving consultancy duties;
- providing services to their places of work; and
- becoming involved in small- to medium-sized businesses.

Working closer to home villages

Many Malawians working in the formal employment sector are also involved in farming. Some health professionals, even when they do not work in their home districts, choose to work in a district close to their home village, providing the opportunity to farm in their home districts should they wish to do so. Farming was identified as one way for health professionals to earn extra money through the sale of farm produce, to reduce expenditure on food, and to support relatives who may provide labour on the farms.

Stealing drugs

Significant quantities of drugs supplied to the public health sector end up being pilfered and sold. While unknown robbers are among the culprits, some health workers are reported to be involved in stealing drugs and selling them to drug vendors or private clinics (Yiwombe et al, 2004). Some pharmacy assistants and technicians in particular are reported to be heavily involved. This practice has been reported in many other African countries (Ferrinho et al, 2004).

To cut down on theft, the government started labelling drug tablets with the letters 'MG'. However, this has not had the required effect, and drug thefts continue to be discharged at the courts "for lack of sufficient evidence" even when culprits have been caught with tablets with 'MG' labels. An administrator in the MoH said: "Much of the drugs are stolen by pharmacy personnel themselves. This is a fact. Now, even when you catch someone red-handed, it does not get very far. The culprit gets bail the next day and you can never win a case like that. Even

the judges and the lawyers say the 'MG' on the tablet could mean Margaret Gama. This is absurd."

Another administrator was rather sympathetic: "It ought to be known that if you cheat when paying someone, she will also cheat you when she can. The pharmacy staff are stealing medicines, the administrators are running from one workshop to the other while some don't report for duty. Pay them well and these evils will reduce."

Short-term and long-term training

Health professionals who enrol in either short- or long-term sponsored training programs have the opportunity to enhance their financial situation. These training programmes come with reasonable living allowances that enable the employee and their family to live comfortably and may contribute to the acquisition of household property and/or fixed assets.

A lack of promotional opportunities for enrolled nurses has resulted in some of them training as psychiatric nurses or as anaesthetic clinical officers. An enrolled nurse who trains as a psychiatric nurse is promoted from her TA grade to a TO (diploma grade) level. However, many trained psychiatric nurses are no longer providing specialist psychiatric care but rather are employed in units or hospital departments providing routine care where there may not be as much need for specialist psychiatric training. In contrast, many medical assistants who have benefited from training in orthopaedics and anaesthesia contribute significantly in the provision of specialist services (Fenton et al, 2003). The bulk of anaesthetic services in Malawi are provided by anaesthetic clinical officers who have upgraded from being medical assistants.

Allowances/per diems from meetings

Another source of extra-salary income for health professionals is per diems and reimbursements (for real and potential expenses incurred or expected to be incurred) for attending workshops, seminars and conferences. Some meetings provide 'reasonable' per diems, which more than cover the expenses incurred, enabling health professional to have extra cash to take home. Even when the per diems are not as lucrative, savings can be made by, for instance, having a heavy breakfast or lunch if these are already included in the conference package and only having to pay for a lighter meal later.

Health professionals also make money from attendance to meetings through reimbursements for approved expenses. For example senior cadres may use their own or MoH vehicles and get fuel reimbursements. When using their own vehicles, health workers may deliberately over-estimate fuel costs. When using an institutional vehicle and institutional fuel, they may collect the reimbursement on behalf of the institution, but may not reimburse the institution. One reason given for such failure to take back the reimbursement is that there is currently no mechanism that would allow money to be deposited back into government accounts (for public service employees). The other reason given was that "everyone knows about this," and if you try to enforce reimbursements to the institution, "you are unlikely to get any support from anyone."

The possibility of getting extra money from attending meetings is perceived to be the reason why some senior cadres are continually travelling from one meeting to another, even when the agenda would have been more applicable to another health professional. This results in a perception among the junior cadres that they are only sent to the less lucrative meeting while their seniors are monopolising attendance of out-of-station, better-paying meetings.

Workers in senior management either at MoH or district level may also 'leapfrog' from one workshop to the other, even when the meetings are running concurrently. According to one health professional, "What you have to do is just be available for some time, register for the workshop and move on to the next workshop that you have been invited to. In so doing, you are assured of the allowances."

