WHO Global Health Forum 2017

"Rural and remote retention: what does the evidence tell us?"

Updatng:
Increasing access to health workers in remote and rural areas through improved retention
Global Policy Recommendations 2010
Case studies: India & Kenya
Discussion

Chair Prof S. Strasser
Wednesday 15/11/17
Initial presentation: review of current literature.

Case studies:

• Making doctors serve in underserved areas: Findings from a review of regulatory measures across five Indian states
  
  **Dr Dilip Singh Mairembam**

• Improving recruitment and retention of medical & nursing staffs in difficult areas: Learning from Rajasthan, India.
  
  **Dr Rajnish Ranjan Prasad**

• Implementing a human resources information system in for effective health workforce decision-making at county level.
  
  **Dr Robert Nguni**

Discussion of paradoxes
Paradoxes for discussion focussed on retention:

- Public : private
- Female HC Providers need but no provision of child care
- Migration: LIC most in need yet greatest migration out
- Task shifting / role substitution or task sharing?
- ROS: short term recruitment but not long term retention
- Community engagement & empowerment: HPs come & go but communities stay.
- Oversupply: undersupply
- Cost: benefit – can’t afford not to

Please make a note of any additional paradoxes to discuss
"Rural and remote retention: what does the evidence tell us?"

Updating:
Increasing access to health workers in remote and rural areas through improved retention
Global Policy Recommendations 2010

Presented by Prof S. Strasser
On behalf of 31 collaborators
Wednesday 15/11/17
31 Collaborators:

Gary Bourke    David Campbell    Narelle Campbell    Bruce Chater
Hwee Sin Chong    Kaye Cummings    Jacky Cribb    Barb Doty    Di Eley
Jay Erickson    Mayara Floss    Jane Greacon    Katie Goote    Yvonne Jonks
Kean ‘Casey’ Khoo    Sri Kondalsamy-Chennakes    Margaret Lamb
Randy Longnecke    Matthew McGrail    Bushra Nasir    Davis Patterson
Riitta Partanen    David Shaker    Dave Schmitz    Sam Stevens
Ruth Stewart    Roger Strasser    Pat Stuart    Maree Toombs
George Tucker    Anne Tynan
Right person with the right skills in the right place at the right time supported by a sustained Health Care service and community.

One of their most complex challenges is ensuring people living in rural and remote locations have access to trained health workers. Skilled and motivated health workers in sufficient numbers at the right place and at the right time are critical to deliver effective health services and improve health outcomes. A shortage of qualified health workers in remote and rural areas impedes access to health-care services for a significant percentage of the population challenges the aspirations of achieving health for all.

Requires continuing effort to make it sustainable
"if you are to fix a problem, you have to acknowledge it." S. Duckett

Targeting zero: the review of hospital safety & quality assurance in Victoria 2016

Retention in the summary as key to department failure:

The department has become increasingly reliant on external consultancies when the work would have been done better, and more cost-effectively, had the department retained capacity to deliver it in-house. A recent capability review noted the department has struggled to retain talent, so that capable leaders are thinly spread.
3 commissioned reports: impact of compulsory service, realistic evaluation of an intervention & role of outreach support
2009 WHO Global recommendations:

The choice of interventions should be informed by an in-depth understanding of the health workforce. This requires, at a minimum, a comprehensive situation analysis, a labour market analysis, and an analysis of the factors that influence the decisions of health workers to relocate to, stay in or leave rural and remote areas. Giving due consideration to the broader social, economic and political factors at national, subnational and community levels that influence retention will help to ensure the choice of policy interventions are anchored in and tailored to the specific context of each country.
## Annex 1 level of evidence table

### Intervention heading & sub category

<table>
<thead>
<tr>
<th>Quality assessment</th>
<th>Summary of findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of studies and study reference</td>
<td>No. of participants/sample size</td>
</tr>
<tr>
<td>Targeted cadre of health worker</td>
<td>Value from a control group?</td>
</tr>
<tr>
<td>Design</td>
<td>Reported effects/outcomes</td>
</tr>
<tr>
<td>Limitations</td>
<td></td>
</tr>
<tr>
<td>Inconsistency</td>
<td></td>
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<tr>
<td>Intactness</td>
<td></td>
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<tr>
<td>Inspection</td>
<td></td>
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<tr>
<td>Other considerations</td>
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<td>Quality of evidence</td>
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</table>

