

Report on the second expert
consultation on increasing access
to health workers in remote and
rural areas through improved
retention

29 June to 1 July 2009

Geneva, Switzerland



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Introduction

On 2 February 2009, WHO launched a new programme to increase access to health workers in remote and rural areas through improved retention. The programme is an integral part of WHO's renewed efforts to strengthen health systems through a primary healthcare approach.

The evidence-based recommendations, which are expected to be published in May 2010, are being developed by a group of more than 30 international experts on health workforce rural retention. The first expert group meeting was held in Geneva 2-4 February, during which experts discussed the scope of the recommendations, a common research framework for the analysis of retention strategies, methodological challenges and possible solutions, and mapped out a plan of action to develop. The report from this first meeting is available at this link: http://www.who.int/hrh/migration/expert_meeting/en/index.html

It was decided at the first expert group meeting that a smaller group, called the "core group" would be formed to undertake further research and analysis between the meetings of the larger group. This core expert group met for the first time in Geneva 6-7 April 2009. During this meeting, policy and research questions were defined, a template for conducting new country case studies was discussed, the first draft outline of the recommendations was presented and debated, and a plan of action specific to the core expert group was mapped out.

The second full expert group meeting was held in Geneva 29 June to 1 July. The expected outcomes of this meeting were:

- to provide an update on the progress of the core expert group:
 - conceptual framework for monitoring and evaluation
 - costing tool for retention interventions
 - progress on realist review of retention studies
- to further develop and agree on a draft outline of the recommendations
- to share further experiences from countries and debate challenges specific to implementation of these recommendations
- to disseminate the call for papers for the upcoming special theme issue of WHO Bulletin, May 2010, "Health workforce retention in remote and rural areas: towards universal access"
- to agree on a plan of action for the coming months, including:
 - additional research needs
 - planning for the thematic workshop to be held in November 2009, in Hanoi, Viet Nam
 - brainstorming for the launch of the recommendations

This report presents a synthesis of the presentations and discussions held in plenary and working groups in the meeting. The provisional agenda, list of presentations, and the list of participants are given in Annex 1, 2 and 3, respectively. In addition, all presentations made at the second full expert meeting shall be shall on the web-based platform for information exchange available for all experts¹.

¹ <http://ezcollab.who.int/retention>



Filling the evidence gaps - updates

The meeting discussed various updates on filling the evidence gaps, based on the plan of action agreed upon at the first full expert meeting in February as well as from the core expert group meeting held in April. A presentation from each expert or group of experts responsible for an area of work gave a short update on the status of their work, followed by open discussions.

Conceptual framework for monitoring and evaluation

The need for a conceptual framework for monitoring and evaluation emerged during the discussions on the template for future country case studies during the core expert group meeting in April 2009. This conceptual framework aims to guide policy makers and decisions makers the design, implementation, monitoring and evaluation of retention strategies. This tool will make as comparable as possible the many different evaluations conducted on retention strategies with the aim to better understand how these different strategies did or did not work. The framework highlights the importance of context when evaluating retention strategies, something that has been stressed as essential for the development of these recommendations. On behalf of the group, Luis Huicho presented the first draft of the conceptual framework for and detailed the group's intentions to refine the framework with further inputs, and to present updates at the next core expert group. Additionally, it is envisaged that this conceptual framework shall eventually be tested/piloted in country case studies and shall be disseminated for policy and research use as a key tool coming out of the global recommendations.

Costing of interventions

In addition to the monitoring and evaluation framework and tool, there is also a costing tool being developed by members of the expert group. There is a need for guidance on how to cost retention interventions. Jim Campbell presented on behalf of the small group working on the costing tool. There is a significant lack of knowledge on associated costs of these interventions and a need to encourage information and data-driven decision-making amongst policy makers. The tool will provide a simple, step-by-step guide that will aim to answer three key questions:

- How much will the intervention cost?
- How will it be financed? (Who will pay?)
- Is it financially sustainable?

Various elements to consider when attempting to cost an intervention were highlighted. Policy makers will need to identify the goods and services required for the intervention, as well as consider both variable and fixed costs, incremental costs and the timeline of the intervention. There are many stakeholders that could potentially fund the intervention, such as the government, communities or even patients themselves. Furthermore, funding streams can include domestic tax revenues, earmarking, social insurance and official development assistance, to name but a few. It is also crucial to ensure the financial sustainability of retention interventions before their implementation. Costs will need to be compared to the fiscal space over time, as well as considerations for relative costs, anticipated benefits, 'survival' rates and a cost/benefit analysis. Reflections upon the necessity for a costing tool were provided through experiences from China.

Realist review

Marjolein Dieleman provided an overview of the intermediary findings from the realist synthesis of retention interventions. The realist review approach considers the context or the setting within which the intervention occurred: a different context can lead to a different outcome. Context includes the organizational, socio-economic, cultural and political conditions, the stakeholders involved, their interests and convictions, and the process of implementation. It also considers the mechanism(s) that triggered change.

Realist enquiry was applied to the 30 studies/documents retrieved for the original background paper. Each study was reviewed in an attempt to further understand what mechanisms (reactions) were triggered by the intervention, as well as which contextual factors may have contributed to the success or failure of that particular intervention.

Several initial findings from the realist inquiry were shared with the group. For example, through reviewing studies from Ecuador and Japan, one could propose a recommendation that community representatives should be involved in the selection of candidates for rural practice and that their support for the retention intervention improves the likelihood of the intervention's success.

Overall, the group agreed that the use of realist review for these types of complex policy interventions could potentially provide additional information on the context and mechanisms, and therefore a greater understanding of which interventions will work for whom and in what context. It is hoped that through using realist review, unintended effects of interventions may be better addressed and the appropriateness of different retention strategies will be more confidently commented on within the recommendations themselves.

Draft outline of recommendations and working group discussions

Carmen Dolea presented the current format and outline of the global recommendations. It is intended that the final recommendations document will include both evidence-based recommendations for each of the four categories of retention interventions as decided upon at the previous expert group meetings, as well as a "how to" guide section that will be specifically designed to focus and advise on implementation.

