



Helpdesk Research Report

External support for retention allowances

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Question

What are the experiences and approaches of external agencies in relation to support for retention allowances for health and education professionals, including measures for their sustainability or appropriate exit strategies?

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1. Overview

This rapid review looks at available literature on the experiences and approaches of external agencies in relation to support for retention allowances for health and education professionals in countries which risk losing them. Retention allowances can come in the form of separate payments or salary top-ups. Most of the available literature uncovered by this review looks at donor support for retention allowances for health sector workers in Sub-Saharan Africa. The majority of the literature is grey literature published by the donors involved or independent evaluations commissioned by them. There were a number of reviews providing an overview of multiple cases but the majority of the literature focused on individual cases. Experts with experience of multiple programmes have also provided input based on their research and experiences. Very little of the literature focuses specifically on the details of the experiences and approaches of donors in relation to support for retention allowances, and even less on detailing the exit strategies and measures for sustainability. The literature considered in this review was largely gender-blind.

Donors have generally been reluctant to support retention allowances because they feel salaries are a government responsibility and because of concerns over the sustainability of such support. However, in a number of cases, the scale of the crisis has been so great that they have stepped in to provide support. It is generally agreed that this support cannot be ongoing and that measures should be put in place to replace

external financing with additional domestic revenues. However, often this support has had to remain in place longer than originally planned as the government has been unable to take responsibility for the additional costs. Support is often provided by a variety of donors, and may come in the form of budget support for the government. Schemes have tended to focus on financial incentives and allowances, despite evidence indicating that a balanced package of measures is better for retaining staff.

Cases where there has been donor support for retention allowances include:

- **Zimbabwe:** The Global Fund, European Commission, Expanded Support Programme on HIV/AIDS (ESP), the UK Government's Department for International Development (DFID), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and the government provided support to the Harmonised Health Worker Retention Scheme (HHWRS). The five year scheme (2006-2013) provided a tax-free salary top-up to health workers, paid monthly, conditional on attendance at work and dependent on grade and location of work. The Global Fund and the government agreed that the scheme would be phased out by the end of 2013, with the first (25 per cent) reduction in funding in January 2011, and the government increasing health worker salaries at a rate corresponding to the reduction. Despite this exit strategy being agreed, it has not gone to plan and exit plans are being renegotiated. Evaluations recommend extending support, alongside improving the sector, realistic sector financing plans, and combined interventions to support retention which go beyond financial incentives.
- **Malawi:** DFID, the Global Fund and the government provided support to the six year (2004-2010) Emergency Human Resource Programme (EHRP). The scheme enabled the government to offer a 52 per cent salary top-up for public health workers, and included other measures to support human resources for health. Despite provision for it, little was done to create a system that would sustain the top-ups, and evaluations suggested donors would have to continue to support the programmes.
- **Sierra Leone:** DFID and the Global Fund provided support to top-up frontline health workers' salaries and pay remote area allowances for 5 years (2010-2015) in support of the introduction of the 'Free Healthcare Initiative'. Funding for the salary top-ups was allocated as budget support to the Government of Sierra Leone, while the remote area allowances were paid through the Ministry of Health and Sanitation. An agreement was made that the Government would progressively increase its share of the increased cost and until the economic downturn and the Ebola crisis it was on track to absorb the full cost of health workers salaries by 2015. The final project report recommended continuing support.
- **Liberia:** DFID provided funding for an incentive allowance for Ministry of Health workers, organised through the NGO, Merlin. The scheme was only supposed to last for two years (2005-2006) and Merlin worked to prepare the Ministry for the end of the incentive scheme, although little change occurred. Merlin recommended continuing to pay incentive payments in the short-term to allow for more time to prepare the government to support the incentive payments themselves.
- **Zambia:** The Netherlands embassy, and later basket funding, supported a pilot retention scheme for doctors. An evaluation suggested that stakeholder participation and a balance of financial and non-financial incentives was important for its sustainability.

2. Donor support for health/education sector workers' retention allowances (including salary top-ups)

Staffing and retention are often problems for health and education sectors in developing countries. However, donors have been reluctant to address this issue comprehensively 'given social and political sensitivities, and concerns regarding sustainability of interventions and risks of rising donor dependency' (Holley, 2011, p. 4). However, as a result of the scale of the crisis, donors have stepped in some cases to support governments to pay or top-up salaries, or provide other benefits such as housing to health and education sector workers in order to retain them (Holley, 2011). However, 'any external financing must eventually be replaced by additional domestic revenues or by reallocating expenditures from other sectors' in order to be sustainable, and governments should carefully consider commitments they make to their populations on the basis of temporary external financing (Holley, 2011, p. 6). Donors need to work together to coordinate their support (Holley, 2011, p. 6). A review of incentives for health worker retention in east and southern Africa found that 'sector-wide approaches and budget support for health worker financing lend stability and sustainability to the financing of health worker incentives and are preferable to localised project initiatives' (Dambisya, 2007, p. 48).