<table>
<thead>
<tr>
<th>Availability*</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Competence</th>
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<table>
<thead>
<tr>
<th>Responsiveness</th>
<th></th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Unintended effects</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>None</td>
<td></td>
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</table>
Annex 2 Descriptive evidence table

<table>
<thead>
<tr>
<th>Category of intervention</th>
<th>Country</th>
<th>Intervention</th>
<th>Cadre(s)</th>
<th>Description</th>
<th>Study design and methods</th>
<th>Reported results</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retention intervention:</td>
<td></td>
<td>Educational;</td>
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<td></td>
<td></td>
<td>Financial;</td>
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<td></td>
<td></td>
<td>Regulatory;</td>
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<tr>
<td></td>
<td></td>
<td>Support (personal and Professional)</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
**RECOMMENDATION:** Insert the recommendation statement

**Population:** This is the target population to which the intervention is applied

**Intervention:** Insert a very brief description of the intervention

<table>
<thead>
<tr>
<th>Factors</th>
<th>Decision</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of the evidence</td>
<td>□ High</td>
<td>The higher the quality of the evidence, the stronger the recommendation.</td>
</tr>
<tr>
<td></td>
<td>□ Moderate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Low</td>
<td></td>
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<tr>
<td></td>
<td>□ Very low</td>
<td></td>
</tr>
<tr>
<td>Values and preferences</td>
<td>□ No variation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Significant variation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Small</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Large</td>
<td>This refers to the potential of the intervention to have large effects in terms of increasing the availability of health workers in rural or remote areas. The effects can be enhanced by combining with other interventions. Consider what are the possible associations (or “bundles”) that will enhance the effect.</td>
</tr>
<tr>
<td></td>
<td>□ Small effect for short duration</td>
<td></td>
</tr>
<tr>
<td>Resource use</td>
<td>□ Less resource-intensive</td>
<td>The resource needed for implementing the recommendation may comprise financial resources, human resources, and infrastructure or equipment. Ideally, the benefits of the intervention should come at reasonable, affordable and sustainable costs. One should consider that capital costs, such as for infrastructure development, even if initially high, may yield benefits in the long run.</td>
</tr>
<tr>
<td></td>
<td>□ More resource-intensive</td>
<td>The higher the incremental or recurrent costs, all other things being equal, the less likely it is to have a strong recommendation.</td>
</tr>
<tr>
<td>Balance of benefit versus disadvantage</td>
<td>□ Yes, globally</td>
<td>All interventions require political commitment and wide stakeholder engagement as a prerequisite. In addition, “technical” feasibility requires functional organizational and institutional structures necessary to manage, follow through, and monitor the implementation of the</td>
</tr>
<tr>
<td></td>
<td>□ Yes, conditionally</td>
<td></td>
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</tbody>
</table>

**Feasibility**

**Overall ranking:**

**Research gaps:**
- Consider types of health workers and settings for which there is a lack of evidence
- Consider stronger study designs and methods
- Consider potential synergies between interventions.
Right person with the right skills in the right place at the right time supported by a sustained HC service and community.

Research gaps:
- Study all types of health workers
- More research in low-income countries
- More well-designed evaluations
- Quality of the evidence – not only “what works”, but also “why” and “how”

Research agenda – research action plan

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### Table: Measuring the results of rural retention interventions

<table>
<thead>
<tr>
<th>CONTEXT: Social determinants, political situation, stakeholder power and interests, economic issues (fiscal space, fiscal decentralization), Individual factors (marital status, gender, age)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LEVEL</strong></td>
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</tbody>
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**Education, Regulatory, Financial incentives Professional & Personal support**
Search plan: Focus on retention and intervention with an evaluation:

5591 initial article abstracts,
Plus 64 reports, grey matter and PhD theses between 2010-2017
Removal of duplications, not relevant / best fit reduced to 3615

