Tools for implementing rural retention strategies: towards a “how to” guide for “Discrete Choice Experiments”

A methods workshop

Meeting report

19–20 November 2010

Geneva, Switzerland
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1. Introduction

The World Health Organization (WHO) has established a programme of work to increase access to health workers in remote and rural areas through improved retention, with three strategic pillars: (i) building the evidence; (ii) developing global policy recommendations from the evidence; and then (iii) supporting countries in implementing the recommendations and evaluating their impact. The evidence-based global policy recommendations were produced with the support of a large international group of experts and policy-makers and were officially launched in September 2010 (www.who.int/hrh/retention/guidelines/en/index.html).

To support the third pillar (implementation), WHO, the World Bank and Capacity Plus organized a meeting in November 2010 to bring together a small group of policy-makers, researchers and funders to begin discussions about how to develop an implementation road map that will help governments wishing to address the inequitable distribution of health workers in their countries.

Jean-Marc Braichet, Health Workforce Migration and Retention Unit, WHO, chaired the first session and started by welcoming the participants, including some who were involved in developing the global policy recommendations on increasing access to health workers in remote and rural areas through improved retention. Other participants were new to the process. He noted that the focus of this meeting and others that will follow is to develop a number of tools to assist countries in implementing these recommendations. Work has already begun in a few countries that have made formal requests to WHO for technical support, including Lao People’s Democratic Republic, Mali, Sudan and Viet Nam. “We want to see successes and so political commitment is the most important criteria,” he said.

Carmen Dolea, Health Workforce Migration and Retention Unit, WHO, outlined the two main objectives of the meeting. The first was to get feedback from the group on a first draft of the roadmap for implementing rural retention strategies. The second, which was the main focus of the meeting, was to begin the process of developing a “how to” guide for Discrete Choice Experiments (DCEs), an innovative research method that can help policy-makers identify health workers preferences and propose relevant rural retention strategies. This is a priority because there is a lot of demand for using DCEs in human resources for health, especially among low-income countries, and at the same time there are many challenges in conducting a DCE. “It’s the right time to move with developing these tools,” she said. “We have to be practical, we have to move fast and we have to move together.”

2. Challenges at the country level in selecting and implementing rural retention strategies – the need for stronger research tools

This session was comprised of short presentations from current activities related to rural retention in Australia, Romania and Sudan. It was meant to set the scene and ground the discussions in country realities.

Elsheikh Badr of Sudan’s Federal Ministry of Health said inequitable distribution of health workers is affecting the coverage of health services in the country. For example, 34% of remote health-care facilities are not functioning because of the absence of health workers. The problem is further exacerbated by a critical overall shortage of health workers, especially nurses and midwives and other mid-level cadres. The fact that Sudan produces six medical doctors for every nurse contributes to the problem. Sudan is ready to start the work of implementing the retention guidelines and commissioning research to explore further the issue...
of health worker preferences. A broad range of stakeholders at all levels are well aware of the difficulties in retaining health workers in rural areas, and political commitment is high. Sudan has human resources for health (HRH) strategy, resources for HRH research, and a local institutional framework to do the research. Qualitative studies on health workforce preferences have prepared the ground for DCEs – the broad issues related to attracting health workers to remote and rural areas are understood. Now there is a need to give policy-makers information that will help them decide how best to go about achieving more equitable distribution.

Adriana Galan of the National Institute of Public Health in Romania noted that the Government has yet to officially adopt an HRH strategy. In recent years the focus has been on adapting training programmes so diplomas for health professionals would be fully recognized by other countries in the European Union. Romania’s two big challenges are external migration and deep inequalities in the geographical distribution of health professionals. Most doctors work in the major university centres in Bucharest, many medical specialists migrate to other EU countries, and many rural areas have no nurses or midwives with a university degree. Data sources need to be integrated and information quality improved. Recognizing the need to improve planning and managerial capacity, the Ministry of Health recently asked WHO for support in implementing the migration code and the retention guidelines. A meeting to raise awareness of the two documents is planned for early 2011 in Bucharest for countries from south eastern Europe. It is a good opportunity for the Romanian Government to move forward and draft a coherent HRH strategy, including a strategy to recruit and retain health workers in remote and rural areas.