Effective methods of donor support for salaries of health staff

A 2011 rapid literature review looked at the most effective methods of donor support for salaries of health staff in government clinics (Holley, 2011). Donors may provide support through support to government budgets, which some experts argue is the most effective method under some conditions (Holley, 2011, p. 1). However, there is a risk that with donor support for salaries, governments may reduce their support to the health sector and divert it elsewhere (Holley, 2011, p. 1). There was also support for donors not paying salaries, as a result of their uncertain funding flows for a permanent expenditure like salaries (Holley, 2011, p. 1). However, this may be countered by supporting organisations which have been promised sustained funding, such as the Global Fund for AIDS, Tuberculosis and Malaria, to ensure consistency (Holley, 2011, p. 1). Donors may also support salaries through NGOs, although this could risk creating 'islands of excellence' and may lead to the privatisation of health services (Holley, 2011, p. 2).

Incentive environments for health staff in post-conflict contexts

Research by the ReBUILD Consortium looking at health system reconstruction in post-conflict contexts found that in 'post-conflict contexts, there is often a proliferation of actors, which in turn tends to encourage a proliferation of incentive schemes for health staff' (Expert comment). These can be hard to defragment and are not easy to remove (Expert comment). Schemes tended to focus on financial incentives and allowances, despite evidence indicating that a balanced package of measures is better for retaining health staff (Expert comment). Human resources for health policies are 'often crafted with a high involvement of external expertise, but limited local traction (and therefore weak links with changed practice and resourcing, as well as monitoring)' (Expert comment). 'Implementation of financial incentives is typically weak, with low transparency, irregularity of payments, and weak links to performance' (Expert comment). In all four context studies by ReBUILD, on northern Uganda, Cambodia, Sierra Leone and Zimbabwe, 'there is a continued dependence (directly or indirectly) on external funding to maintain retention schemes' (Expert comment).

Lessons for external actors from the ReBUILD research include: i) the ability of retention allowances to provide a critical short term input to stabilising a health system in crisis; ii) the understanding that even where exit plans have been laid down in advance (as done in Zimbabwe), they may not be respected; iii) willingness to provide financial support to health worker pay and the probable need for allowances to extend over the medium term; iv) support to be framed within a broader approach to staff recruitment, retention and management which utilises a wider range of approaches and allows for localised solutions;

and v) the need for monitoring of implementation and effectiveness to be consistent and be regularly reviewed by government and partners (Expert comment).

Donor support and teacher's salaries in conflict contexts

A 2013 rapid literature review looked at teacher pay and retention in conflict-affected contexts (Lucas and Bolton, 2013). Many international agencies do not pay salaries directly to teachers, considering that to be the exclusive responsibility of government (Lucas and Bolton, 2011, p. 2). Where education programmes are wholly supported by non-state actors, interventions should be coordinated with existing policies and practices and should be sustainable or have an appropriate exit strategy (INEE, 2009, p. 11). NGOs and UN agencies can pay a stipend to teachers while the government creates a payroll system, as long as the level of compensation is agreed with the government in advance (INEE, 2006, p. 14). The government should also demonstrate a clear commitment to hire and pay teachers when the NGO or UN programme ends (INEE, 2006, p. 14). An inter-agency roundtable discussion event concluded that 'governments tend to become 'disempowered' and lose the incentive to support education if they get a sense that someone else will foot the bill. Neither the UN nor NGOs should be the primary source of funding for teachers for an extended period of time' (INEE, 2006, p. 16). Instead, they often provide other forms of assistance such as supplies, training, and pay cash incentives for participation (Lucas and Bolton, 2013, p. 2). Communities may also be active partners in supporting teachers through school fees or in-kind support (Lucas and Bolton, 2013, p. 2).