NB. Rural & remote rather than underserved

• 263+ articles on retention & reports/theses
• 100+ on recruitment,
• 200+ on digital health
• 466+ on education
• 100+ on community and patient initiatives
where have we got to: 2010......2017

<table>
<thead>
<tr>
<th>Research gaps in 2010:</th>
<th>In 2017:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study all types of health workers</td>
<td>✓ many different professionals and within a</td>
</tr>
<tr>
<td></td>
<td>group, different disciplines</td>
</tr>
<tr>
<td>More research in low-income countries</td>
<td>✓</td>
</tr>
<tr>
<td>More well-designed evaluations</td>
<td>?</td>
</tr>
<tr>
<td>Quality of the evidence – not only “what</td>
<td>✓Attrition &amp; retention</td>
</tr>
<tr>
<td>works”, but also “why” and “how”</td>
<td>?</td>
</tr>
<tr>
<td>Research agenda – research action plan</td>
<td>?</td>
</tr>
<tr>
<td>Argentina</td>
<td>Haiti</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>Australia</td>
<td>Honduras</td>
</tr>
<tr>
<td>Botswana</td>
<td>India</td>
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<tr>
<td>Bangladesh</td>
<td>Indonesia</td>
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<tr>
<td>Burkina Faso</td>
<td>Ireland</td>
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<tr>
<td>Cambodia</td>
<td>Japan</td>
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<tr>
<td>Canada</td>
<td>Kenya</td>
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<tr>
<td>Cuba</td>
<td>Lao</td>
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<tr>
<td>Ethiopia</td>
<td>Lebanon</td>
</tr>
<tr>
<td>Ghana</td>
<td>Lithuania</td>
</tr>
</tbody>
</table>

- Argentina
- Australia
- Botswana
- Bangladesh
- Burkina Faso
- Cambodia
- Canada
- Cuba
- Ethiopia
- Ghana
- Haiti
- Honduras
- India
- Indonesia
- Ireland
- Japan
- Kenya
- Lao
- Lebanon
- Lithuania
- Malawi
- Mali
- Mexico
- Mozambique
- Nepal
- Norway
- Pakistan
- Peru
- Portugal
- Rwanda
- Romania
- South Africa
- Sudan
- Taiwan
- Tanzania
- Thailand
- Turkey
- Uganda
- UK (Scotland & Wales)
- Uruguay
- USA
- West Africa
- Zambia
interventions work or not, why they work and in which context.

- difficult to attribute the improvement directly to a certain health workforce intervention.
- evaluations lack a baseline against which to assess the results, particularly in countries with a major health worker deficit
- lack of specific intervention logic that clarifies the expectations of the intervention designers
- the social, political and economic context in which interventions are designed and implemented is rarely considered in monitoring and evaluation of human resource interventions.
“How long is a piece of string?”
The lack of a standard definitions hinders research efforts.

• **Recruitment**: The human resource process of identifying, securing, and developing a pool of job applicants (Ratna & Chawla, 2012).

• **Retention**: The actions undertaken to encourage professionals to maintain employment with the organization for extended periods (Ratna & Chawla, 2012).

• **Rural**: Relatively small, scattered clusters of the population with poorly developed, fragile economic infrastructures and substantial physical barriers to health care (Douthit et al., 2015); a population of fewer than 500 inhabitants per square kilometer (Weinhold & Gurtner, 2014).

• **Urban**: A population of 500 inhabitants or more per square kilometer (Weinhold & Gurtner, 2014).

Flemming PhD thesis: Strategies for recruiting & retaining Rural ED Physicians July 2017
Synergy between different initiatives: Integrated approach to retention

Pitched against a backdrop of failed promises in rural areas, and the additional compounding influence of a number of variables which can lead to HP burnout.
Unrealistic expectations & unintended consequences

I am supposed to see or attend 300 patients. What if people in the communities hear that this is my target? I don’t know how they would feel. It could mean that we are praying for them to get sick so that we can achieve our targets. I don’t get the logic behind that. Should we go to the churches and mosques praying to get more patients? (AMO, district hospital, IDI).