Kim Weber of Rural Health Workforce Australia (RHWA) said the NGO spends its annual US$ 40 million budget on things such as locums, campaigns to sell the rural lifestyle to health workers in urban areas, international recruitment (mainly from the United Kingdom), and programmes to support overseas-trained health workers and their families. Although Australia has had a maldistribution problem for 40 years, rural areas are better served now than they were a decade ago. One reason is that 90% of migrant doctors remain in the same rural practice even after their 10-year bonding service is over. Although a lot is done in Australia related to rural retention there has not been much research, so it isn’t known which policies and programmes work and which ones don’t. It is difficult to get researchers interested as it is such a complex area and interventions are rarely implemented one at a time. When RHWA decided to conduct its own DCE, it found literature available about how to do it difficult to follow, and in the end opted to use another DCE as a template to design their questionnaire, which was given to 315 university students attending a conference. However, when the responses were sent to academics for analysis, RHWA was told the DCE was not done properly and it was not possible to analyse the results. Weber hopes that in the near future RHWA and others will be able to use the “how to” guide to do better-quality DCEs that generate meaningful information.

### 3. Developing a road map for selecting and implementing the most appropriate rural retention strategies

This session, presented by Christophe Lemiere of the World Bank and Carmen Dolea of WHO, focused on how policy-makers can select the most appropriate package of interventions for their respective countries from the 16 global policy recommendations. A preliminary draft of the road map was circulated to participants and key aspects were highlighted.

The purpose of the road map is to put together the available tools and methods that can be used at each stage of the policy cycle to facilitate the selection, implementation, monitoring and evaluation of the most appropriate strategies. Table 1 below sets out these steps and shows
what methods and implementation tools are available, are in the process of being developed, or still need to be developed for each of the steps. Participants broadly agreed that this is in the best way to present the information and the team will move forward with its development.

### Table 1. Tools to support implementation of rural retention strategies

<table>
<thead>
<tr>
<th>Step in the implementation process</th>
<th>Tools and methods available</th>
<th>Source or stage of development</th>
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<tbody>
<tr>
<td>1) Understanding the problem – situation analysis</td>
<td>Stocks and distribution of health workers by rural/urban, by types/specialities, and by rural health needs</td>
<td>Human Resources for Health Assessment tools (WHO website)</td>
</tr>
<tr>
<td>b) Understand the health labour market</td>
<td>Labour force surveys to document unemployment, vacant positions, etc.</td>
<td>World Bank labour force survey methodology</td>
</tr>
<tr>
<td>c) Understand the needs and expectations of health workers:</td>
<td>Focus group discussions, questionnaires, key-informant interviews</td>
<td>Extensive literature in this field including WHO/ASPR case studies</td>
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<tr>
<td>i) factors influencing the choice for rural practice</td>
<td>Discrete Choice Experiments tool</td>
<td>World Bank/CapacityPlus draft – for discussion during the meeting</td>
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<tr>
<td>ii) preferences for rural work (for students and health workers)</td>
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<tr>
<td>2) Selecting the most appropriate strategies – criteria to select the most appropriate interventions</td>
<td>International best practices, literature reviews</td>
<td>WHO global policy recommendations</td>
</tr>
<tr>
<td>a) Effectiveness and complementarities – does it work?</td>
<td>Decision-making tool</td>
<td>World Bank draft paper for discussion during the meeting</td>
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<tr>
<td>b) Relevance: is it appropriate to my context –</td>
<td></td>
<td></td>
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<tr>
<td>i) Time-to-effect/time to implement</td>
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<td>ii) Enforcement capacity</td>
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<td>iii) Urban surplus/unemployment</td>
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<td>iv) Complementarities</td>
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<td>v) Broader health sector policy environment</td>
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<tr>
<td>c) Acceptability: is it accepted by all stakeholders?</td>
<td>Stakeholder analysis</td>
<td>GHWA CDF?</td>
</tr>
<tr>
<td>d) Affordability: can we afford it?</td>
<td>(costing tool)</td>
<td>CapacityPlus/WHO under development</td>
</tr>
<tr>
<td>3) Implementation of rural retention strategies</td>
<td>Pocket guide to assess the functions of an effective HR management system</td>
<td>CapacityPlus/WHO under development</td>
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<tr>
<td>a) HR management systems</td>
<td></td>
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<tr>
<td>b) Regulatory framework for task shifting/different types of health workers</td>
<td>Gap!</td>
<td>Gap!</td>
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<tr>
<td>c) Awards systems</td>
<td>Gap!</td>
<td>Gap!</td>
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<tr>
<td>d) Career ladders – guide for performance improvement</td>
<td>Gap!</td>
<td>Gap!</td>
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<tr>
<td>4) Monitoring and evaluation of rural retention strategies</td>
<td>Framework for monitoring and evaluation</td>
<td>WHO draft</td>
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<tr>
<td>a) Framework and methods: outcomes of interest and impact evaluation</td>
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</table>