General challenges for effective exit and sustainability

An expert in human resources for health outlined a number of general challenges for effective exit and sustainability of externally funded retention schemes. These include: i) limited fiscal space/financing for health sector and health workforce expansion; ii) the withdrawal of human resources management systems funding at the same time as funding for retention allowances; iii) human resources management systems lacking capacity to retain health workers, even when sufficient funding is available; iv) health workers coming to see allowances as an entitlement, especially when not linked to performance or job role and responsibilities; v) weak governance, leadership capacity, high turnover of managers, and loss of institutional memory; vi) lack of community engagement in design and implementation of retention schemes; vii) allowances not integrated into the payroll system; and viii) lack of a M&E framework with milestones and targets to monitor impact of retention scheme and track progress towards an exit strategy (Expert comment).

3. Case studies

While donors and other external agencies have tended to be reluctant to support retention allowances due to concerns over sustainability, there are a number of cases where this has occurred in the health sector, including in Zimbabwe, Malawi, Sierra Leone, Liberia, and Zambia.

Zimbabwe

Following an emergency response in 2008 as a result of the cholera outbreak, the Harmonised Health Worker Retention Scheme (HHWRS) was set up in 2009 by the government and the Global Fund¹, European Commission, Expanded Support Programme on HIV/AIDS (ESP), DFID, UNICEF, WHO and UNFPA (Dieleman et al, 2012, p. 2; Gordon et al, 2011, p. 29). Administrative costs were kept as low as possible by donors pooling funding, although one evaluation questioned the value for money of some of the implementers (Gordon et al, 2011, p. 29; Dieleman et al, 2012, p. 24). The total funding until August 2011 was USD 70m

¹ for AIDS, Tuberculosis and Malaria – hereafter referred to as the Global Fund

(Global Fund: 65 per cent, DFID: 19 per cent, others: 16 per cent) (Dieleman et al, 2012, p. 2). An evaluation of DFID support to Zimbabwe found that its support for the retention scheme helped avoid the total collapse of the health system during the crisis years of 2007-2009 (ICAI, 2011, p. 1).

The scheme provided a tax-free salary top-up to health workers, paid monthly, and was conditional on attendance at work (Dieleman et al, 2012, p. 2). It was also dependent on grade and location of work (Dieleman et al, 2012, p. 2). At the end of 2011, donors were funding 40 per cent of the health sector wage bill (ICAI, 2011, p. 18). The scheme has been modified over time (for example, lower grade cadres and city council health workers no longer receive the top-up) (Dieleman et al, 2012, p. 2, 15; Gordon et al, 2011, p. 29). Initially it was administered by Crown Agents and since 2011 it has been administered by the Health Service Board (Dieleman et al, 2012, p. 2). Delays in funding meant that health workers did not get their monthly top-ups on time on at least 23 occasions (Dieleman et al, 2012, p. 3, 32). The Global Fund's funds were not adequate to cover all the top-ups because health worker numbers increased (Dieleman et al, 2012, p. 4).

The Global Fund and the Government agreed that the five year scheme would be phased out by the end of 2013, with the first (25 per cent) reduction in funding in January 2011 (Dieleman et al, 2012, p. 2, 34). When the retention scheme began, the Government and donors agreed that health worker salaries would increase at a rate corresponding to the reduction in the retention allowance (Chirwa et al, 2014, p. 36). However, it was clear in 2012 that 'this will not be achieved without significant additional funding' (Dieleman et al, 2012, p. 4, 15). This is despite the fact that the first reduction in January 2011 was met by the government (Dieleman et al, 2012, p. 4, 15). Concerns have been voiced in relation to donor dependency and the sustainability of the programme, especially as reducing this dependency 'will depend on politically sensitive and very challenging wider public sector reform' (ICAI, 2011, p. 18). Despite this exit strategy of gradual handover to the government being agreed, it has not gone to plan and exit plans are being renegotiated (Expert comment).

A literature review found that as a result of retention policies not being funded well, the long term effects were negative despite initial increases in motivation levels which indicate that incentives can work to retain skilled health workers if they are professionally managed (Chirwa et al, 2014, p. 9, 10). Several studies and assessments have 'concluded that the short term retention scheme has begun to elicit negative reactions between the health workers receiving it and those not receiving it' (Chirwa et al, 2014, p. 36; Dieleman et al, 2012, p. 23, 34). In addition, those receiving it were disillusioned and demotivated by the 'phased reduction of the retention allowance and the impending total cessation' (Chirwa et al, 2014, p. 36; Dieleman et al, 2012, p. 23, 34).