The particular format for each recommendation was also presented. It was proposed that each recommendation should include

1. Recommendation statement
2. Summary of the evidence for that recommendation
3. Commentary on risks, benefits and values
4. Example of country experiences in relation to this recommendation/intervention

The expert group was then split into four working groups, each responsible for validating the above proposed structure and outline for the recommendations, as well as proposing 2-5 draft recommendations for their category of intervention, identification of placeholders for the missing evidence/information and any proposals for recommendations on implementation.

Education working group

The working group held a lengthy discussion, which began with an agreement that the recommendations should address both pre-service and during service education for health workers. The group highlighted that although there is a great deal of evidence available concerning education as a retention strategy, the majority of this evidence emanates from developed countries and they emphasized the need to remain wary of problems in transferring experiences from developed to developing countries. There was also a debate concerning whether new cadres of health care providers may be more likely to work in remote and rural areas.

The proposed recommendations and links to evidence from the education working group are included in the draft recommendations, attached in annex 4. There were four such recommendations proposed:

- There should be strong encouragement for student from rural areas to take up medical training.
- Training centres should be located in remote and rural areas
- Education should have some degree of focus on remote and rural issues
- Continuing education opportunities should be part of the career pathway for those working remote and rural areas.

The group emphasized the need for further evidence, particularly from developing countries, in order to further develop these recommendations and the need to be clear about where these policies have been put into practice and what outcomes were reported as a result.

Regulatory working group

This working group proposed that the recommendations should address three thematic regulatory areas: 1) Mandatory compulsory service; 2) Priority/incentives based on conditional choice and 3) Scope of practice.

The proposed recommendations and links to evidence from the education working group are included in the draft recommendations, attached in annex 4. There were four such recommendations proposed:

- Compulsory service can improve geographical (rural) distribution of the health workforce
- Career development opportunities (training and promotion) can be linked to rural service
- Changes in scope of practice of health workers are usually aimed at improving access to health services, but can also improve, either directly or indirectly, health worker retention.

The group highlighted that the WHO-George Washington commissioned study on compulsory service will significantly contribute to the evidence base, particularly for recommendation one. Efforts were already made to begin discussing some of the risks, benefits and values of compulsory service, priority incentives and scope of practice, and these can be seen in greater detail in the draft outline of recommendations.

Financial incentives working group

The financial incentives working group began with an introductory presentation highlighting the notable evidence gap addressing the impact of financial incentives on the retention of health workers. The link between financial incentives and broader health systems financing was emphasized, and it should be acknowledged that the macro economic context and external dependence limits the possibilities of financial incentives.

The group chose at this point not to follow the proposed template for recommendations, but to have a more general discussion regarding financial incentives due to their complex nature and the limited evidence regarding evaluations of financial incentives. However, it was proposed that the recommendations may want to address both salary related financial incentives, such as allowances and pay for performance, as well as compensation related financial incentives, such as loans and social benefits. A more detailed summary of the discussions of the financial incentives group can be found in annex 4.

However, the group did produce many key points already crucial to consider in the development of financial incentives recommendations. For example, the recommendations should include some cautionary measures to consider when implementing financial incentives, such as potential spill over effects for other professions and the importance of social dialogue before setting up these incentives.

Management, workplace environment and social support

The group wished to suggest that although this section of the recommendations will primarily address health workers, there may also be a need to address different service delivery models for remote and rural areas. The group stressed the importance of recognizing the distinction between management and leadership develop, and human resource management system strengthening. Additionally, although the group acknowledged there is a lack of strong evidence for their category of interventions, there are patterns in the current evidence and important lessons and proposals that can already be detracted from this evidence.

There were various recommendations discussed:

- Advocate for improved rural infrastructure and physical working conditions
- Improved living conditions may encourage rural practice
- Strengthen HR management support systems
- Strengthen management and leadership development programmes to improve supervision and raise the profile of rural health care providers
- Create clear and varied contract mechanisms that help get people to remote and rural areas

The proposed recommendations from the management, workplace environment and social support working group are included in further detail in the draft recommendations, attached in annex 4.



Countries: From experiences to implementation

Several members of the expert group presented updates on studies in progress as well as country experiences that help reflect on implementation issues, as well as contributing relevant information for the development of the recommendations.

Small island states

There are many context-specific issues that will be raised and discussed as part of the recommendations, and the difficulties encountered by small remote islands for recruiting and retaining health workers are complex. In many small island states, there is a limited management and planning capacity in the health systems and they may be no human resources specialists in the health system. Their small size and population often mean they are too small to sustain training institutes for higher level professional occupations and they are extremely volatile and vulnerable to migration flows. The case study shall focus upon two pacific small island states and investigate issues related to the retention of health workers in these remote islands, using the agreed case study template as validated at the previous expert group meeting.

Norway

As decided by the experts, the recommendations will include country examples from both developed and developing countries. Norway was presented as a high-income country with a well-established primary health care system and the attainment of universal coverage. However, there is a maldistribution of health workers seen in Norway as well, with difficulties in retaining consultants, physicians, nurses, pharmacists and dentists in hard-to-reach and remote practices. This study shall focus on the efforts being made to improve retention of health workers in these areas through the establishment of remote medical universities, such as in Tromsø, distance-learning education opportunities for nurses, compulsory internship for medical graduates, postgraduate training and the consultant recruitment and retention programme.

Brazil

Brazil is the fifth largest country in the world with 90% of the population covered under the national health system. Despite over 2.4 million health workers working in the core health care services, there is a marked and severe maldistribution of health professionals in some areas of Brazil. Yet there are retention strategies that are working to address this problem. The Family Health Programme, created in 1994 for example, is the national strategy based on primary care and sends teams of health workers (comprising one physician, one nurse, one nursing assistant, six community health agents, one dentist, one dental assistant and one dental hygienist) into rural areas. The family health teams are now successfully providing basic health care to over 90 million people (47% of the population) and their efforts are being complemented by another scheme, Health Workers Programme for Inner Cities, as well as tele-health developments and continuous professional development opportunities through the SUS Open University.

Thailand

Pawit Vanichanon, a rural physician, provided a comprehensive overview and personal experiences related to the retention strategies employed in remote and rural areas of Thailand. Thailand combines various efforts towards retention: three years compulsory public service for all medical graduates, education and continuous professional development opportunities offered to those serving in remote and rural areas, financial incentives and the development and expansion of the Rural Doctor Society. Physicians working in remote or rural areas are recognized for their service at the national level, with specific awards and award ceremonies set up to publicly acknowledge their service to society.

