Upscaling the recruitment and retention of human resources for health at primary healthcare centres in Lebanon: a qualitative study

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Accepted for publication 29 December 2014

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What is known about this topic
• Adequate supply of a qualified human resource for health (HRH) has been highly correlated with better community health outcomes.
• The sustainability of primary healthcare (PHC) services has been challenged by a global shortage in HRH, exacerbated in developing countries.

What this paper adds
• Interviewing community stakeholders is essential for assessing the uniformity of provided PHC services, identifying the existing HRH recruitment and retention strategies, and the means to optimise them.
• Targeted HRH recruitment and retention strategies for nurses, female care providers, and rural and semi-urban settings are necessary to ensure equitable access to quality PHC services.
• The recruitment and retention of HRH specialised in community mental and geriatric care services is essential to support the success of such programmes.

Abstract
The sustainability of primary healthcare (PHC) worldwide has been challenged by a global shortage in human resources for health (HRH). This study is a unique attempt at systematically soliciting and synthesising the voice of PHC and community stakeholders on the HRH recruitment and retention strategies at the PHC sector in Lebanon, the obstacles and challenges hindering their optimisation and the recommendations to overcome such obstacles. A qualitative design was utilised, involving 22 semi-structured interviews with PHC experts in Lebanon conducted in 2013. Nvivo qualitative data analysis software was employed for the thematic analysis of data collected from interviews. Five comprehensive themes emerged: understanding PHC scope, HRH recruitment issues, HRH retention challenges, rural areas’ specific challenges and stakeholders’ recommendations. Analysis of stakeholders’ responses revealed a lack of a unified understanding of the PHC scope impacting the capacity for appropriate HRH planning. Identified impediments to recruitment included the suboptimal supply of HRH, financial constraints and poor management. Retention difficulties were attributed to poor working environments, financial constraints and lack of professional development. There was consensus that HRH challenges faced were aggravated in rural areas, jeopardising the equitable access to PHC services of quality. Equitable access was also jeopardised by the reported shortage of female HRH in a sociocultural context where many females prefer providers of the same gender. The study sets the path towards upscaling recruitment and retention policies and practices through the endorsement of a nationally acknowledged PHC definition and scope, the sustainable development of the PHC workforce and through the implementation of targeted recruitment and retention strategies addressing rural settings and gender equity. Decision-makers and planners are urged to identify HRH as the most important input for the success of PHC programmes and interventions, especially in the growing fields of mental health and geriatric care.

Keywords: community healthcare, human resources for health, Lebanon, primary healthcare, recruitment, retention

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Introduction

The importance of primary healthcare (PHC) in the delivery of efficient, effective and safe services to the community is well documented (Starfield 1994, Shi et al. 2002, Starfield & Shi 2002, Starfield et al. 2005, Saltman et al. 2006, Carey et al. 2013). The presence of an adequate number of well educated and experienced human resources for health (HRH), including physicians, nurses as well as other health professionals, is a prerequisite for the delivery of comprehensive care to individuals and communities and is highly correlated with better health outcomes, including lower mortality (Shi 1992, 1994, Shi et al. 2003, Kringos et al. 2010). Moreover, a balanced gender distribution among specialties in PHC is of utmost importance to support equitable and continuous access to efficient PHC services (Wilson & Childs 2002). Such a consideration is particularly relevant in countries in which sociocultural and religious beliefs dictate care provision by a provider of the same gender (Rizk et al. 2005).

Today, however, the sustainability of PHC and community services has been challenged by a global shortage in HRH, exacerbated in low-to-middle-income countries (Lehmann et al. 2008). Several factors have been associated with this shortage, including poor HRH supply, high turnover rate, insufficient training, poor working conditions, vague/restricted scope of practice, and poor/suboptimal infrastructures, particularly in remote and rural areas (Keenan 2003, McGuire et al. 2003, Lehmann et al. 2008).

PHC context in Lebanon

Lebanon is a small country located along the Eastern Mediterranean coast that has experienced multiple wars and civil unrests over the last three decades. These have eventually eroded public healthcare services provision, and have led to the establishment of a strong private sector that dominates the delivery of services across all sectors of care (Kronfol 2006).