It was also reported that when workshops are being conducted at the local institution, the senior management are all implicitly invited to attend to give their "blessing" to such a meeting. One clinical officer indicated: "The DHO is the overall in-charge of the district. Although he may not be physically at the workshop, he is spiritually with you and so he deserves the allowances."

The instances discussed above have potential to augment the health workers' salaries.

Locum/part-time duties

Locum and part-time work for health professionals is one other way of making extra money. Ferrinho et al (2004a) have described the practice of working in both the public and private health sector as "dual practice". Professional qualifications and the particular needs of the clinic or hospital influence the cadre of staff employed for part-time duties. Large private hospitals may hire anaesthetic clinical officers and radiographers but do not hire clinical officers or medical assistants in favour of doctors. Nurses are likely to be hired by smaller private clinics for part-time duties. Institutions normally serviced by doctors also hire locum doctors, some of whom are still doing their internships, contrary to Medical Council of Malawi (MCM) regulations. Although the MCM requires that health professionals should have clearance from their main employer for locum practice and an individual private practice license, many do not get the necessary employer's authorisation, nor do they have the MCM private practice licence. The lack of awareness of such requirements and the high cost of the license underlie non-compliance.

Some health professionals, especially clinical officers, are proprietors of private clinics where they employ full-time or part-time staff, and also consult themselves after hours. Some have been reprimanded by the MoH Clinical services department, who felt that staff neglected MoH duties in favour of their personal interests at the private clinics. There is also a perception that some of the drugs and pharmaceutical supplies used at these private clinics owned by MoH employees have been pilfered from the public sector. Some health professionals teach part-time at training institutions for para-medics and nurses. They may even double their income this way, as part-time pay may be lucrative.

Change of work station

In order to make extra money some workers request transfer from one type of work environment to another either to facilitate off-duty clinic work or to allow travel to other places during off-duty days. Employment in a unit that only operates during day working hours allows for after-hours part-time work at a private facility. Employment in a district or central hospital in a ward where there are shifts allows for several full days off in a month, which can be used to generate personal income.

Over-time work at public health facility

The shortage of health workers in most of government health facilities necessitates overtime work, often paid for from user-fees. Mzuzu Central Hospital, for example makes provision to

hire its own staff for part-time duties. Over-time creates work opportunities for those who would otherwise have been off-duty. Even though the money may not be substantial, the income from overtime may make up a significant proportion of a worker's income. There are, however, concerns as to the quality of health services that can be delivered by exhausted staff, who are driven just by desire to make more money but may not be fit to work.

Treating private patients during official work hours

Some health professionals who are fully employed in the public health sector treat private patients during work hours either at their private clinics or even within public health facilities. Patients are required to pay for services provided at the public health facility in exchange for being attended to much faster than would have normally been the case. Some health professionals do receive gifts from patients and/or relatives in order to facilitate procurement of services such as blood for transfusion, speedy consultations and clinical reviews.

Double salaries and supplementation

Almost all health professionals are guaranteed employment into the public sector when they graduate from the training institutions in Malawi. In fact, students in the health professionals most often are identified for positions before they receive their final examinations results. The public sector is therefore the natural first employer of potentially all health workers in the country.

From the public sector, health professionals then move to other job positions, including the training institutions, which can be described as quasi-state organisations as they are mostly run with state financial resources. Some health workers do not formally resign from the public sector and may continue to receive public sector salaries despite the fact that they are no longer employed.

A different situation occurs when a health professional is still employed within the public sector but has been transferred to another district. It may take a long time for that person to start receiving their salaries from the new unit. One administrator talked about workers who are still in the public sector but have moved to new workstations: "You do not normally remove a person from the payroll once they have transferred to another station because it takes long for them to start receiving their salaries from their new work station. Now, you do not know when they have started receiving at their new site. Many people continue receiving salaries from their previous workstations and I am discovering that some are also receiving salaries at their new station."

There are also reports of workers within health units and training institutions benefiting from a number of salary supplements from donors who are unaware that a worker is already receiving another supplement.