Latin America

There has been two categories of retention schemes uncovered to date by Luis Huicho in Latin America: retention strategies included within broader health reform initiatives and specific retention strategies. Retention has been partially addressed within broader health reforms such as the community administration of health services in Peru and comprehensive primary health care efforts in Cuba, Brazil, Mexico, Columbia and Peru. Although retention strategies are being implemented in Latin American countries, there are little to no evaluations of these strategies available at present. Although there is compulsory rural health service in both Ecuador and Peru, for example, good-quality evaluations of these and their impact on retention have yet to be thoroughly studied. Various potential case studies were raised, including Cuba that reports very impressive rural population health indicators and it would be of great interest to evaluate the effectiveness and any potential links that could be made between these indicators and their rural health plan and expanding rural health teaching facilities. A final appraisal of the evidence from the region shall hopefully be ready for the next core expert group meeting.

Australia

Over 30% of Australia's population is found in remote or rural areas and at present, 70% of those delivering health care to them are overseas trained doctors. Yet there are impressive domestic efforts to improve retention of health workers in these areas. Australia now has a specific Minister devoted to rural, remote and indigenous health, who may be the first of his kind in the world. In addition, a new rural classification has been rolled out along with increased funding assigned to the rural health workforce strategy. These all contribute towards retention schemes such as relocation grants available for doctors moving to remote and rural practice as well as retention grants paid to them according to their 'remoteness' and the new national rural locum programme. Challenges do remain however, such as how to increase the viability and working environment of rural practices and how to design strategies that directly respond to the demands and wishes of health professionals.

Mobilizing health workforce to outreach remote areas

Efforts are also being made to analyse facility based health workforce outreach services in remote and rural areas. With regards to physical outreach, mobile teams and rotation of health workers in remote facilities could be considered. For virtual outreach, it is essential to better understand the role of telemedicine, e-health applications and remote support availability for health workers and the impact of these upon their retention. Work shall be done to try and fill in these evidence gaps to better support the recommendations, including the mapping of these modalities across levels of care, analysing the benefits for the population, assessing the cost-effectiveness of these types of interventions and discussing their possible consequences on human resource management.

Working groups on country implementation

All working groups also held a brief discussion concerning implementation of the recommendations. Most groups reiterated several points already raised, such as the need to cost these interventions, to monitor and evaluate them effectively and to be sensitive when transferring experiences between developed to developing countries. Furthermore, all agreed that it is essential to encourage countries to expand the evidence-base related to retention strategies and ensure that future evaluations are of good quality. One group also chose to present a suggested decision-making process to be followed before establishing a specific retention scheme. The essential elements of this process are:

- Know the health sector needs and the needs of your rural population.
- Know your workforce. Analyse your labour market.

- Understand the choices available. Decide which criteria you will use. Eg: (short / medium / long term impact, level of impact, cost, support / pre-conditions from other interventions required, potential conflicts between interventions, sustainability).
- Decide how you will evaluate the impact

Draft outline of the recommendations

A refined draft outline of the recommendations was presented to the group, incorporating feedback, comments and suggestions gathered from the working groups and plenary discussions from the previous two days. There was a general agreement that the new draft outline reflected well the discussions of the group and captured the initial suggestions for potential recommendations within the four categories. Appeals were made for interested group members to volunteer to contribute and write specific sections of the recommendations. The revised draft outline of the recommendations can be found in annex 4.

Plan of action and next steps

Special theme issue of WHO Bulletin, May 2010, "Health workforce retention in remote and rural areas: towards universal access"

There will be a special theme issue of the WHO Bulletin, to be published May 2010, focusing specifically on the issue of health workforce retention in remote and rural areas. This will provide great visibility for the launch of the global recommendations and will portray the issue of retention of health workers to an international audience. Experts were encouraged to submit papers to the special theme issue.

Plan of action for coming months and distribution of tasks

Over the next few months, there will be a concerted effort made to continue expanding the evidence base for the recommendations. The second round of the global literature review will be conducted before the next expert meeting, as well as the compulsory service review and the realist review on the thirty articles retrieved for the background paper. In addition, case studies from Australia, Brazil, Ethiopia, Norway, Zambia and small island states shall all be well under way in the coming months. Smaller groups of experts shall also contribute their time and expertise in order to further refine and develop both the monitoring and evaluation conceptual framework and costing tool.

Experts were also informed of the planned thematic workshop to take place in Hanoi, Viet Nam in late November 2009. It is foreseen that this thematic workshop shall be a joint conference held with the Asia Pacific Action Alliance on Human Resources for Health (AAAH) and the WHO. There shall also be a specific one-day meeting held in Hanoi just for the WHO expert group, which shall act as the third full expert group meeting. More information shall be shared with the experts in the coming months concerning this thematic workshop, but ideas were shared concerning the content of the workshop. For example, parallel sessions on each of the four categories of interventions, the idea to invite African countries to join and possible field trips for all participants.

All experts were encouraged to keep in touch and remain involved in the drafting of the recommendations. The next expert group meeting shall be a core expert group meeting, to be held the 20-21 October 2009 in Geneva.

Calendar for drafting the recommendations

July - September 2009	End September 2009	Mid October 2009	October 2009	November 2009	March 2010	Spring 2010
Writing groups	Submissions to WHO bulletin	Final deadline for evidence	2nd Core group expert meeting	Thematic Workshop	Thematic Workshop / 3rd full expert group meeting	Launching of recommendations
Can begin writing those sections not heavily dependent upon evidence (A,B,C,E and F)	Deadline for WHO call for papers	Deliver all evidence gathered, to allow time for grading of evidence	Assess quality and grading of evidence Validate evidence Begin drafting the recommendations Prepare the November workshop	Exchange country experiences Pre-test draft recommendations Identified pilot – countries for implementation	Exchange country experiences Review and finalize the draft of recommendations	More than just launching? Advocacy event ?
July – September Various locations	30 September	15 October	20-21 October Geneva	23 – 27 November Hanoi, Viet Nam	March Dakar, Senegal	TBD

ANNEX 1. Provisional agenda

Increasing access to health workers in remote and rural areas through improved retention