The 'phased withdrawal of the emergency retention scheme has begun to revive the brain drain' and the Ministry of Health and Child Welfare needs to secure replacement funding quickly before the attrition gains momentum (Chirwa et al, 2014, p. 10). An evaluation of the scheme for DFID recommended that the HHWRS should be extended by two (or preferably three) years as the phased reduction was happening too soon (Dieleman et al, 2012, p. 5). However, the extension of the HHWRS should be on the basis of measures to improve the sector and embedded in realistic sector financing plans (Dieleman et al, 2012, p. 5, 38). Future retention schemes are recommended to cover more than the payment of financial incentives, which have been found to be less successful than combined interventions (Dieleman et al, 2012, p. 40). A survey found that options which workers felt would motivate them to stay on the job, include: i) loans for housing and cars; ii) competitive salary; iii) hardship allowance for workers working in a particularly challenging environment; iv) improved communication and infrastructure with utilities; and v) attending workshops (capacity building) (Dieleman et al, 2012, p. 40). In addition, they mentioned free medical services for health workers and their families; contributions towards educational assistance for children; recreational

activities; supplementary food hampers (containing basic commodities such as sugar, salt and cooking oil); meals for staff during working hours; and an increase in uniform allowances (Dieleman et al, 2012, p. 41). Challenging working environments and increasing workloads also need to be addressed (Gordon et al, 2011, p. 31).

Malawi

Malawi has had a variety of different externally supported retention schemes. Various donor agencies, including the Interchurch Organisation for Development Cooperation (ICCO), German Technical Cooperation (GTZ) and Norwegian Church Aid (NCA), provided support for a Ministry of Health and Christian Health Association of Malawi (CHAM) incentive scheme in 2001 for the retention of nurse tutors (Dambisya, 2007, p. 17). The scheme included salary top-ups, and a bonding arrangement where they would work for two years in the training institutions in return for fully paid tuition for further studies (Dambisya, 2007, p. 17). A district level approach involved local government in the Thyolo District and Medicines Sans Frontier (MSF) and employed a mix of financial and non-financial incentives (Dambisya, 2007, p. 19). All district staff were eligible for a monthly performance-linked monetary incentive, ranging from USD 13 to USD 25 (Dambisya, 2007, p. 19).

Launched in 2004, the Emergency Human Resource Programme (EHRP) was a more comprehensive approach which used government funds and donor support, as part of the sector-wide approach (SWAP), to enable the government to offer a 52 per cent salary top-up for public health workers (Dambisya, 2007, p. 18; Palmer, 2006, p. 28). Due to taxation, the income from SWAP top-ups does not represent a true 52 per cent increase in take-home pay but rather ranges from 25 per cent to 41 per cent (MSH/MSC, 2010, p. 54). The incentive payments element of the EHRP cost around USD 34.3 million up to 2009; with major funding from the Government of Malawi, DFID and the Global Fund (MSH/MSC, 2010, p. 3; Palmer, 2006, p. 32).

The EHRP design was based on a situational analysis which drew heavily on a wider range of stakeholders (GHWA, 2007, p. 4). The six year programme started in earnest in April 2005 (Palmer, 2006, p. 32). As well as salary top-ups, the EHRP programme included 'expanding domestic training capacity, using international volunteer doctors and nurse tutors as a stop-gap measure, providing international technical assistance to bolster planning and management capacity and skills, and establishing more robust monitoring and evaluation capacity' (Palmer, 2006, p. 27, 33; MSH/MSC, 2010, p. 10). In addition, attempts were made to improve location-specific incentives to improve the distribution of staffing across the country (Palmer, 2006, p. 33). The accompanying Essential Health Package would impact on workplace satisfaction (Palmer, 2006, p. 33; GHWA, 2007, p. 7).

The programmes were designed to be fully funded by donors as a result of the country's tight macro-economic situation, with some contribution from the government of the resources gained by taxing donor-funded top-ups (Palmer, 2006, p. 33). Six salary top-up scenarios were initially discussed in great detail over a period of months and over twelve further arrangements were also considered (Palmer, 2006, p. 33). The scheme had 'implications for the Government's pension fund and agreements with the International Monetary Fund (IMF), with whom a special agreement was reached' (Palmer, 2006, p. 33). Donors felt that the scale of the crisis and the likelihood that Malawi would continue to receive high levels of aid for the foreseeable future meant they could consider a scheme which would normally be dismissed as unsustainable (Palmer, 2006, p. 33; GHWA, 2007, p. 5). Donors also 'reached an explicit agreement with the government that the proportion of the national budget spent on health would be maintained or increased over the course of the six years' (Palmer, 2006, p. 33). In order to 'persuade the government to undertake the risk of higher levels of expenditure supported by aid, DFID committed to giving two financial

years' notice of the withdrawal of the salary component of its aid' (Palmer, 2006, p. 34). The top-ups were framed within the government's pay policy (Palmer, 2006, p. 34).