One of the tools listed in the table is DCEs, which can be used to help understand what package of interventions may lead a health worker to choose to work in a rural area (on the assumption that policies can be built upon the preferences identified by this tool). Selecting the most appropriate strategies also requires thinking about what is most effective, relevant, acceptable and affordable. Another tool is the monitoring and evaluation framework that has already been developed but still needs to be tested.

Three factors can be used to elaborate on the relevance criteria (see Figure 1 below). A DCE will tell policy-makers how much a group of health workers prefer one thing over another. This is important, but then additional analysis is needed to see if these preferences can be implemented. One factor is time to impact. For example, all recommendations related to pre-service education will take many years to have an impact on retention of health workers in rural areas. A second factor, the enforcement capacity principle, is based on the idea that some policies and recommendations are easier to enforce than others. A third factor considers the labour market and whether or not there is underemployment of health workers in urban areas. If there is a surplus then it is easier to implement some policies such as bonding and financial incentives.
Figure 1. Decision-making toolkit for choosing the strategies

- Be realistic about what might be possible in a country. It may be better to do this analysis before a DCE so as not to waste time measuring things that can’t be implemented.

- Some important activities are missing in framework. First is the importance of talking to policy-makers and managers about what they perceive to be the problem. Second is the need to do a formal and detailed institutional analysis to determine if they function and if rules and regulations can be acted on. Third is a formal communication strategy to inform health workers and communities about changes. All too often, authorities do things without telling people what they are doing and why.

- There are two issues to enforcement capacity – there may be the will to enforce a policy but not the capacity and/or the capacity might not be harmonized across all stakeholders. Need a discussion on how to capitalize on and make the best use of existing capacity.

- Suggest taking a different perspective and packaging the interventions into three levels of effectiveness – interventions 1, 2 and 3 would be effective, but also doing 4, 5 and 6 would be more effective, and even further adding 7, 8 and 9 would be even more effective. This would challenge policy-makers.

- The road map comes across as quite linear and decision-making in HRH is never going to be like that.

- Decision-making at the national level must involve the actors where the policies are to be implemented. The focus here is on retention but sometimes recruitment is the bigger problem.

- Cost–benefit analysis is an important consideration, as is the HR management system, bundling the interventions and looking at the synergies between the recommendations. Also need to take into consideration what strategies are in the HRH plan as countries will not be starting from a blank sheet.
4. Overview of the use of Discrete Choice Experiments in HRH research

Duane Blaauw of the University of Witwatersrand in Johannesburg, South Africa gave an update of a review of DCEs that was published in *Human Resources for Health* in 2009. DCEs have a 20-year history of being used in the health sector, mostly on patients’ preferences. Interest in using DCEs in HRH has been escalating in recent years, although few to date have specifically looked at rural recruitment and retention. This is an evolving field, methods from four years ago are already out of date, and the software used for the design is not readily available, which are all constraints to conducting DCEs.

DCEs provide information about stated preferences of health workers or students for different job characteristics. They have similar demands to traditional survey tools but provide richer data. DCEs can be used to measure the relative importance of job characteristics in job choices; evaluate characteristics not yet available; model effectiveness of different policies and investigate differences between subgroups. But DCEs are complex tools for the researcher to design and analyse and for respondents to complete. These cognitive challenges will be compounded in low- and middle-income countries and also due to language barriers. Despite their methodological challenges, the number of DCEs being carried out in low- and middle-income countries is on the rise, driven by the need for more rigorous evaluations of impact. DCEs can provide information about the relative impact and cost-effectiveness of different interventions, alone and in combination, in different contexts. However, the question from the research community perspective is: Are more DCEs needed or would it be better to focus on improving other types of HRH data such as strengthening revealed preferences databases, doing more labour market surveys, collecting longitudinal HRH data to understand career paths, and evaluating and monitoring interventions?