Second expert group meeting
29 June – 1 July 2009, World Health Organization, Geneva
Salle B, 3rd floor

Provisional agenda

Monday, 29 June 2009

08:30 Registration

09:00 Welcome and introduction

Welcome and opening remarks : overview of HRH and renewal of primary health care

Badara Samb, ADGO, Health Systems and Services, WHO

09:20 Session I – Update on progress from the core expert group

Chair: Seble Frehywot, George Washington University, USA

09:20 **Review of progress of the expert group – key points**

Jean-Marc Braichet, Coordinator, Health Workforce Migration and Retention, WHO

09:40 **Filling of evidence gaps (cross-cutting areas)**

- **Conceptual framework for monitoring and evaluation (Luis Huicho)**
- **Costing of interventions (Jim Campbell)**
- **Realist review (Marjolein Dieleman)**

10:10 **Discussion**

10:45 – *Coffee break*

11:15 Session II – Draft outline of recommendations and working groups

Chair: Jim Buchan, Professor, Queen Margaret University, Edinburgh, UK

11:15 **Draft outline of recommendations – introduction**

Carmen Dolea, Technical Officer, Health Workforce Migration and Retention, WHO

11:35 **Discussion**

12:00 – *Lunch break*

13:30 Session II – Draft outline of recommendations and working groups (continued)

Chair: Jim Buchan, Professor, Queen Margaret University, Edinburgh, UK

13:30 **Introduction to the work of the working groups – expected outcomes and methods of work**

Daniel Shaw, Technical Officer, Health Workforce Migration and Retention, WHO

13:45 **Group 1: Education**

Group 2: Regulatory interventions

Group 3: Financial incentives

Group 4: Management, working and living environment and social support

Each group will initially present and discuss updates on evidence gaps if any in the group, and then will identify 2-5 recommendations that can be made under the respective category

15:15 – *Coffee break*

15:45 **Working group** (*continued*)

17:30 **End of day one**

18:00 **Reception**

Tuesday, 30 June 2009

09:00 **Session II – Draft outline of recommendations and working groups**
(*continued*)

Chair: **Jim Buchan, Professor, Queen Margaret University, Edinburgh, UK**

Summary of Day One

09:15 **Working group reports back to plenary**

10:15 – *Coffee break*

10:45 **Discussion**

11:45 **Session III – Countries: Challenges for implementation**

Chair: **Grace Allen-Young, Ministry of Health, Jamaica**

11:45 **Shared experiences from countries**

- Brazil (Sabado Nicolau Girardi)
- Norway (Karin Straume)
- Small Island States (Jim Buchan)

12:15 **Discussion**

13:00 – *Lunch break*

14:00 **Session III – Countries: Challenges for implementation** (*continued*)

Chair: **Grace Allen-Young, Ministry of Health, Jamaica**

14:00 **Shared experiences from countries**

- Australia (Kim Webber)
- Latin America (Luis Huicho)
- Thailand (Pawit Vanichanon)

14:30 **Discussion**

15:00 – *Coffee break*

15:30 **Working groups on country implementation**

Each group will discuss both challenges and the factors contributing to successful implementation of the 2-5 recommendations they decided upon in yesterday's session

17:00 **End of day two**

Wednesday, 1st July 2009

09:00 **Session IV – Draft outline of recommendations**

Chair: **Estelle Quain, USAID, USA**

Summary of Day Two

09:15 **Working group reports back to plenary**

10:00 **Partnership and collaboration**
Global Health Workforce Alliance (GHWA)

- 10:15 **Presentation of the revised draft outline of recommendations**
Jean-Marc Braichet, Co-ordinator, Health Workforce Migration and Retention, WHO
Carmen Dolea, Technical Officer, Health Workforce Migration and Retention, WHO

10:45 – *Coffee break*

- 11:15 **Discussion**

12:00 – *Lunch break*

13:30 Session V – Plan of action and next steps

Chair: Percy Mahlathi, Ministry of Health, South Africa

- 13:30 **Special theme issue of WHO Bulletin, May 2010, "Health workforce retention in remote and rural areas: towards universal access"**

Daniel Shaw, Technical Officer, Health Workforce Migration and Retention, WHO

- 13:40 **Plan of action for coming months and distribution of tasks**

Jean-Marc Braichet, Health Workforce Migration and Retention Unit, WHO
Carmen Dolea, Health Workforce Migration and Retention Unit, WHO

- 14:00 **Discussion**

14:30 – *Coffee break*

- 15:00 **Upcoming meetings and brainstorming**

Core expert group meeting, 20-21 October 2009

Plan of action of thematic workshop in November 2009, place and dates TBD

Brainstorming for the launch of recommendations

- 16:00 **Closure of the meeting**

Badara Samb, ADGO, Health Systems and Services, WHO

ANNEX 2: List of presentations

The following background papers and presentations from the meeting are available at: [insert link \(core-expert-meeting\)](#)

Day 1

Review of progress of the expert group - key points - Jean-Marc Braichet

Conceptual framework for monitoring and evaluation - Luis Huicho

Costing of interventions - Jim Campbell

Realist review - Marjolein Dieleman

Draft outline of recommendations - introduction - Carmen Dolea

Introduction to the work of the working groups - expected outcomes and methods of work - Daniel Shaw

Day 2

Working group one (education) report back - Estelle Quain

Working group two (regulatory) report back - Seble Frehywot

Working group three (financial incentives) report back - Eric de Roodenbeke

Working group four (management, environment and social support) report back - Jim McCaffery

Brazil - Sabado Nicolau Girardi

Norway - Karin Straume

Small island states - Jim Buchan

Australia - Kim Webber

Latin America - Luis Huicho

Thailand - Pawit Vanichanon

Day 3

Working groups on implementation. Presentation on decision-making process - Tim Martineau

Presentation of the revised draft outline of recommendation - Jean-Marc Braichet and Carmen Dolea

Special theme issue of WHO Bulletin, May 2010 - Daniel Shaw

Plan of action for coming months and distribution of tasks - Jean-Marc Braichet and Carmen Dolea

ANNEX 3: Provisional list of participants

Second expert consultation: Increasing access to health workers in remote and rural areas
through improved retention