Although there was an assumption that an autonomous Health Service Commission (HSC) would 'establish a separate health service with more competitive salaries that would replace the top-ups by 2009' this did not happen (MSH/MSC, 2010, p. 69). Therefore an evaluation carried out in 2010, recommended a strategy should be designed and implemented which would develop a new pay structure for the Ministry of Health that would sustain top-ups (MSH/MSC, 2010, p. 75). The evaluation also found that in terms of sustainability of the programme, development partners seemed likely to support the next programme of work (2011-2016), while government expenditure on health has increased (MSH/MSC, 2010, p. 55). However, concerns were raised that the most recent budget (2009/2010) at the time of the evaluation had reduced its allocation for health (MSH/MSC, 2010, p. 56).

An evaluation of the EHRP programmes found that the gains made are fragile due to 'the lack of a plan for sustainability, weak health systems, population growth and a continuing high burden of disease' (MSH/MSC, 2010, p. 4). A few of the lessons learnt include: i) donor willingness to support the 52 per cent salary top-ups and the Government of Malawi's willingness to allow the different pay scales was a key success factor; ii) planning for sustainability must be considered from the beginning; iii) implementation of short-term emergency interventions and longer-term interventions combine well for success, but short-term measures by themselves will not produce lasting impact; and iv) a comprehensive approach which invests in human resources in the context of a broader programme to improve health service facilities and management systems is needed to prevent retention investments being undermined (MSH/MSC, 2010, p. 5; GHWA, 2007, p. 9).

Sierra Leone

DFID committed £12,000,000 to top-up frontline health workers' salaries in Sierra Leone from 2010 to 2015 to support the introduction of the 'Free Healthcare Initiative' (FHCI) in 2010 (DFID, 2015, p. 2, 4; Witter et al, 2015, p. 5). Funding was allocated as budget support to the Government of Sierra Leone², with payments released based on progress made against agreed milestones that were monitored by a joint donor-government Payroll Steering Committee (PSC) (DFID, 2015, p. 2). Funding was frontloaded based on the assumption that the Government would progressively increase its share of the increased cost (Stevenson et al, 2012, p. 6). Underperformance against some of the milestones, especially relating to auditing, led to £600,000 of the funding not being disbursed (DFID, 2015, p. 2, 5, 21). Funding for the salary uplift was also provided by the Global Fund (Witter et al, 2015, p. 8; Stevenson et al, 2012, p. 6).

Transaction costs were minimised by having the funds dispersed by the Ministry of Finance and Economic Development through the existing payroll system and there have been no reported delays in paying salaries, except in very remote areas without access to banks (DFID, 2015, p. 20). Complementary technical assistance was also provided to enhance management and monitoring of the programme until 2012, after which the Global Fund took over the technical assistance costs until December 2012 (DFID, 2015, p. 2). The Global Fund also started paying remote area allowances to encourage the retention of health workers in rural areas, worth UDS 16.9 million (2013-2015) (DFID, 2015, p. 2, 4). This was paid to an account in the Ministry of Health and Sanitation and was separate but complementary to DFID's support to the salary uplift (DFID, 2015, p. 2). The Global Fund suspended the payments of its funding in June 2014, citing the poor quality of the audit report received from the government on the remote area allowances (DFID, 2015,

² From the inception of the project until June 2012, DFID payments to the government were made via Crown Agents Bank, who then disbursed the funds to the Sierra Leonean government. From June 2012 DFID's financial aid policy changed and payments were made directly to the government from DFID (DFID, 2015, p. 20).

p. 21). The Global Fund and DFID collaborated closely in implementing the tripartite agreement for joint contributions to health workers salaries (DFID, 2015, p. 22; Stevenson et al, 2012, p. 6). An evaluation suggests that this donor coordination contributed to the success of the programme (Witter et al, 2015, p. 8).