Selected comments from participants

- We must give a clear (and modest) message about what DCEs can provide to policy-makers. They are not the solution to the problem of rural retention. A DCE can be used as one input (of many) to inform a range of policy options.

- A DCE is just one tool among many to help in the decision-making process – it is not going to drive decision-making. Need to step back and get an agenda from the stakeholders. We should go back to the road map and position DCEs among other tools.

- What are the alternatives? How does this compare with participatory action research and policy modelling? This is important when considering time and money to do a DCE.

- How to design and analyse a DCE questionnaire and how to model variation are subjects of big debate, and there is a big problem around scale – some researchers say this undermines the interpretation of all DCE results.

- Is there a difference between what is necessary from a DCE for academic publication and what is necessary for a policy-maker wanting information to inform a recruitment and retention strategy? Is there a way to get “good enough” data for the latter, which may not be acceptable for academic publication?

- DCEs need to be tailored to the question that is being asked – this is the value of the pilot work.

- External validity is another big question. Very few DCEs have been followed through to individual decision-making.

- The experience from India is that while it was difficult to design the DCE, the respondents had no problem completing the questionnaires.
5. Towards a guide for conducting Discrete Choice Experiments at country level

Extensive brainstorming took place in the late afternoon session, followed by a more structured discussion the following morning. The aim was to identify what DCEs can do for rural retention, to understand the key issues in each step of a DCE, and to share experiences about how to overcome the challenges of doing DCEs in low-income countries. What follows is an attempt to structure these discussions along three main areas: the product; the policy-relevant questions; and the methodological challenges.

**The product:** It was reiterated that the goal is to produce a 20-30 page document about DCEs related to the retention of health workers in remote and rural areas. The document will be aimed at two audiences: higher level decision-makers and technicians/researchers. This is in response to rapidly increasing demand from Member States wishing to use this technique. DCEs are being planned, are in progress or have been completed in many countries including, among others, Australia, Ethiopia, Ghana, India (several states), Kenya, Laos, Liberia, Mali, Niger, Nigeria, Peru, Romania, Sudan, Tanzania, Thailand, Uganda and Viet Nam.

No one who is not already experienced in using the technique will be able to do a DCE after reading this guide. It should be pitched as policy guidance and capacity support.

The document should give policy-makers the information they need to do a critical appraisal of a DCE: Is this a good study and can the results be taken seriously? Some general guidelines on conducting a DCE should be included.

The guide should provide information to policy-makers about how much the DCE is going to cost, how long it is going to take and what needs to be done before it can start.

The document should be clear on limitations and potential uses of DCEs.

There is no one way to do a DCE. Perhaps it would be helpful to have three case studies that run through the guide.

**Policy-relevant questions:** As interest in DCEs rises there are concerns that a DCE may sometimes be used when it may not be the most appropriate technique and that many proponents of DCEs lack awareness of the limitations of the tool. Whether or not a DCE is the best method to use depends on the policy question. The key element is the idea of a trade-off between attributes – not just in a ranking exercise but the strength of preference and how people are willing to trade. It is the quantification provided by a DCE that is valuable.

The first questions to ask are: Is a DCE appropriate and what information will it provide? If a policy question can be broken down into attributes then a DCE may be beneficial.

The starting point should be that a DCE is an input to help inform policy-makers. What is the appropriate level of investment given what can be expected out of this particular method?

Is there any evidence that a completed DCE has been translated into a package of interventions and delivered the result that was expected from the findings?

To what extent can this method be used for the purposes of advising policy-makers on how to improve the retention of health workers in rural areas and to what extent is it still in the research phase?

How would a policy-maker who doesn’t know anything about DCEs decide whether or not to do a DCE? What is the added value of a DCE? What does it give you in addition to what you would do otherwise?