In Lebanon, community care mainly includes PHC services, which are the most developed and dispersed geographically. Other community care services remain underdeveloped. Lebanon has more than 800 primary healthcare centres (PHCC) (WHO 2010). Non-governmental organisations (NGOs) have the lion’s share of PHCC as they owned and managed approximately two-thirds of centres within the national network in 2012 accounts (Ministry of Public Health 2012). In an attempt to increase accessibility to PHC and community services, the Ministry of Public Health (MOPH) has been contracting with centres satisfying pre-identified community care delivery standards, thus creating and expanding Lebanon’s official PHC network. In 2013, the number of PHCC within this network reached 183, distributed across Lebanon’s six governorates (Ministry of Public Health 2013). According to the Lebanese MOPH, healthcare provided at these centres entails community-based services oriented towards promotion and prevention. Such services comprise general medical care including paediatrics, cardiology, reproductive and oral health. It further includes immunisation services, health and nutrition education and drug provision (Ammar 2009). There is no established referral system associated with PHC; access to secondary and tertiary care may take place without passing through the PHC level (WHO 2006).

Despite the above efforts at enhancing the status and delivery of PHC, the sector still suffers from a number of challenges, including inadequate resources (Steir 2007), shortage of generalists and overspecialisation among physicians (70% are specialists) (El-Jardali et al. 2012), and a shortage of nurses (El-Jardali et al. 2009). One main contributor to HRH shortages in Lebanon is the growing migration of Lebanese healthcare providers to rich neighbouring Gulf countries (El-Jardali et al. 2012) or to Europe and North America (Aki et al. 2008).

According to the MOPH, there are 2778 physicians working at PHCC that are within the national network. A total of 2394 are physicians with specialities, out of which only three are from Family Medicine (FM); the remaining 384 are general practitioners (GPs). Additionally, there are 482 nurses, 34 midwives and 511 support personnel (including pharmacists, laboratory and radiology technicians, dietitians and social workers) employed at these PHCC (Ministry of Public Health 2013). One key contributor to the low level of employment of family physicians in PHCC relates to the organisation of practice of medicine in Lebanon. In fact, according to the law of ‘Regulating the Practice of Medicine’ that dates back to 17 January 1979, in order to be licensed to practice, physicians should hold a medical degree and pass an oral test of medical knowledge and competence referred to as the ‘national medical colloquium exam’ (Lebanese Parliament 1979). Therefore, specialisation is not a prerequisite for practising medicine. This law was still applicable at the time of write up of this manuscript.

Considering the above HRH shortages and imbalances, it is critical for the country to adopt and implement optimal recruitment and retention strategies as an effective overarching approach to improving PHC
and augmenting its associated financial and health benefits to individuals and communities. Lebanon could learn from the experience of other countries with appropriate configuration of incentives that would enhance retention (Willis-Shattuck et al. 2008, Buykx et al. 2010, Katzenellenbogen et al. 2013). Any retention initiative needs to consider the effects of financial compensation, working environment, performance-based reward system and organisational support (Buykx et al. 2010). Any retention initiative needs to consider the effects of financial compensation, working environment, performance-based reward system and organisational support (Buykx et al. 2010).

Objectives
The study systematically solicited and synthesised the voice of PHC and community stakeholders on the HRH recruitment and retention strategies and practices in Lebanon, as well as the obstacles and challenges hindering their optimisation and the means to overcome them.

Methods
Study design
The study utilised a qualitative design in which a series of semi-structured interviews were carried out with stakeholders in the PHC sector. The use of key informant interviews is deemed to be effective in yielding a comprehensive picture of the HRH reality in the PHC sector, along with the challenges encountered and existing opportunities to enhance recruitment and retention. A multitude of inputs and perspectives can be provided via this approach that would not be deciphered otherwise (Klassen & Le-Blanc 1993, Polkinghorne 2005).

Selection of interviewees
A list of key stakeholders in the PHC sector was compiled from a review of public information sources. The list was thoroughly validated to ensure both its comprehensiveness and accuracy. Interviewee selection criteria ensured maximum variability across institutions, disciplines and geographical locations (i.e. across the six governorates of Lebanon). It also allowed for maximum variability with respect to organisational and workplace characteristics, including public versus private affiliation, urban versus semi-urban/rural settings, and individual background, including academicians, policy makers and managers, among others. Moreover, in order to ensure that the invited stakeholders’ responses were reflective of the current recruitment and retention policies and contexts of their respective PHCC, inclusion criteria entailed holding of the current position for a minimum of 12 months.