The salary uplift is evaluated as having helped to attract and retain health workers in the public health sector (DFID, 2015, p. 2; Witter et al, 2015, p. 5; Stevenson et al, 2012, p. 8). Savings of USD 408,200 were made as a result of payroll cleaning and maintenance that resulted in the removal of 'ghost workers' from the payroll (DFID, 2015, p. 2; Stevenson et al, 2012, p. 7). In order to protect the investment in the salary uplift, the government developed a Conduct and Sanctions Framework in 2010 (DFID, 2015, p. 4; Witter et al, 2015, p. 5). This 'introduced an official HR management mechanism to reduce the high rate of staff absence, and sanction poor health worker performance to increase the efficient and effective implementation of the FHCI' (DFID, 2015, p. 4). The late payment of the remote area allowances due to poor administrative capacity in the Ministry of Health and Sanitation has demotivated staff, despite DFID's support to the salary uplift (DFID, 2015, p. 12).

There are serious concerns about whether the government can afford and sustain the public sector payroll, especially in light of the economic downturn and the Ebola crisis (DFID, 2015, p. 12, 20, 24). Prior to this, a 2012 evaluation found that the government was on track to absorb the full cost of health workers salaries by 2015 (DFID, 2015, p. 24; Stevenson et al, 2012, p. 8). The final DFID report on the programme recommends donors consider 'continued support to health workers salaries and human resource management system at the central and district level to safeguard the gains made through this project' (DFID, 2015, p. 3, 14). DFID providing budget support to the government 'was a good initiative with regards to strengthening the systems and contributing towards sustainability in the long run' (DFID, 2015, p. 13).

Liberia

DFID provided funding for an incentive allowance for Ministry of Health workers in Liberia, organised through the NGO, Merlin (Holley, 2011, p. 12). At the time of planning in 2005, Merlin agreed with DFID that incentive payments for Ministry of Health staff would not continue beyond December 2006 in order to decrease dependence on external support and increase government ownership and responsibility (Holley, 2011, p. 14). DFID and Merlin agreed that both donors and INGOs would need to inform and advocate heavily for the shift to government funding (Holley, 2011, p. 14). Merlin tried to prepare the Ministry for the end of the incentive scheme, and:

- 'Established a memorandum of understanding with the Maryland County Health Team outlining the incentive policy and the removal of incentive support at the end of 2006.
- Discussed in recent County Health Team meetings about the planned withdrawal in December 2006.
- Discussed at the Liberia health sector inter-agency meeting Merlin's plan for phasing out of incentives and the importance of other NGOs assisting in advocacy with the Ministry of Health for putting staff on government payroll.
- Held discussions with the Minister of Health and the deputy ministers regarding the issue of incentives, donor's reluctance to continue paying allowances, and the need for increased financing for facility staff.
- Brought the issue to the table at USAID, OFDA, and ECHO partner meetings held in country and with Irish and Netherlands donor representatives.'

The report looking at this case suggests that the implications of early incentive withdrawal included ‘loss of existing qualified staff, increased fees at point of service, and overall reduction in quality and accessibility to services that will negatively impact on morbidity and mortality within the population’ (Holley, 2011, p. 12, 14). The Liberian government did not have enough public funding to pay salaries for 2007 and economic prospects did not look promising (Holley, 2011, p. 12, 14). Despite Merlin taking ‘numerous actions to prepare the Ministry for the planned incentive withdrawal in Maryland County at central and decentralised levels’, little change occurred (Holley, 2011, p. 12). As a result, and in order to prevent an immediate health and human resource crisis, Merlin recommended continuing to pay incentive payments in the short-term, which could be gradually reduced in 2008, in order to allow for sufficient time for donors and partners to liaise with the government about how they can support the incentive payments themselves (Holley, 2011, p. 12-13). In addition, Merlin recommended that other NGOs and donors advocate for the central budget to provide for salaries (Holley, 2011, p. 13).

Zambia

A pilot retention scheme for doctors was started in 2003 to encourage doctors to work in rural areas; initially financed by the Netherlands embassy, the programme later became part of basket funding (Dieleman and Harnmeijer, 2006, p. 39). The scheme costs an average of USD 652 to USD 717 per month per doctor (Dieleman and Harnmeijer, 2006, p. 39). There were no assessments of performance and management procedures for implementing the scheme were considered time-consuming (Dieleman and Harnmeijer, 2006, p. 39).

Experience with the scheme emphasised the ‘importance of stakeholder participation in the design and development of the sustainable scheme as well as an effective and efficient remuneration system’, alongside a balance between financial and non-financial incentives (Gordon et al, 2011, p. 50). The success of the scheme ‘led to expansion of the scheme to other cadres including nurses, clinical officers and nurse tutors and funding from EU, DFID, SIDA, USAID and CIDA’ (Expert comment).

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