Where does this tool fit in the broader context? After all, the reality is that DCE or no DCE, a large proportion of doctors (85% or more) will never move to a rural area.
The question is: I want to get 10% of my population to move to rural areas and this is going to help because the DCE will tell me how much I will have to pay. What assurance can a DCE give to policy-makers that these people will actually move?

One participant noted three sets of questions to ask when deciding if a DCE is appropriate:

1. Policy-makers have to be curious about questioning their assumptions and looking at alternatives: Are they interested in trusting analytic results?
2. Are a sufficient number of people willing to make trade-offs and is there a reasonable basis to think so?
3. Is the problem amenable to a supply-side approach? Is there a set of actions that the government could offer these people?

Methodological challenges: Like any other research method no one can just pick up a manual and execute a research tool with no prior experience. A DCE is an especially complex technique – it cannot be done by one individual even after an intensive three-day workshop. A sense of the time, cost and expertise/training needed to do a credible job using this method needs to be established.

Most low-income countries will need a considerable amount of capacity building and support in order to do a DCE.

A poor quality DCE (as judged by academics and that would not be published in a peer-reviewed journal) can still provide some useful and practical information to policy-makers about how best to entice health workers from urban to rural areas. This was the case in Niger where a poor quality DCE showed financial incentives had to be much higher than the government had predicted, so it was decided to drop the incentive and focus on housing and more long-term incentives.

There are five steps in designing and conducting a DCE: 1) derive job attributes and levels; 2) define choice sets; 3) administer the questionnaires; 4) analyse the data; and 5) assess the policy implications and communicate the results to policy-makers. The discussion was focussed on the first two steps.

Attributes selection

The first step is the most important: if the attributes are not right then the data from the DCE will not be of any value. This requires extensive qualitative work. When these are piloted it is important to check that there is a common understanding of descriptions and definitions. The ideal number depends on the context of the study, but because of constraints due to experimental design and limited cognitive ability, usually a DCE has a maximum of six or seven attributes.

The underlying assumption of a DCE is that individuals consider the choices and make tradeoffs.

When setting attributes and levels one should understand the policy space and decide whether it is worth trying to push the boundaries.

A key assumption is that people read into the attribute wording what researchers and/or policy-makers intend. It is essential in a DCE to be explicit about what the attribute means. For example, there is often no consensus of what is urban and what is rural.

Policy-makers need to be involved in the preliminary qualitative work in order to see what is implementable. Designers of the DCE need to take into account results of the qualitative studies along with the expectations of policy-makers.

Choice sets

Usually, through an experimental design that has to fulfil criteria of orthogonality and efficiency, a manageable number of choice sets are produced. These are combinations of the
job attributes and levels, expressed as pairs of hypothetical jobs, which will then need to be piloted before being administered to a certain sample of health workers. Creating a representative sample can be very expensive. Cost in part depends on how many cadres a DCE is trying to survey – it can be expensive to reach nurses and other mid-level health workers in desert and mountainous areas.

Experimental design allows distinct attributes to be analysed and in the post-analysis phase, modelling techniques allow for creating different packages for presentation to policy-makers.

In terms of the steps, non-experts in DCEs can only go so far. Sophisticated statistical skills are required for the development of the experimental design, as well as for data analysis. The document needs to be clear on the skills required for each step. For example, an “opt out” option asks respondents if they would prefer job A or B or to stay in their current job. This is another dimension of the choice set design. The guide needs to explain all these implications.

6. Consensus points on Discrete Choice Experiments in the context of rural retention

- A DCE is a research method that can be used for eliciting stated preferences for rural health work.
- A DCE takes about a year to complete and costs range from US$ 70 000 to US$ 150 000.
- The document should not give the impression that it will be possible to conduct a DCE after reading the guide. However, sufficient information should be given on technical resources and references for specific software or other relevant documentation.
- The target audiences are policy-makers and their technical staff.
- The document should state what policy-makers can expect out of a DCE, describe how to use the results and dispel common misperceptions.
- It should give examples of the kind of policy questions that a DCE can answer and list any other methods that can provide equally useful answers. It should also describe the kind of questions that a DCE cannot answer and that are better suited to other methods.
- It is important to set out the necessary steps in conducting a DCE (good practice in terms of what to do and what not to do), without going into all the technical details, which are already widely available.
- The document should explain clearly the methodological challenges and illustrate them with concrete examples from the literature.