29 June - 1 July 2009, World Health Organization, Geneva

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ANNEX 4: Revised draft outline of the recommendations

Increasing access to health workers in remote and rural areas through improved retention

Global recommendations

Annotated Draft Outline, 12 August 2009

- Executive summary
- Summary of recommendations

A. Introduction and objectives

- Health workers are key to deliver good quality health services that can improve health outcomes. But there are often insufficient numbers and types of qualified health workers where they are most needed, which is in remote and rural areas, in developed and developing countries alike. Without local access, it is likely that communities will not have access to important primary health care services. This is a high priority issue for both developed and developing countries [give examples of imbalances between rural and urban areas, including data on health outcomes being poorer in rural areas]. This is even more important in the context of a renewed focus on primary health care as a comprehensive framework to address health inequalities and social determinants of health, and to achieve the MDGs.
- A number of recent calls to action have further stressed the importance of this issue. First, the WHO resolutions on migration and rapid scaling up of health workers (WHA57.19² and WHA59.23³) requested Member States to put in place mechanisms to address the issue of retention of health workers. In March 2008, the Kampala Declaration⁴ issued by the first ever Global Forum on Human Resources for Health has requested governments to “assure adequate incentives and an enabling and safe working environment for effective retention and equitable distribution of the health workforce.” The G8 Communiqué⁵ in July 2008, also restated the need to assure an enabling working environment for the effective retention of existent and newly trained health workers, if a reliable and responsive health workforce is to be produced as part of strengthened health systems [to check G9 communiqué]
- To improve the situation there is an acute need to examine existing knowledge and evidence, and present it to policy makers in a way that is useful for them. Hence the WHO programme to develop evidence based recommendations to guide policy makers in a non-prescriptive way, on how to design, implement and evaluate HW retention strategies in remote and rural areas within country specific context. WHO is working with partners (World Bank, academic institutions and policy makers) to examine the evidence and develop those recommendations.

² http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R19-en.pdf

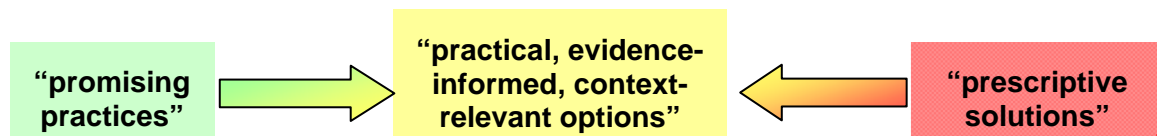
³ http://www.who.int/gb/ebwha/pdf_files/WHA59/A59_R23-en.pdf

⁴ <http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf>

⁵ http://www.g8summit.go.jp/eng/doc/doc080714__en.html

- The purpose of these recommendations is thus to provide up-to-date, practical and evidence-based guidance to policy and decision makers in countries to help them better understand the issue of health workforce retention, and to support countries in the design, implementation, monitoring and evaluation of appropriate strategies/policies to address this issue. The collection of recommendations is intended as a practical, operational tool for all interested in addressing the challenges of health workforce retention within countries.

The product: **Evidence-based recommendations on effective strategies that increase access to health workers in remote and rural areas. Focus on implementation – “how to” guide.**



B. Target audience and scope of recommendations

a. Target audience: policy makers, HRH leaders, civil society

The primary target audience is policy makers and decision makers who have authority over the factors that influence recruitment and retention in rural and remote areas, and who can design and implement effective strategies to address these factors. This will be different in each country but is likely to focus on governments, other employers (both public and private), provider groups, etc. HRH leaders and practitioners, professional associations, as well as civil society can be secondary target audiences.

b. Scope of the recommendations:

i. Type of health workers targeted:

All health workers that are in the formal/regulated health workforce (exception volunteer HW). This includes not only health care providers (such as doctors, nurses, midwives, mid-level health workers, pharmacists, dentists, lab technicians, paid CHWs) but also management and support workers (such as HR managers, health managers and leaders, public health workers, epidemiologists, clinical engineers, HMIS personnel, as well as teachers/faculty).

ii. Categories of interventions included:

1. education and continuous professional development interventions
2. regulatory interventions
3. financial incentives, direct and indirect
4. management, workplace environment and social support interventions (including HR management systems, and different models of service delivery)

iii. Geographical areas

Recommendations will be made for underserved, remote and rural areas, which require specific interventions due to their characteristic geographical isolation. It may include, for example: remote rural areas; small or remote islands; urban slum areas; areas that are in conflict or post-conflict; refugee camps; and areas inhabited by minority or indigenous groups. While there isn't a universal definition of “rural” or “remote”, this will be adapted by each country, taking into account in most cases two main elements: the settlement profile (population density, availability of economic structures) and the accessibility from an urban area or high service district (distance in kilometres or hours drive).

C. Conceptual framework to assess the situation

This section will be replaced with the work of the small group looking into this issue. Inputs, process, output, outcomes and impact indicators will be identified. However, comments made by experts on the original section have still been recorded below, and will be considered in the revised version. It has been suggested also to merge this section with section G on monitoring and evaluation.

[Outcome measures/measuring retention

- c. **What indicators/outcomes** show there is a problem, and can help assess the success in implementation:
 - i. **health workforce-related indicators:**
 1. changes over time in the rural/urban ratio of health workers to population density
 2. percentage of health professionals who choose to work in a rural or underserved community as a consequence of an intervention
 3. reduction in the number of existing health workers from rural and remote areas
 4. increase in the number of entrant health workers into rural and remote areas.
 5. lower vacancy rates in remote and rural areas
 6. duration in service of the health workers in remote and rural areas
 7. health worker satisfaction about working in rural or remote areas
 8. Density of public health workforce , skilled– invested in by the state- per 1000 population and density in terms of actually the number of people on the job. Also compare this with the number of private –for fee health care providers in the same areas and see whether this adds. The concern is that in many countries the problem is a lack of public investment to create public posts and not of attraction or retention as there are unemployed graduate also available.
 - ii. **health systems-related indicators:**
 1. number of outpatient visits at public health facilities in rural facilities before and after an intervention
 2. patient satisfaction with care provided by rural providers (in before and after studies)
 3. MDGs
 4. health outcomes indicators (morbidity rates, mortality rates, in particular infant and post-neonatal mortality, maternal mortality; these can improve in the long-run, but there is a need to carefully address the potential confounding factors)
- d. **Data sources and methodologies** to measure retention (*e.g. rank districts or facilities according to their vacancy and turnover rates to identify priority areas*)]

D. Evidence-based recommendations:

This section presents the results of the systematic review and analysis of the evidence. For each category of interventions small statements will be made, based on this analysis, saying whether the intervention has worked, where, how and why. This is the main section of the overall document. It will need the most of the work to draft the recommendations in such a way as not to sound prescriptive or to be too general. It will also be based on the analysis coming out of the realist synthesis.