Interview schedule
The instrument used was a one-page semi-structured interview schedule composed of open-ended questions, which covered community stakeholders’ perception of PHC and the way it reflects on HRH needs (three questions), current status of recruitment, challenges and recommendations (three questions) and the status quo in regard to the retention of HRH, along with identified challenges and suggested recommendations (three questions). Additional questions solicited stakeholders’ feedback in regard to HRH challenges in rural/semi-urban settings, as well as overall recommendations and identification of additional stakeholders who should be invited to participate in the study.

Data collection
A number of key informants were initially selected from the compiled list of stakeholders within or related to the PHC sector. This was followed by snowball sampling, in which interviewees were asked to identify other stakeholders who could contribute to the study. This technique was used to engage with ‘hard to reach’ research subjects, as was deemed useful in other studies (Atkinson & Flint 2001).

Stakeholders were invited to participate and were briefed on the objectives of the study via an email message or a phone call. One week after the initial invitation, invitees were re-contacted via a follow-up phone call. A final phone reminder was made 15 days after receipt of the initial invitation. Invitees were considered non-respondents if consent to participate was not provided within 1 week of the final reminder. The interviewing process continued until the ‘saturation’ point was reached, when further information did not alter the results already attained and the names of additional stakeholders suggested by interviewees were being repeated (Strauss & Corbin 1998). The time period for the interviews extended from May till August 2013. Overall, 22 out of a total of 25 invited key informants accepted to participate in the study (response rate of 88.0%). The three key informants who did not accept to participate apologised due to their busy work schedules. Participants included policy and decision-makers in the PHC/community sector (PM), PHCC directors (PD), human resource managers in PHCC (HM),
professionals/physicians (PP), academicians in the PHC field (PA) and co-ordinators of NGOs (NC) (Figure 1). Note that close to half of the interviewees were PD with extensive experience. Out of these 14 PD, seven were practising physicians (six are generalists and one is a specialist), and one of the directors had a background in nursing. In addition, one of the interviewed academicians is a practising nurse. Therefore, the representation of physicians and nurses among the interviewees serves to add an HRH grassroots perspective to the overall findings of the study. Moreover, there was a fair representation of both genders among the interviewees (14 females and eight males).

The study proposal conformed to the guidelines of the Institutional Review Board (IRB) at the American University of Beirut. The study and all associated tools were reviewed and approved by the IRB office (protocol number FHS.MA.05).

Prior to the initiation of the interview, interviewees were asked to sign the consent form which described the nature and objectives of the research study and detailed information on their rights as participants. Additional approval was required for digital recording of interviews. In the case of participants’ refusal of digital recording, the interviewers took written notes of responses. Interviews lasted an average of 30 minutes.

Data analysis

Thematic and content analyses were conducted on the data collected from the interviews to identify main themes (Coffey & Atkinson 1996, Mason 1996). The five-stage ‘framework approach’ was followed for the thematic analysis: familiarisation, identification of thematic framework, indexing of the transcripts, abstraction and synthesis through charting and conceptual mapping and interpretation (Bryman et al. 1993, Pope & Ziebland 2000).

Transcription of the interviews was performed by one member of the research team and cross-checked by a second member. Disagreements were discussed until consensus was reached. The transcription of interviews accounted for any non-verbal language. For example, exclamation or question marks were used when suggested by the tone of voice, capital letters were used for words/phrases that were emphasized and brackets were used to highlight smiles, laughter and moments of silence. Sixteen interviews were conducted in English. For the six interviews conducted in Arabic, responses were transcribed in Arabic by researchers who are native speakers. Abstracted data were then translated into English for data analysis.

Transcribed interviews were thoroughly read for familiarisation and for gaining preliminary insight into the responses of the interviewees. The identification of the thematic framework was defined by the objectives of the research study, review of literature and additional themes of relevance that arose from the data during the familiarisation step. The transcribed interviews were then imported to Nvivo, a qualitative data analysis computer software package, according to the nodes and sub-nodes identified in the developed conceptual map (Bazeley & Jackson 2013). Relevant quotes were selected from the individual transcripts and placed under the appropriate sub-node as supportive data. After indexing the responses into similar concepts, axial coding was used. This process was followed by charting of collected data into categories and relating them to each other according to context and determinants of each category. The synthesised findings then underwent extensive mapping and interpretation in order to better understand the nature of the subject at hand (Pope & Ziebland 2000). All team members reviewed and approved the final themes and sub-themes emanating from the data analysis phase.