7. Qualitative methods for analysing the factors influencing choices for rural work – lessons from the field

Luis Huicho of Universidad Peruana Cayetano Heredia in Lima, Peru presented the design of a DCE on the retention of health workers in a rural underserved area of Peru and highlighted some of the challenges. Ayacucho is one of the poorest regions of Peru with marked urban-rural inequities, one of the worst maternal, neonatal and child death and malnutrition indicators, and a scarcity of health workers. The context-specific problems include the
remoteness of health facilities, the reliability of information on health workers’ availability at health facilities, and a labour market that is extremely heterogeneous and changing.

The following lessons were learned about how to ensure a DCE leads to meaningful results: prepare a theory-based qualitative study; perform in advance a labour-market study; strengthen health information systems to get accurate information about health workers; combine qualitative studies with a literature review and policy options to better inform the DCE design process; and prepare, conduct and report an efficient DCE that is meaningful to policy-makers.

Fadi El-Jardali of the American University in Beirut, Lebanon spoke of an ongoing study exploring the problem of the scarcity of nurses in underserved areas in Jordan, Lebanon and Yemen and the factors, reasons and incentives for recruitment and retention. The study is using both qualitative and quantitative methods. Among the many challenges were selecting underserved areas (the theoretical definition of an underserved area is different than the actual definition), access to data on the selected indicators was different across study countries, and some health-care centres are not available through official sources and could not be identified until certain areas had been visited. In addition, there were considerable difficulties identifying nurses within the sampling frame for the interview. There is no system to locate these nurses except through personal contacts, and many had difficulty with the career-choice scenarios and filling in the lifeline chart. Some key government officials did not have much awareness about the situation in remote areas and administrators in different regions gave conflicting accounts/information about trends in nursing retention issues in underserved areas.

Lingui Li of Ningxia Medical University in Yinchuan, China reported preliminary findings of a qualitative study of job satisfaction-based incentives to attract and retain qualified health workers in underserved areas of western China. He noted the need for more methods of social sciences in doing such studies. Living conditions are harsh, one health worker typically does the work of three, conditions in township hospitals are poor and health workers’ salary levels are extremely low. The study concluded that there is a conflict between the personal incentives of health workers and the health policies of rural facilities and the government. After the SARS outbreak, the central government’s emphasis on public health activities has weakened medical services in rural areas. One of the key issues that need to be addressed in HRH in western China is the highly centralized government compared with eastern China. Hospital leaders and local health administrators need to be given more rights to manage HRH and solve HR problems. Li also made a few cultural and philosophical observations. After 30 years of free-market economic reforms, people have lost their sense of obligation to serve society. The question is how to rebuild the importance of community and public service among the Chinese people?

Krishna Rao of the Public Health Foundation of India in New Delhi presented an overview of three case studies undertaken recently in India. The first documented the various state-level strategies and experiments to improve rural recruitment and retention. These include compulsory rural service, education incentives (e.g. postgraduate seats for in-service candidates), monetary compensation, contracting-in doctors and other health workers, workforce management, non-physician clinicians in primary care, allopathic clinicians with shorter duration of training and AYUSH doctors. A second study explored why some health workers remain in rural areas through 37 in-depth interviews conducted with clinical care providers in eight districts of Chhattisgarh, between June and August 2009. Among the reasons were: serving in their own communities/closeness to family, post-graduation opportunities, rural upbringing (most respondents were from a rural background), good schools (for children) in the area, personal values of service, professional interest in rural work, and opportunity for both spouses to work. The third study was a DCE analysis. Across all cadres the most important factors were salary increases, good clinical infrastructure, adequate workload and policies on leave. The most important contextual factors were living facilities, proximity to family, children’s development (education), security and connectivity (transport).
8. Moving forward

The meeting proposed to develop two main products. The first is the road map, which will be a collection of tools and methods to support implementation of rural retention strategies. It should bring together all available tools as well as additional tools that are under development or will be developed in the coming months, such as the DCE guide, the costing tool and the monitoring and evaluation framework. The second product will be the DCE guide, for which this meeting provided initial thoughts. After the meeting, a teleconference among the co-organizers established that the road map will be developed under the leadership of WHO, with contributions from the World Bank and Capacity Plus, whereas the DCE guide will be developed under the leadership of the World Bank, with contributions from Capacity Plus and WHO. An initial draft of the DCE guide will be available in early March 2011. For both products, comments and contributions are welcome from all participants.