Consultancy duties

Skilled health professionals are able to undertake consultancy research and/or training duties on behalf of the MoH, donor agencies, NGOs and other institutions. This is an important source of income especially for tutors and other faculty members within training institutions. Various compensation rates are in operation and a consultant can earn more for one day's consultancy work than he or she would normally earn for an entire month's work.

Providing services to their places of work

Some health workers are suppliers of goods and services to their places of work. This privilege is mainly the domain of persons in management and administration. Such services include the provision of maintenance services and selling stationary and other consumables to the institution. Some health professionals either own firms or are associated with vendors who are suppliers to the organisation. Some health professionals who may be associated with suppliers get commissions for goods and services provided to the organisation. The existence of pre-qualification for suppliers does not seem to reduce this practice. One administrator said: *"It is mostly the accounts people that are into this. But the district health office administrator can stop this. But you create hatred if you do that."*

Involvement in small- to medium-sized businesses

Hospital environments are suitable sites for small-scale businesses such as selling soft drinks, doughnuts and other groceries. Some health professionals engage in these businesses as a means to earn extra income. Soft drinks might be stored in hospital food refrigerators for the Expanded Programme on Immunisation (EPI) or other hospital refrigerators and sold to patients, visitors and other staff. A nurse reported: "My children sell soft drinks at home when they have knocked off from school. Since my house is close by, I can also keep an eye on what is going on there."

Health professionals also reported engaging in various other types of business not necessarily on health facility grounds. These involved running a minibus service and grocery shops.

3.2.2 Minimising expenditure

Health workers may minimise expenditure by:

- minimising personal expenditure; and
- choosing to work in rural areas.

Minimising personal expenditure

The general perception of health workers was that the cost of living was far beyond the means of their salaries. Strategies for minimising personal costs include:

- walking to work for some part or the whole trip, rather than taking a bus;
- sending children to public schools despite having negative attitudes towards these schools;
- taking packed meals from home to eat at work or missing meals at work altogether; and
- using workplace resources for personal use, such as the use of work phones for personal calls and vehicles for personal errands.

Choosing to work in rural areas

According to the Ministry of Health and Population Health Human Resources Plan 1999 (MoHP, 1999), the majority of the health professionals in Malawi worked in urban areas (see *Table 2* below).

Despite the rural-urban difference, which would suggest that most health workers were in urban areas, some prefer to work in rural areas where the cost of living is perceived to be lower than in urban areas. In rural areas, institutional houses are normally made available to civil servants to rent. The rental charges are much lower than the market value of the houses. This privilege, although much more likely in the MoH, is also available to other government departments. The MoH is only second to the Ministry of Education in having its own accommodation, which it rents to its employees.

Table 2: Urban Vs. Rural Distribution of MoH Personnel (1999)

Category of Staff	Urban	Rural	% Urban
Clinical officer	148	7	95
Registered nurses	259	18	94
Environmental health officer	61	21	71
Psychiatric nurses	64	19	77
Enrolled nurse midwife	1011	407	71
Community enrolled nurse	9	15	24
Medical assistant	126	302	29
Health assistant	46	139	25
Health surveillance assistant	821	2533	24

Source: Malawi National Health Plan 1999-2004: Health Sector Human Resources Plan, 1999.

3.2.3 Perceptions of health professions towards survival practices

There were mixed feelings towards the various survival practices of health professionals in Malawi. These depended on the nature of the survival practice and whether individuals were assessing their own or another person's practice, when attitudes tended to be more negative. There was a general feeling of futility because they felt that there was not much else the health professional could do to earn a livelihood, and that the health system itself was responsible for the creation of an environment in which corrupt practices were possible. However, some health professionals expressed their dislike of practices that involved inflating prices, earning commission on the purchase of hospital consumables, and stealing and selling medicines meant to be supplied free to patients.

One expatriate administrator, commenting on reliance on allowances said: "This is something I have observed here in Malawi and it is sad. But people get low salaries. Those that fund the health sector must also realise that if workers continue to be poorly paid, they (the workers) will find a way to supplement their salaries through various means. In the end it makes sense just to pool the resources for salaries and cheating will reduce."