All recommendations will follow a similar format:

- **Recommendation statement:** brief text stating what the recommendation is. It will be phrased as an observation/result from the evidence (see below examples from the regulatory group)

- **Summary of Evidence:** this paragraph will presents succinctly what the evidence shows up to now on the respective recommendation: what is the strength of the evidence (type of study design, number of studies showing this result); type of country/context in which the evidence was found

- **Commentary on benefits, risks and values:** this paragraph will be developed towards the end of the process to develop the recommendations, and it will provide some justification and reasoning that will help policy and decision makers judge to what extent the recommendation is suitable for their own context or not, or what are the implications of choosing or not choosing this type of recommendation.

- **Example of Country Expression:** this will be a box displaying examples from the literature or from our own country case studies, illustrating the evidence, and giving a flavour of how the recommendation was implemented or evaluated in a specific country.

This section will present key messages on effective interventions for the four categories as they appeared in the evidence base (only the interventions for which there is good evidence)

- i. education and continuous professional development interventions
- ii. regulatory interventions
- iii. financial incentives, direct and indirect
- iv. management, workplace environment and social support interventions (including HRH managers and leaders, HR management systems, and different models of service delivery)

Below is a list of recommendations as proposed during the 2nd expert group meeting in Geneva, between 29 June -1 July. Further refinements of these recommendations will be made between now and End-September through the work of the expert group.

Table x. Categories of interventions used to improve retention of health workers in remote and rural areas

Category of intervention	Examples
A. Education and continuous professional development interventions	• Targeted admission of students from rural background
	• Recruitment from and training in rural areas
	• Changes / improvements in medical curricula
	• Early and increased exposure to rural practice during undergraduate studies (diversification of location of training sites)
	• Educational outreach programmes
	• Community involvement in selection of students
	• Support for continuous professional development, career paths
B. Regulatory interventions	• Compulsory service requirements for health professionals (bonding schemes)
	• Conditional licensing (license to practice in exchange of location in rural areas for foreign doctors)
	• Loan repayment schemes (paid studies in exchange of services in rural areas for 4-6 years)
	• Increased opportunities for recruitment to civil service
	• Recognize overseas qualifications
	• Policies enabling the production of different types of health workers (mid-level cadres, substitution, task shifting)
C. Financial incentives (direct and indirect)	• Higher salaries for rural practice
	• Rural allowances, including installation kit
	• Pay for performance
	• Different remuneration methods (fee for service, capitation etc)
	• Loans (housing, vehicle)
	• Grants for family education
	• Other non-wage benefits
D. Management, workplace environment, and social support	• General improvement in rural infrastructure (housing, roads, phones, water supplies, radio communication etc)
	• Improved working and living conditions, including opportunities for child schooling and spouse employment, ensured adequate supplies of technologies and drugs
	• Strengthening HR management support systems
	• Supportive supervision
	• Special awards, civic movement, and social recognition
	• Flexible contract opportunities for part-time work
	• Measures to reduce the feeling of isolation of health workers (professional/specialist networks, remote contact through telemedicine and telehealth)

A. Education interventions

Recommendation A1:

Statement: “Additional training centres should be located in remote and rural areas”

Evidence: [to complete]

Comments: Concerns were raised over financial sustainability of this location strategy.

These training centres must be adequately supplied, equipped and staffed.

Country examples: [to complete]

Recommendation A2:

Statement: Education should have some degree of focus on remote and rural issues Education should be directed towards PHC, and should consider team building and training as well as management (these are all vital in rural areas). Rural exposure is very important

Evidence: Lacking strong evidence concerning this, particularly with regard to implementation of this in developing countries. Need more evidence about how these things work in practice and what it takes to work

Comments: [to complete]

Country examples: [to complete]

Recommendation A3:

Statement: Continuing education opportunities should be part of the career pathway for those working in remote/rural areas. Rural health workers should be given priority for in-service training as part of the condition for working in rural areas. Might involve distance learning depending on context. Fast-tracking of education for higher education for rural health workers.

Evidence: [to complete]

Comments: This has to be a part of a wider package.

Country examples: [to complete]

B. Regulatory interventions

The main areas in which regulatory types of recommendations can be made are as follows:

- 1. Compulsory Service (mandatory)**
 - through contracts(ROS, scholarship)
 - through employment contract (condition of service)
 - through training requirements (rural placements)
 - licensing/ registration→ domestic +international
- 2. Priority/Incentives (conditional choice)**
 - selection for post-graduate training
 - selection for promotion
- 3. Scope of Practice**
 - enhance scope for rural (prescribing, procedures, team skill mix)
 - new professions/cadres
 - task shifting

Recommendation B1.

Statement: “Compulsory service can improve geographical (rural) distribution of the health workforce”

Evidence (This will vary according to initiative and implementation)

- a. contracting→ return of service (global review by Oct), scholarships/fees (evidence?)
 - (look outside health +++ evidence
 - employment condition of service posting (Nepal)
- b. compulsory rural experience during training (+++ evidence, ??impact) (Thailand)
- c. licensing and registration→ domestic, international (US, Canada, Australia)

Commentary

- short term....long term impacts need other initiatives (a)
- political risk, opposition from professional groups
- managed well +equitable (buy outs ok) (a,b,c)
- risk of continual turn over (a,c)
- Inexperienced health prof. (also as managers) in needy health communities (a b[?], c)
- lets health system of the hook (a,c)
- Big impact/low cost?
- community involvement support

Country examples

- See evidence section

Recommendation B2.