Findings

Data analysis of the interviews revealed five major themes and several associated sub-themes (Figure 2) that drew an overall picture on the role and current situation of the PHC sector in Lebanon. The five themes identified were understanding of PHC scope and services, HRH recruitment issues, HRH retention challenges, rural areas’ specific HRH challenges and stakeholders’ recommendations.
Stakeholders’ understanding of PHC scope and services

Under this theme, responses fell under two sub-themes: the lack of unified understanding of PHC scope and services and the absence of some essential services—most notably mental health and geriatric care—due to lack of available HRH.

While a number of stakeholders provided an international definition of PHC, many defined PHC by the workforce employed within this sector. The scope of PHC services was mainly described at the level of the community, as a whole, with no discrimination among segments of the population. While stakeholders did not agree on a unified definition, there was a general consensus among them that the situation of care at the PHC level and associated HRH does not reflect a health promotion and disease prevention-oriented sector, but rather curative care remains dominant with a poor referral system in place. This was clearly stated in the quote below:

We have an advanced, secondary PHC. And sometimes they forget to provide the initial care because it is medically oriented rather than preventive oriented. [NC02]

Stakeholders further reflected on PHC services that they deemed missing, attributing this mainly to shortages of qualified HRH. While five of the interviewed stakeholders elaborated on the lack of availability of geriatric care services, most (12 stakeholders) agreed that mental health is the most commonly missing service to individuals and communities. The quotes below further elaborate on this sub-theme:

It is very important to include mental health into the services that are usually overlooked. We started now to focus seriously on these services and to integrate them into PHC and we are conducting pilot testing for mental health within some PHCC. [PM01]

Due to the shortage of mental health providers, we are trying to fill the gap by training the general practitioners and nurses to detect patients. [PD02]

It is very difficult to find geriatric specialists … we have lots of elderly coming to the centres whose care is not being planned and managed as it should be! [PD03]

HRH recruitment issues

Key informants reported numerous obstacles related to HRH recruitment. The main identified barrier to the recruitment of HRH was the workforce shortage. Several types of shortages were recounted, including insufficient overall supply of HRH, shortage in qualified HRH and HRH gender imbalances. Generally, the professional group associated with the most acute shortage was identified by interviewees as the FM specialists. While some stakeholders attributed this to

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<th>Understanding of PHC scope and services</th>
<th>• Lack of a unified PHC definition and understanding • Missing services, most notably mental health services</th>
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<td>HRH recruitment issues</td>
<td>• Insufficient supply • Poor credentials • Gender imbalances • Financial constraints and poor leadership</td>
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<td>HRH recruitment issues</td>
<td>• Financial pressure • Poor working environment • Poor professional development</td>
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<td>Rural areas' specific challenges</td>
<td>• Severe shortage in quantity and sub-optimal quality • Remoteness and financial constraints</td>
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<td>Stakeholders’ recommendations</td>
<td>• Enhancement of HRH recruitment criteria • Enhancement of HRH retention plans • New Physician Placement Program in rural areas • Awareness media campaigns on importance of PHC • Updated HRH registry to be used during recruitment • Scholarships for nursing and medical students • Required work in rural areas upon graduation • Community care part of medical/nursing curricula</td>
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**Figure 2** Main themes and sub-themes emerging from the thematic analysis of key informant interviews. PHC, primary healthcare; HRH, human resources for health.
a national shortage in family physicians, others felt there were adequate numbers of family physicians, yet low reimbursement rates not only failed to attract them but also resulted in their replacement with GPs. Note that GPs in Lebanon are medical school graduates with no specialisation, i.e. physicians who have not completed a residency programme. Scarcity in the nursing workforce, specifically at the level of community nurses, was also identified as a national challenge in Lebanon that may be detrimental to availability and quality of care. The following quote reflects this point:

The basic element in PHC is the nursing level: well-qualified nurses either work in big institutions because of the compensations or overtime work or travel abroad because Lebanon is still a major exporter of HRH. [PD05]

Additionally, stakeholders within the academic field expressed concern related to the low admission of students into specialties directed towards community care, as stated by one:

We are finding difficulties in directing our graduates towards the PHC sector. [PA02]

Stakeholders also highlighted major difficulties in recruiting mental health professionals, whether psychologists or psychiatrists due to their under-supply. PHCC are compensating for this shortage by training GPs and nurses to screen for psychological cases.