3.3 Potential strategies to strengthen retention

A combination of nine financial and non-financial measures are proposed, together with a proposed bonding mechanism, supported by advocacy with international bodies including the World Bank and the International Monetary Fund (IMF):

- increasing remuneration;
- using the 'cash budget policy';
- assisting with house ownership;
- providing free anti-retrovirals (ARVs);
- ensuring mandatory public health sector employment;
- providing re-employment after leaving public sector;
- strengthening health professionals' associations;
- using the Health Services Commission; and
- decentralising health services.

3.3.1 Increasing remuneration

One of the reasons most commonly cited for the migration of health professionals from most African countries is poor remuneration. It follows that measures to increase salaries should impact positively on reducing migration and maybe even result in the return of workers who have left the country.

So it is important to understand why most health workers are poorly paid in Malawi and what the constraints to increasing remuneration are:

- A major constraint is that the public sector is often the largest employer and therefore remuneration for health professionals is tied to the pay conditions of the public/civil service.
- A second constraint is fairness. As remuneration is not linked to productivity, issues of equity arise. There are often large variations in workload, which result in health professionals reaping the same pay for vastly different outputs. For instance, many rural health centres in Malawi are not patronised in the afternoon, and some may be closed even though the working day is from 7:30 am to 5:00 pm. Some health workers use this opportunity to take a second job at an alternative private facility.

If increased remuneration is to be implemented where would the money come from, given that the public resource envelope (domestic revenue plus donor aid) cannot support increasing workers salaries in Malawi?

One option is for the country to borrow either domestically or externally, which would imply increasing the budget deficit. At present, that cannot be done without attracting sanctions from the IMF, the World Bank and the bilateral and multilateral donors for Malawi. For example, in order to retain health professionals, Ghana offered salary increases to its health workers and civil servants in 2002. The wage bill as 'agreed to' by the IMF was exceeded. The country was therefore punished by the withdrawal of US\$147 million in loans in the last quarter of 2002 (ActionAid International US et al, 2004).

The other option is debt relief, which would allow funds currently used on debt repayment to be channelled into salaries. Unfortunately, this strategy is also likely to attract sanctions. For example, Zambia qualified for debt reduction under the Highly Indebted Poor Countries Initiative (HIPC) in 2002. The country was expected to follow IMF loan conditions strictly for three years, making it eligible for 50% debt reduction of the \$6.8 billion loan. Among the conditions of the loan was that the wage bill should not be more than 8% of GDP. Within the three-year period of agreement, Zambia introduced a housing allowance for civil servants and the military, hired more teachers and increased wages. Zambia's wage bill reached 9% and the country's economy was deemed 'off-track' by the IMF and debt relief under HIPC was suspended. (ActionAid International US et al, 2004; Dawson, 2004).

3.3.2 The 'cash budget policy'

The Malawi government has in the past few years adopted what is known as the 'cash budget policy'. This policy prohibits spending unless the money is available. Although it is argued by many that the current internal, revenue coupled with external aid, cannot support increased remuneration for health professionals without borrowing, there is one school of thought that believes that Malawi can mobilise the necessary resources. Zimbabwe is cited as an example where significant resources for HIV and AIDS have been raised through taxes, in contrast with many countries that are meeting costs of HIV/AIDS through donor funds. As a result Zimbabwe does not have to deal with donor conditions. Even in Malawi, significant resources

have been mobilised for road construction and maintenance, and drought relief through a fuel levy. Part of this levy could, in theory, be used to supplement health workers salaries. The drawback is obviously the unpopularity of increased taxation. Accountability and transparency of these levies is also questionable.

There are also potential savings to be made from within the health budget itself through increasing the efficient use of financial resources and minimising financial waste that arise from poor financial management, dubious procurement practices and pilferage of drugs and other supplies.

3.3.3 Assistance with house ownership

From the monthly public services salary alone, it is extremely difficult for a health professional to either construct or purchase a house built from 'permanent' materials. House ownership by health professionals can be used as an incentive to promote retention of staff within the public health sector. The challenges with this approach may include the following:

- What happens if health professionals leave the public service before they have fully paid for the house (either in cash or years of service)? Provision can possibly be made to allow the health professional to pay for the house based on market rates or for the government to repossess the house based on market practices.
- What happens if health professionals die? Perhaps eligibility for the house ownership scheme should require that health professionals should have worked for at least five years to ensure that their service is perceived to have contributed significantly to the housing cost.