Statement: “Career development opportunities (training + promotion) can be linked to rural service”

Evidence (This will vary according to initiative and implementation). It can be done by

- a. Promotion criteria (Nepal)
- b. Selection criteria (P/G training etc).....point system (Thailand, China)

Commentary

- Realistic possibility
- well managed/equitable/trusted
- Framework for implementation
- needs inter sectoral partnership
- must be well understood + transparent; must be marketed
- Why hasn't been tried
- might undermine choosing the “best” person

Country examples

- See evidence section

Recommendation B3.

Statement: “Changes in scope of practice of health workers are usually aimed at improving access to health services, but can also improve health worker retention directly or indirectly”

Evidence: This will vary according to initiative and implementation. This can be done by:

- a) enhanced scope of work prescribing(many countries like Ethiopia, Malawi, Australia, US): procedures (e.g Brazil, Mozambique, Tanzania, Australia); Team (Brazil)
- b) new and/or dedicated cadres (Australia, Mozambique, US, Thailand, China...)

Commentary for all a and b

- Risk—professional opposition
- dependant on responsiveness of regulatory bodies
- dependant on well defined, well constructed regulatory framework
- needs effective management +regulatory structure
- enables appropriate use of skills be well understood + transparent
- reduces burnout, balances work load
- Could be seen as increasing work load of staff if not linked to increase pay and career opportunities
- should be situated in wider HRH planning

Country examples

- See evidence section

C. Financial incentives

NOTE: for the moment, not yet structured according the agreed format

Recommendations from the group:

Possible financial incentives (many others from country experiences):

- **Salary related**
 - Allowance, fee for service, capitation, pay for performance
 - Skilled based pay, rare skill allowance,....
- **Compensation related**
 - Investment credit, tax credit
 - Loans and grants for housing, education,...
 - Social benefits for pension, health,...

General comments:

- Importance to link up financial incentive to the changing health financing context
- Very limited evidence on impact of financial incentives
- Strong links between health financing systems and incentives models
- Emerging new models of health financing are affecting financial incentives models
- Macro eco context and external dependence limits possibilities of financial incentives
- Difficulties to isolate one by one financial incentives from other policy design measures.
- Many country examples of financial incentives but limited assessments allowing recommendations and scaling up.
- Issue of timing between health care demand related financial incentives and HW availability.
- Issue of magnitude of financial incentive is critical but related to country specific context.
- Strong distinction between recruitment and retention financial incentives
- Importance to bundle financial incentives to other incentives
- Education financing strategies are also important to engage
- Strong links with HRH management capacities and processes.
- MoH may not be the decision maker and do not fund measures
- Vertical program incentives for HR cause harm (system).
- Spill over effects (civil service, professions, sector).
- Link financial incentives to labor market (critical shortage).
- Customize financial incentive to profession
- Importance of social dialogue (salary is not all !)
- Take into account results on HR motivation studies
- Ring fencing financing has also negative side effect

D. Management, workplace environment and social support interventions

NOTE: for the moment, not yet structured according the agreed format

Recommendations from the group:

- Advocate to policy makers to ensure general improvement in rural infrastructure (e.g., roads, electricity, water supplies, radio communication)
- Measures to reduce feelings of isolation may attract HWs to rural areas – including supportive supervision, supporting the development of professional/specialists networks, set up a system of remote contact through telemedicine;
- Improve physical working conditions including adequate access to technologies, drugs, and supplies will allow providers to use all professional competencies; maintenance of facilities (Positive practice environment should have results by October)
- Improved living conditions may encourage rural practice, including decent housing, access to water, opportunities for child schooling and spouse employment; engage community groups to assist in the identification of opportunities for housing and schooling. (FBO lessons)
- Strengthen HR management support systems (special focus on rural and hard to reach places), including recruitment, hiring, deployment, payroll, supportive supervision and performance management:
 - Make certain that there are competent HRM officers at the regional level; or an officer at the district level that has clear responsibility for HRM function;
 - Initiate and support HRM professional development program including training, coaching, mentoring, professional support for HRM.
- Management/leadership development programs may improve supervision capacity in rural areas and create workplace environment to attract and retain HW; reward and recognize good management.
- Raising professional profile and identity of the rural provider may create aspirations to be rural provider – support the development of active rural professional associations, initiate a Chair of rural medicine at a university
- Create clear and varied contract mechanisms that fit needs of getting people to go to rural and hard to reach areas:
 - flexible contract opportunity for part time work (helps with women);
 - fixed term contract with clear end date (e.g., 2 years);
 - contract with clear terms of service (what is expected of them);
 - opportunities to replace provider so they don't have to be there 7 days a week (also this item is related to the finance or regulatory group, especially as it relates to what is *in* the contract).

Section D will also contain a discussion about importance of context in the success of an intervention (eventually about realist review), and why interventions might work in some context and might fail in others and how they worked, and how in certain contexts some mechanisms/strategies do better and some are constrained. It will propose a **categorization of countries/contexts** based on a series of criteria (geographical, economic or political aspects, health systems characteristics etc). [Careful on potential negative implications of categorizations.]

E. How to choose the appropriate interventions to ensure maximum impact

The review of evidence has shown clearly that design and implementation issues play an important role in whether policies are successful and help explain why a policy works in one country or context but not in another. This section presents the necessary steps for identifying whether there is a need for a retention intervention, and how to choose the most appropriate type of intervention given the country context to ensure its maximum impact.

a. Situation analysis

- i. **Health labour market analysis** (imbalances, maldistribution of health workers between rural and urban areas, health labour market indicators)

- ii. **Factors influencing choices of location and reasons to remain (DCE, focus groups, key informant interviews)**

b. Health systems and HRH environment (linkages with retention)