Beyond the availability of such resources, their degree of qualification was also of concern to many stakeholders, who described the performance of HRH in PHC as variable and inadequate. This point is clearly highlighted in the following quote:

PHC centres have no proper financial resources and cannot afford to pay for the best skills and competencies, so they end up recruiting the less qualified with fewer wages. Plus, there are no clear and strict selection or recruitment criteria for physicians. [PP01]

Importantly, stakeholders further declared that there is a gender imbalance in the health providers’ workforce. For example, stakeholders described a shortage in the number of female gynaecologists in certain regions. This is believed to prevent women from seeking care and to have further consequences on women’s well-being.

Fourteen of the 22 interviewed stakeholders listed the presence of one or more of the following recruitment strategies at their centres: financial incentives (salaries and benefits), flexible employment (e.g. allowing for a second job), as well as agreements with universities to recruit graduates from their medical and nursing schools at PHCC. The rest of the interviewees did not report any recruitment strategy in place. With respect to PHCC in remote and rural areas, the most effective strategy reported by stakeholders was recruiting HRH residing in nearby areas.

**HRH retention challenges**

Interestingly, the majority of stakeholders, particularly directors of PHCC, claimed that retention of HRH is acceptable and that centres do not suffer from high turnover rates. Others pointed out that the retention status in their PHCC is poor due to the existence of more attractive job opportunities in other sectors. Thus, the need to reassess the reimbursement policies and offered benefits in order to enhance HRH retention at PHCC was identified by stakeholders.

We should upgrade the salary according to the experience, this would enhance the retention. [PD07]

The benefits and holidays we provide – as much as we can – motivate them to stay and be more productive. [PD01]

Another retention strategy is to provide an annual merit depending on the annual appraisal or evaluation, plus a fixed per cent earned annually. [PD04]

In terms of effective retention strategies, there was a consensus among stakeholders that those shown to retain staff are the provision of professional development opportunities and establishment of supportive work environments. Other retention strategies deemed effective in improving staff retention included establishing a decentralised management approach consisting of a flat hierarchy that fosters partnership and team spirit, and offering flexible work schedules.

**Rural areas’ specific challenges**

In general, stakeholders perceived rural areas as the weakest element in Lebanon’s PHC sector. This could be attributed to the financial constraints, the scarcity of equipment, the lack of professional development and the remoteness of the areas.

Thirteen key informants acknowledged that HRH shortage is significantly pronounced in rural areas and the workload is assigned to a small unequipped group of staff, sometimes consisting of one or two individuals. This shortage has serious implications on the quality, safety and sustainability of services. It further jeopardises the equitable access to health services. The following quote highlights this issue:

Rural areas suffer from a severe shortage of HRH, as well as equipment and financial resources. Most HRH are freshly
graduated physicians and nurses that do their residency or internships there and then leave. The present HRH are mainly under-qualified, so they don’t deliver good quality of care. [PD03]

This shortage was associated with a general difficulty in retaining HRH in the PHC sector in general and in PHCC located in rural areas in particular:

Rural areas are very weak in PHC due to urbanisation of physicians. [PP01]

The shortage in quality and skills was highly attributed to a lack of professional development and training in these centres. Moreover, the financial constraints encountered in PHCC of rural areas tend to discourage the more qualified HRH. According to interviewed stakeholders, rural PHCC end up recruiting the less qualified HRH who accept the low salaries offered in order to maintain an acceptable quantity of providers. High turnover was also attributed to the work environment, especially in insecure areas that are exposed to political turmoil due to proximity to areas of conflict at the Lebanese borders.

**Stakeholders’ recommendations**

Stakeholders presented some recommendations to enhance recruitment and retention strategies directed towards PHCC, the government and academicians. Recommendations that addressed PHCC encouraged the provision of higher salaries and more comprehensive benefits to avoid turnover, expansion of professional development opportunities, personal recognition and intrinsic motivation. PHCC, especially those located in semi-urban/rural locations, are further encouraged to recruit from neighbouring areas.