3.3.4 Provision of free anti-retrovirals (ARVs)

HIV and AIDS are likely to become a significant problem among health workers. Kober and Van Damme (2004) report that Malawi, Mozambique, Swaziland and South Africa are unlikely to be able to successfully scale-up ART with current stocks of HRH. Loewenson and McCoy (2004) have advocated for free ARVs for health workers in Africa to help ensure reasonable numbers of health professionals continue to work in these countries. It is also possible that health professionals are likely to stay in employment if the employer is perceived to be caring by providing free ARVs. The provision of ARVs will not only attract health professionals but should also result in reduced absenteeism, reduced loss due to death and prevent work overload amongst those workers that do remain (Uebel et al, 2004). At the time of the study, it was perceived that provision of free ARVs would provide reasonable incentives for health professionals to remain within the public sector. However, over time, ARVs are available to all citizens of 'first come first served' basis. So free ARVs may not provide enough incentive for workers to remain in the public health sector.

3.3.5 Mandatory public health sector employment

Despite increasing (though still inadequate) output of health professionals by training institutions, the shortage of health professionals in the Malawi public health services sector continues to compromise the delivery of services, both in quantity and quality.

Currently doctors undertake an 18-month mandatory internship within the public health sector by default because only the two public central hospitals (Kamuzu Central and Queen Elizabeth Central Hospital) are recognised by the Medical Council of Malawi as of adequate quality for the internship training of doctors. Given that the majority of medical students in Malawi are not fully fee-paying but are either on government loans or heavily subsidised, there

is need to consider seriously possibility of mandatory public health sector employment for an agreed period of time before health workers are free to choose their own employment.

Bonding arrangements of this nature have attracted criticism on the grounds that they infringe on doctors' rights. However, there cannot be rights without responsibilities, and the privileges of government-subsidised tertiary medical education come with the responsibility to pay back the investment that has been made to the community (Muula et al, 2003). Individuals who do not wish to be employed within the public health sector for the agreed period would have to pay the full market value of their tuition.

In an increasingly globalised world, such arrangements are unlikely to be implementable and those who emigrate can easily pay back the loans, implying that such a policy will not be an effective deterrent against the brain drain. However, such a policy has potential to plough finances back into the health sector, which would have not been the case were the policy not in existence. Still, experience of these type of arrangements in Malawi have demonstrated the pitfalls.

The University of Malawi has provided students from under-privileged families with government loans. Upon graduation however, many of the individuals who had received the loans default on the repayments. One reason for this is the lack of national personal identifications for Malawi, resulting in difficulty in tracing individuals once they graduate. This shortcoming could potentially be overcome with health professionals, by working in collaboration with the regulatory/registration bodies so that registration licences would only be given when an individual has 'demonstrated personal integrity' by paying back their loans.

The government has supported the training of para-medicals and nurse-midwives under the HIPC initiative. These nurses and para-medicals were provided full scholarships on the understanding that they would eventually work in the public sector upon completion of their studies. However, the 'agreement', which in some cases was verbal, has proved difficult to enforce. In one training institution, several months after the trainees had graduated from a three-year course, the MoH was yet to come and collect the signed copies of the agreements from the institution.

One tutor at a health training institution said: "Up to now, three years later, we are waiting for the government to come and collect the forms that the students signed three years ago."

Some health profession trainees had refused to sign and still got the scholarship and some had signed but with no counterpart MoH official who signed.

3.3.6 Re-employment after leaving public sector

While employment in the public sector for newly graduated health professionals is almost guaranteed, health professionals who have left find it extremely hard if and when they choose to rejoin the public sector. They reported that they are "not wanted back". Making re-employment easier could potentially be a strategy for increasing the pool of health workers, However, making re-entry easier might have the unintended consequence of facilitating the departure of some health professionals, as they realise that they can return whenever they choose to.