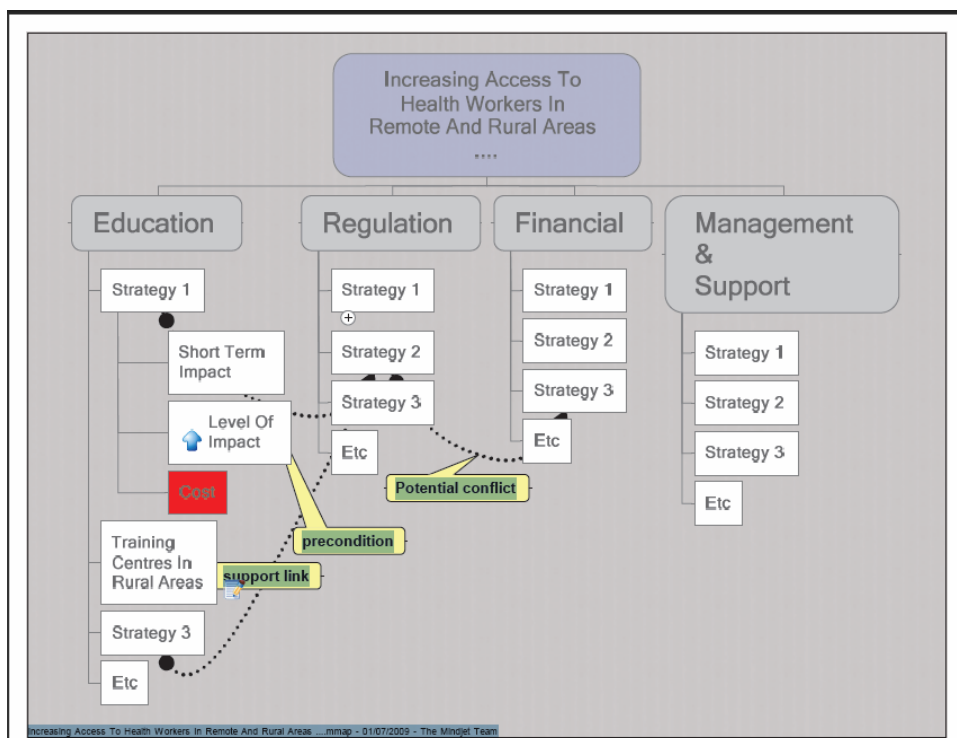
- i. Health systems reforms
- ii. Decentralization
- iii. Recruitment policies
- iv. Regulatory environment
- v. Education policies
- vi. Deployment policies

The choice of interventions needs to be viewed in relation to other ongoing or forthcoming retention policies. If a package of reforms is being put forth, this needs to be taken into account. For example, if housing schemes are being implemented in rural areas, this will affect the level of allowances required by health workers. In addition, the unintended consequences of a retention policy should be examined.

Countries need an overriding national health policy about the importance of serving the health needs of all the population, even in rural hard to reach areas; health sector is center of national development. Important to consider intersectoral approach to health, gives importance to infrastructure development – goes well beyond health sector. Every intervention should take into consideration gender issues within a particular location – factors that are positive or problematic, and need to be accounted for in implementation design.

c. Decision making process (from the working groups)

- Know the health sector needs and the needs of your rural population.
 - What personnel do you require (types, numbers etc), now and in the future (where possible taking into account estimate of health needs, workforce planning, scenario modeling, linking to any existing HRH strategy)
- Know your workforce. Analyze your labour market.
 - Conduct Discrete Choice Experiments
 - Understand why they go, why they don't go to rural areas, why they stay, why they don't stay
- Understand the choices available. Decide which criteria you will use. Eg: (short / medium / long term impact, level of impact, cost, support / pre-conditions from other interventions required, potential conflicts between interventions, sustainability).
- Decide how you will monitor and evaluate the impact
- Decide which stakeholders will be involved



F. How to implement retention strategies (Factors that influence the success of interventions)

a. Involvement of all stakeholders

Appropriate stakeholders (national and when appropriate international) need to be engaged. Who has authority over key decisions will determine what is feasible. Authority over many of the financial incentive reforms will be scattered across different agencies within the country. It is important to map this out and engage relevant stakeholders (e.g. MOF)

b. Political feasibility

The scheme needs to be politically feasible. Can certain groups or geographic areas be exclusively targeted without leading to labor unrest? Does the policy fit into the overall strategy of the government in the health and civil service sector?

c. Time dimension

The time dimension needs to be considered. Three aspects: the time to set up and implement an intervention, the time dimension of the impact (some interventions have an impact in the short term, whereas others can only show results in the long-term); the time dimension in the sustainability of an intervention over years. There may be some policies that can be implemented in the short term and others only in the mid to long term. For financial incentives, this might be less relevant as most of these do not take much time to implement. However, there are cases, for example, where overall budgetary restrictions may prevent increases in compensation in the short term, limiting the feasibility of any targeted wage increases

d. Fiscal sustainability and other sustainability issues

How much the interventions will cost (key Q for policy makers). Who will pay (donors, state intervention, patients?) How will it be financed (increased taxation, through re-evaluation) The policy reform needs to be fiscally sustainable. In many cases, the incentives for retention are funded by donors for 2-3 yrs. What is the follow up plan? Are countries putting in place mechanisms to ensure the retention interventions are sustainable in the mid to long term time frame? If there is no commitment to keeping the scheme going, is this clearly communicated to health workers and other stakeholders? Has the incentives scheme been fully costed and does it fit into the overall budget strategy of the relevant stakeholders (e.g consistent with MTEF and overall wage bill policies). Costs also need to be addressed. How this will influence PEPFAR, GAVI, GF, WB P4P? These questions will all lead on to conclusions concerning sustainability. It is critical that an intervention is sustainable, because once an incentive is implemented it cannot be removed. So if short term funding is available, better to use for infrastructure rather than salary, so you have long term benefits after funding is no longer available - long term impacts must be considered.

e. Accountability and governance issues.

Include discussion about space for health workers to have their voices heard and their rights defended

f. Change management

How the change process will be planned and be guided, and issues around it. What to do when scheme doesn't work? Stress that HRH retention needs to be on-going. What processes and systems are in place to guide the change process, and to sustain it if the interventions are effective?

G. Monitoring and evaluation

Methods for evaluation – outcome measures. This section will be informed by the work of the small group looking into this issue (see also section C)

Annexes

- **Methodology for the literature review and for assessing the quality of the evidence**
 - Literature review – methods for the search and for expanding the pool (briefly, the extent methodology should be in the annex)
 - Expert consultations (summary of meetings and of their results)
 - Thematic workshops and country consultations (idem)
- **References**
- **List of experts and stakeholders**
- **Evidence tables (maybe only on CD)**
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Use by date:

The recommendations will be reviewed in light of the progress made within the next five years in countries that have been using the recommendations, and in light of the new evidence that will appear until then (2014 is proposed as the year when the revised version will be issued)