Further recommendations were directed towards the government/MOPH who were urged to impose a regulation requiring all physicians to complete a 2- to 3-year rotation in PHC settings prior to receiving their official license to practice, or to reactivate the law that stipulates all fresh graduate physicians are to work for 2 years in a rural setting; this law can be amended to place more emphasis on PHC. Boosting the image of the public health sector in general and that of PHC, in particular, via widespread awareness media campaigns targeting the population as a whole, was another identified strategy/initiative. One interviewee recommended that:

MOPH should direct medical students towards FM specialty. Therefore, the syndicate of physicians and MOPH need to collaborate. [PD11]

Key informants also presented recommendations to the MOPH to enhance their financial support to centres affiliated with the Ministry. The Order of Physicians is also considered to play a crucial role in the retention of physicians in remote PHCC by emphasising the importance of practising in rural settings.

Stakeholders from the academic field suggested a review of the medical and nursing curricula to increase the exposure of students to PHC and community health. A stakeholder highlighted this in the below quote:

Some additions should be done to the medical curriculum whereby importance should be given to community health and working in PHC. [HM01]

Another recommendation directed at universities was to further incorporate the concepts of ‘public health’ and ‘community care’ into their medical curricula in order to direct more medical students towards PHC. This was underscored by one of the stakeholders as stated:

Universities are the main shaper of the policies. From here arises the importance of collaboration with the universities. [NC01]

Finally, the MOPH, the Order of Physicians, the Order of Nurses and universities are urged to collaborate and ensure a supply-demand balance for HRH in the healthcare sector in general and the PHC sector in particular. This collaboration was identified to be of importance to enhance sustainability and equity in healthcare delivery, as elucidated by one stakeholder:

We need to look at the needs of the society and try to redesign the system accordingly. This needs feedback from both the government and the PHC providers. We need planners and policy makers and not copy pasted policies! [PD05]

**Discussion**

The study findings denote that the current status of recruitment and retention within the PHC sector in Lebanon is not conducive to a solid and stable workforce. The HRH recruitment and retention dilemma emanates from an evident lack of a unified understanding of PHC both in terms of scope and services. According to stakeholders, this has impacted the uniformity of care across PHCC and precipitated fragmented and incoherent planning, especially in regard to the current and future needs of HRH. It is, therefore, essential to establish a cohesive and contextualised definition of PHC to be applied across all PHCC. Such a definition would help support the forecasting of current and future anticipated needs of healthcare
providers required for the equitable delivery of care along with their required skill sets. Once a consensus on the definition and scope of PHC services is reached, HRH planners could benefit from tools that provide health managers with a systematic means of reaching staffing decisions. For example, the WHO has developed a human resource management tool entitled Workload Indicators of Staffing Need. This tool can be applied to all cadres of HRH and all types of health facilities (WHO 2010).

Most interviewed stakeholders flagged mental health and geriatric care as two key deficiencies in offered services at PHCC. With regard to mental health, the findings are alarming as mental health disorders are among the main burdens of disease in Lebanese communities (Adams 2011). Mental health services are mostly restricted to secondary and tertiary healthcare institutions with no prominent presence in PHC (Chahine & Chemali 2009). However, recent efforts by the MOPH have been centred on launching a ‘Mental Health Program’ that aims at integrating mental health services into the PHC system (Kullab 2014). This is a step in the right direction, yet successful implementation of such an initiative hinges on the availability of specialised HRH (Chahine & Chemali 2009). Recent evidence shows that the number of professionals working in this field in the Middle East is far below the requirements needed to address the mental health needs of the region’s population (Okasha et al. 2012).

The lack of geriatric care at the PHC level is also disconcerting taking into consideration that a forecasted 26% of the Lebanese population will fall in the 65 years or older age group by 2050 (United Nations, Department of Economic and Social Affairs, Population Division 2013). Hence, it is crucial to strengthen geriatric services across all healthcare institutions with emphasis on PHC to enhance the quality of life and reduce the associated burden of morbidity (Abyad 2001, Chemali et al. 2008). The field of geriatrics has not received due attention in Lebanon, as there are no fellowship programmes offered in geriatrics and only one medical school includes the topic in its curriculum (Chemali et al. 2008). Similar deficiencies are flagged in other countries in the region (Boggatz & Dassen 2005). The Ministry of Higher Education is, therefore, urged to work collaboratively with medical and nursing schools to incorporate mental health and geriatric care into their curricula, along with initiation of residency and fellowship programmes.