3.3.7 Strengthening health professionals' associations

There are three main health professionals associations in Malawi: the Medical Association of Malawi (MAM), the Nurses and Midwives Association of Malawi (NMAM) and the Malawi Laboratory Association (MLA). Both the MAM and the NMAM are by law required to be represented in the respective regulatory bodies for the medical and nursing professions. While the NMAM has been relatively active, the Medical Association was hardly active between 1999 and 2004, with only one meeting of members conducted during this period. This was partly due to the election of relatively junior doctors into leadership positions in 1998. Within a few months of their election, many of the young doctors had started to leave for postgraduate training abroad and no replacements were made. By the beginning of 2004, only two out of the nine elected leaders of MAM were still in the country. MAM seemed to have learnt from this experience and, in May 2004, a new leadership was elected.

The formation of these health professions' associations was primarily intended to facilitate professional networking among their members rather than to act as unions involved in bargaining for improved pay and working conditions. This was understandable within the political environment of one-party rule from 1966 to 1994. However, although the political environment in Malawi has since changed, health professionals associations are yet to change significantly to embrace the new opportunities and challenges.

Their reluctance to change has frustrated health professionals. The lack of a leadership on the part of health professionals' associations has been mooted as an underlying factor of the month long general strike at the Queen Elizabeth Central Hospital (QECH), the major tertiary care health facility in Malawi. Even when health workers went on a two-day strike in November 2004 at the Kamuzu Central Hospital (KCH) in the capital Lilongwe, the health associations were not involved (Muula and Phiri, 2004). If there is to be more effective collective wage bargaining and a united voice of health professions, there is clearly a need for associations to redefine and strengthen their roles.

3.3.8 The Health Services Commission

The Health Services Commission (HSC) was established by an Act of Parliament in 2002 in order to improve the working conditions of health professionals. According to the Act, the HSC would be responsible for hiring and firing of health professionals and determining health professionals' conditions in services. Formation of an HSC has also been proposed in Zimbabwe. In November 2004, the government of Zimbabwe gazetted the Health Services Bill, which when passed, would facilitate the establishment of the Health Services Commission. The Bill would mean that health workers would be under the HSC, which would be responsible for deciding on the establishment, posts and grades and also ensure the "best use of available resources in the interest of patients." (Health Reporter, 2004). It was suggested that with the proposed creation of the HSC in Zimbabwe, health workers will be removed from the Public Services Commission (PSC) "as there is a Defence Services Commission and a Police Services Commission which take care of the working conditions of soldiers and police personnel respectively" (Health Reporter, 2004).

In Malawi the following benefits were expected to result from the HSC:

- it would curb the brain drain of health workers to private health providers and/or abroad;
- there would be meaningful setting of establishments; and
- there would be rational posting of health professionals.

The lack of essential human resources within Malawi has been a matter of concern by the MoH for many years. The Ministry faces many challenges in delivering high-quality health services and several issues are outside the direct mandate of it. Prior to the establishment of the Health Services Commission, some believed that it would have been difficult to raise the salaries for health professionals within the ministry without causing wide sector public sector discontent in other ministries. Others disagreed, noting that the lawyers in the Ministry of Justice have since 1999 enjoyed top-up monthly allowances without having other ministries complain about the situation. However, the MoH suggests that the establishment of the HSC is a step in the right direction to improving health workers salaries and privileges.

However, there seems to be some confusion as to the demarcation of roles between the HSC and the MoH. While the HSC is working, the MoH headquarters is also negotiating its own remuneration packages with donors outside the remit of the HSC. Further complications have arisen because, while the HSC was being established, Malawi was also moving along the path of decentralisation of government functions to the local district level. Decentralisation is intended to enable the local assembly to hire and fire, as well as determine the working conditions of its staff, including health professionals. The relationship between the decentralisation process and the functions of the HSC remain unclear.

3.3.9 Decentralising health services

The government of Malawi is promoting decentralisation, designed to devolve administrative authority from the central level to the district assembly level. This process is underpinned by the National Decentralisation Act. Eventually the district assemblies will be the major decision making body in matters of government at district level. The MoH will focus on formulating and enforcing policies, setting standards and regulation and providing international representation.