It was also announced that a side meeting is being jointly organized by WHO and Capacity Plus during the Second Global Forum on Human Resources for Health in Bangkok, Thailand, 25–29 January 2011, to further advance on the road map and DCE guide discussions.
Annex 1: Agenda

Tools for implementing rural retention strategies: towards a Discrete Choice Experiment (DCE) “how to” guide

19–20 November 2010, Ramada Park Hotel, Geneva, Switzerland

Provisional agenda

Friday, 19 November 2010

Co-chairs: Christophe Lemiere, Jean-Marc Braichet

1400–1530

Session I: What policy-makers need and what research can offer

Objectives and expected outcomes of the meeting
(Carmen Dolea, HMR/HRH)

Challenges at country level in selecting and implementing rural retention strategies – the need for stronger research tools
(Elsheikh Badr, Sudan; Adriana Galan, Romania; Kim Webber, Australia)

Developing a roadmap for selecting and implementing the most appropriate rural retention strategies
(Christophe Lemiere, World Bank; Carmen Dolea, HMR/HRH)

General discussion

1530–1600 Coffee break

Session II: Using discrete choice experiments to inform rural retention strategies

Overview of the use of DCEs in human resources for health research and challenges for rural retention (Mylene Lagarde, LSHTM, Duane Blauuw, University of Witwatersrand)

Towards a “how to” guide for conducting DCEs at country level
(Moderated discussion: Marko Vujicic, World Bank; Mandy Ryan, University of Aberdeen)

1830–2030 Aperitif and dinner
**Saturday 20 November 2010**

**Co-chairs: Carmen Dolea, Jean-Marc Braichet**

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<th>Time</th>
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<td>0900–1030</td>
<td><strong>Session II: Using discrete choice experiments to inform rural retention strategies (continued)</strong></td>
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<td>Methodological and practical issues in using DCEs to inform rural retention policy – outline and content of a “how to” guide for conducting DCEs</td>
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<td></td>
<td>General discussion</td>
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<tr>
<td>1030–1100</td>
<td><strong>Coffee break</strong></td>
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<tr>
<td>1100–1230</td>
<td><strong>Understanding the workforce needs and situation in relation to rural retention</strong></td>
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<td></td>
<td>Qualitative methods for analysing the factors influencing choices for rural work – what can be done better? Lessons from the field (Luis Huicho, Peru; Fadi El-Jardali, Lebanon; Krishna Rao, India; Lingui Li, China)</td>
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<tr>
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<td>General discussion</td>
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<tr>
<td>1230–1330</td>
<td><strong>Lunch</strong></td>
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<tr>
<td>1330–1530</td>
<td><strong>Session III: Moving forward</strong></td>
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<tr>
<td></td>
<td>Next steps in adapting the research methods to policy-makers’ needs</td>
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<td>Next steps in developing “how to” guide for carrying out DCEs</td>
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<td>Next steps in developing a decision making toolkit for rural retention strategies</td>
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<td></td>
<td>Planning the side meeting of the 2nd Global Forum</td>
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<td>General discussion</td>
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<tr>
<td>1530</td>
<td><strong>Closure of the meeting: Manuel M. Dayrit</strong></td>
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</tbody>
</table>

*Increasing access to health workers in remote and rural areas through improved retention: Global policy recommendations can be found at [www.who.int/hrh/retention/guidelines/en/](http://www.who.int/hrh/retention/guidelines/en/)*
### Annex 2: List of participants

**Tools for implementing rural retention strategies: towards a Discrete Choice Experiment (DCE) “how to” guide**

19–20 November 2010, Ramada Park Hotel, Geneva, Switzerland

**Provisional list of participants**

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Tools for implementing rural retention strategies: towards a “how to” guide for “Discrete Choice Experiments” – A methods workshop

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