The redesign and organisation of recruitment strategies is essential to ensure the equitable and adequate staffing of PHCC with competent HRH. Such strategies include providing targeted scholarships to medical and nursing students who commit to practising in the PHC sector in general and rural/semi-urban settings in particular, enhancing medical/nursing school acceptance of students with a rural origin and upbringing, and offering ‘return of service agreements’. Such initiatives have been endorsed by the WHO and have proved effective in enhancing the recruitment and retention of HRH both in developed and developing contexts (Dolea et al. 2010). Another recruitment strategy entails requiring medical graduates to serve in PHC settings as a prerequisite for specialisation (Katzenellenbogen et al. 2013). A timely and congruent step would be for the MOPH to renew and reinforce Decree number 10823 which requires new medical graduates to work in rural settings for 2 years prior to receiving their license to practice (Ministry of Public Health 1962).

In regard to retention, this study unearthed a number of underlying threats that concur with international literature as well-established push factors leading to HRH turnover and migration, including suboptimal salaries and benefits, heavy workloads, poor work environments and lack of access to professional development opportunities (IOM 2006, Stewart et al. 2007). Particular attention should be dedicated to the nursing workforce at PHCC due to the potential to quit jobs and migrate to other countries (El-Jardali et al. 2009). Moreover, Lebanon boasts a nursing and midwifery density of 2.72 per 1000 persons (WHO 2014), falling below the densities reported by other developing countries renowned for their HRH migration, such as Cuba (9.05 per 1000 persons) and Egypt (3.52 per 1000 persons) (PHCC 2013, The World Bank Group 2014, WHO 2014). Improving the wages and working conditions of HRH employed at PHCC is essential for their effective retention and for future care expansion plans. The MOPH is required to foster a strong collaboration among stakeholders, including medical/nursing schools, national orders/syndicates, academic and research institutions, as well as regional and international organisations in order to collectively design a national PHC retention strategy (Packer et al. 2007). Such strategies have been recommended for PHC settings in other contexts and should be coupled with monitoring systems that may expose high turnover rates along with their associated factors (El-Jardali et al. 2008, Katzenellenbogen et al. 2013).

In terms of gender imbalances among HRH, having an adequate number of female PHC practitioners is necessary to ensure equitable access to PHC services to all population segments. This gender preference is highly prominent in, although not restricted to, Islamic socio-religious environments in Middle
Eastern countries where some women refuse to be seen by male physicians (Zuckerman et al. 2002, Fisher et al. 2003, Uskul & Ahmad 2003, Rizk et al. 2005). Hence, strategies need to be set in order to attract more female physicians and other care providers into this sector.

This study has a number of shortcomings worthy of acknowledgement. First, the findings might not be representative of all stakeholders in Lebanon. Nevertheless, as participants mostly held senior managerial positions, it could be safely assumed that they are well informed of the current status of HRH recruitment and retention strategies. Second, it cannot be assured that the stakeholders’ own opinions and biases were omitted during the data analysis. However, such biases were minimised through the identification of recurrent themes among interviews. Third, stakeholder interviews may not allow the representation of the views of less prominent groups.

Conclusions

Overall, the study sets the path towards establishing a set of nationally recognised recruitment and retention policies and procedures for sustainable PHC workforce development. Attention needs to be dedicated to supporting HRH recruitment and retention practices in rural settings. Further attention to nurses and to training female providers is necessary to ensure gender equity in healthcare provision. Decision-makers and planners are urged to endorse a systems thinking approach that identifies HRH as the most important input for the success of future PHC programmes and interventions, especially in the fields of mental health and geriatric care.

Acknowledgements

The authors acknowledge the Qatar National Research Fund – National Priorities Research Program for funding this study (award number NPRP 5-1559-3-314). Deep gratitude is also extended to each one of the interviewed stakeholders for their generous sharing of experience and recommendations. The role of the Lebanese Ministry of Public Health in supporting this study is commendable, especially Dr Walid Ammar and Mrs Randa Hemadeh.

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