The public health sector will be particularly affected by decentralisation, as the following activities will be under the mandate of the district assembly:

- the hiring and firing of medical and nursing and support staff within the health sector;
- the management of all health facilities other than tertiary hospitals and those providing medical training;
- the establishment, maintenance and management of services for the collection, removal and treatment of liquid and solid waste;
- public health inspection;
- the provision and management of maternity and child welfare clinics;
- the control of communicable diseases including HIV and AIDS, leprosy and tuberculosis;
- the control of disease vectors and the promotion of public health; and
- the provision of ambulance services.

For the public health sector, decentralisation was planned to be executed in two phases:

- In Phase 1, the district assemblies would assume responsibility for planning, budgeting, financial management and accountability for all health facilities except district hospitals and tertiary referral centres. All health personnel who were under the MoH would move to the local government assembly, which would have responsibility for hiring, firing and enforcing discipline.
- In Phase 2, district hospitals would be transferred to local government assemblies. The MoH central level would only be available for national policy formulation, guidance and advisory purposes.

Although the decentralisation process was expected to have been at an advanced stage by December 2004, this had not occurred. It has inherent problems since, in Phase I, only health

centres within a district were expected to be under the local assembly, while the district hospitals and district health offices (which manage the health centres) would still be under the MoH headquarters. There is potential for confusion here because, within the same district, health centres would be governed by one authority and the people who control the health centres (the DHO) would be governed by another authority.

In the light of decentralisation there appears to be some lack of clarity as to the respective roles the aims of the HSC and the local assembly. While the government aims to devolve the responsibilities of hiring, firing and general personnel issues to the local assembly level, it has at the same time pursued the formation of the HSC, some of whose functions (hiring, firing and setting remuneration packages for health personnel) are at the central level. This raises the question: what exactly does the government want? One response has been that some sections in the MoH are against the decentralisation process in as far as human resources management is concerned.

While local assemblies have been earmarked as responsible for human resources in the health sector, the problem of how to deal with the potential competition that may arise among the districts has not been resolved. For instance, suppose one district had the means to raise finances to enable it pay its workers well, thereby attracting workers from other hospitals. Or suppose one district attracted more health workers than the other and therefore drew health professionals from other districts. These are examples of an internal brain drain. How would they be dealt with in order to ensure equity in the distribution of personnel?

3.4 Perceptions of efforts by the Ministry of Health (MoH)

Policy makers were invited to assess the perceived effectiveness and feasibility of the policies that the MoH had put in place to retain health workers and to train more professionals. It was generally perceived that training more health professionals, although fraught with its own challenges such as a shortage of tutors (because of the same reasons that other health professionals face), lack of adequate teaching and dormitory space and teaching supplies, this was perceived to be an easier solution to the problem. "It is retaining the health professionals that is the challenge," reported an administrator. It was however noted that more students could be trained if the usual practice of accommodating all students changed. "Students need not always be provided dormitory accommodation. This just adds on to the running expense of the training schools but also works as a cap, as more students cannot be recruited until more dormitory space is created."

Providing training to college and university students who do not live in residence is a new phenomenon that various colleges in the UNIMA family has started for 'parallel programs'. These parallel program students must choose whether to obtain education on a non-residential basis rather than relying on the old system and getting none at all.

4. Conclusion and recommendations

Health professionals in Malawi currently struggle to support themselves on their salaries alone. Many work outside their salaried work to supplement their income. While many of the methods are not in conflict with health professionals' codes of ethics, some survival actions such as drug pilferage and consulting private patients during public service hours obviously create tension between the health workers' ethics and the need to survive.

Due consideration to the health sector's most precious resource, namely its health workers need to be accorded. In order to retain and reduce health worker shortages in Malawi, the following fifteen measures should be seriously considered:

- Promote the use of health workers on leave or off-duty, so long as this does not compromise the quality of health services and workers' health as a result of fatigue.
- Facilitate the re-employment of health workers who have left the public system.
- Improve the remuneration package of health workers. Presently, this also implies global lobbying on the IMF and the World Bank to make them accept increases in workers' remuneration. The battle to improve the remuneration of health workers in many African countries is an uphill struggle. Part of the problem is the lack of support from other professionals such as lawyers and teachers, to fight together for improved wages. Some have questioned why governments should improve remuneration for health workers while the rest of the public sector employees are reeling from minimal wages. Or should the whole public sector receive increased wages? There are already substantial resources provided to HRH to service local and international training. In the 1997 financial year for instance, a total of US\$ 4.5 million was provided for various training. This amount, if reallocated to staff salaries would result in about 50% salary increase for health professionals in Malawi's public health sector. Instead the current situation is that most of this money is spent in workshops/seminars, hotel bills, per diems and transport costs. In the end the money is still spent but not cost effectively.
- Improve the general working conditions (such as resourcing the health facilities with supplies/consumables and improving infection prevention programmes) within the health system.
- Institute a mandatory public or national health service for all health workers whose tuition was funded by public finances. This would make sense if the working condition and remuneration packages are improved, otherwise it may be an instrument of 'oppression' to health workers as even under deteriorating conditions, they may not have an option to leave. It may also create a situation where the wealthy may be able to 'buy their freedom' by paying back the student tuition and be able to join highly paying private institutions.
- Introduce rural 'hardship' allowances to encourage health workers to choose rural postings.
- Refuse to provide certificate for work abroad until a suggested mandatory public service or work in the country is fulfilled.
- Provide specialist training
- Strengthen health professionals' associations.
- Encourage the provision of specialist and other training locally to enable health professionals to obtain higher qualifications nationally without spending much of the training time abroad. During their local training, these health professionals will also

contribute to the delivery of health services, instead of providing the same service to a wealthy foreign country (Broadhead and Muula, 2004).

- The Ministry of Health should employ, equip and motivate people who are training in human resources administration, management and planning. This will ensure that HRH issues are dealt with professionally.
- Another area of 'retention' of health professionals worth exploring is the minimisation of deployment of clinical staff to non-clinical, managerial positions. Incidentally however, the current situation is that the number of privileged workers has increase as they move from clinical/bedside positions to managerial positions. Health professionals who are maintained in the clinical arena must be adequately remunerated if they are not to strive for managerial positions.
- Some health workers may leave the sector for fear of being infected with HIV due to poor infection prevention efforts, so there is need to strengthen infection prevention through training, supplying the requisite prevention supplies and supervising to ensure that the measures are being implemented.
- The issue of dual practice is tricky in a sense that it enables health professionals to remain in public services but may also result in their attending to private patients at the expense of public sector patients. The wealthy may therefore continue being served at the expense of the poor. It may be crucial for government to formally recognise that dual practice exists and to explicitly allow public sector health professionals to work privately in designated time.
- There is a need to define the roles of the DHO and the academic and professional qualifications. The question, 'Does the DHO really need to be a medical doctor?' has been asked many times without a solution. If the DHO were not a doctor, this could release the doctor to clinical duties. However, this process needs to be followed cautiously, as the doctors' overall remuneration (allowances and other income) may be tied up with the DHO.

Unfortunately, there can be loopholes and non-preference towards any of these recommendations. Those loopholes need to be recognised and mechanisms to deal with them should be identified.

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Abbreviations

AIDS:	Acquired Immuno-deficiency Syndrome
ARV:	Anti-retroviral
BLM:	Banja La Mtsogolo
CHAM:	Christian Health Association of Malawi
CME:	Continued Medical Education
CO:	Clinical Officer
COM:	College of Medicine
CPD:	Continued Professional Development
DHO:	District Health Officer
EHO:	Environmental Health Officer
EPI:	Expanded Program on Immunization
HIPC:	Highly Indebted Poor Countries Initiative
HIV:	Human Immunodeficiency Virus
HRH:	Human Resources for Health
HSC:	Health Services Commission
IMF:	International Monetary Fund
KCH:	Kamuzu Central Hospital
KCN:	Kamuzu College of Nursing
MA:	Medical Assistant
MAM:	Medical Association of Malawi
MCHS:	Malawi College of Health Sciences
MCM:	Medical Council of Malawi
MG:	Malawi Government
MO:	Medical Officer
MoH:	Ministry of Health
NGO:	Non-Governmental Organisation
NMAM:	Nurses and Midwives Association of Malawi
NMCM:	Nursing and Midwives Council of Malawi
PSC:	Public Services Commission
QECH:	Queen Elizabeth Central Hospital
STI:	Sexually-Transmitted Infection
UNIMA:	University of Malawi

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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