Up to now there is nothing coming out of filling in the OPRAS form. It is just like an order. After every six months they tell us to fill it in and again. It is just a routine but it has no meaning. (AMO, district hospital, IDI).

Songstad et al 2012

Retention is influenced by social-contextual conditions in the immediate environment
Not a scaled down version of the city:

Many participants provided examples of policies or protocols developed in fully resourced urban environments that had a disproportionate effect on rural communities lacking a full complement of specialists, equipment and/or support staff. In some instances, the tone and tenor of specialist consultations and interactions with urban-based colleagues were less than desirable.

These negative experiences, as well as administrative challenges, appeared to be rooted in a limited understanding of rural health care delivery on the part of specialist physicians and services. This was frustrating for rural physicians, who are acutely aware of the resource limitations of their communities.

Some participants spoke of limiting the scope of practice because of lack of support, resources or confidence; this was cited primarily with regard to new physicians, both by them & about them.

Known by rural residents needs to be emphasized for city inhabitants. Snadden D et al 2017
‘onesize - fits-all’ policy for rural retention incentives does not work

Humphries et al through a DCE showed

25% no incentive would make a difference to stay or not – potentially pay more than need

27% of rural GPs would be more likely to stay with the new incentives

67% would choose to stay with new strongest incentives compared to their current status quo.

<table>
<thead>
<tr>
<th>Retention attribute</th>
<th>Levels of Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum relief guarantee</td>
<td>No paid locum relief\nGuaranteed paid locum 4 weeks in 12 months\nGuaranteed paid locum 6 weeks in 12 months</td>
</tr>
<tr>
<td>GP retention payments</td>
<td>No change in retention payments\n25% increase in payments\n50% increase in payments</td>
</tr>
<tr>
<td>Rural skills loading</td>
<td>No rural skills loading\n10% procedural and emergency/on-call rural skills loading\n20% procedural and emergency/on-call rural skills loading</td>
</tr>
<tr>
<td>Family isolation</td>
<td>No secondary school costs paid\n50% secondary school costs paid for children boarding away from home\n100% secondary school costs paid for children boarding away from home</td>
</tr>
</tbody>
</table>
Gulf between supply & demand

• The problem of attracting physicians to areas of dire need has reached a crisis point, especially in rural areas in the United States (Collins, 2016). Rural connotations often generate distasteful or scary notions, depending on the speaker or writer, and the audience. Weinhold and Gurtner (2014) stated that the term *rural* evokes wide-ranging images and associations, from small settlements to large unoccupied terrains, dependence on agriculture, severe living conditions, and secluded areas.

• Regardless of how they are classified, significant shortages of needed physicians exist in rural areas in many nations and regions (Wang, Su, Zuo, Jia, & Zeng, 2013).

• Fragmented evidence consist primarily of descriptive studies of individual hospitals...lack of empirical evidence about current retention strategies and the influence they have on actual rural practice Li et al. (2014).

Flemming 2017
Generational differences: newer physicians are working hard but working differently.

newer physicians valued:
- flexibility over scheduling and working arrangements that change over time;
- prioritizing work–life blend over remuneration;
- team-based,
- patient-centred care; and
- using technology to ensure information transfer.

Rural medicine remains exciting for many physicians, with collegial relationships, in-house mentorship and educational support found to improve confidence in its wide scope of practice.

Practices can allow flexibility for physicians in their work arrangements, yet there is limited flexibility in physician compensation and how clinics are run and funded.

This creates a disconnect for new physicians, who are trained differently only to graduate into a system that requires them to leave a large part of what they learned behind.

The transition from residency program to rural practice is supported by providing easy access to advice and addressing the tension between established practitioners and the aspirations of new physicians.

Experienced practitioners have a critical role to play in helping new practitioners understand the unique features of their communities.
Push & pull factors: *not going to remain in a rural area for an open-ended period of time.*

Lots of ideas:

- **Improve support**: technical, operational, career development, legal, and even moral support (e.g. improving communication and interaction with the regional office).

- **Targeted recruitment of physicians with rural backgrounds**: particularly those who are from the areas included in the Program, tailored career-development coaching for those who choose to stay in the rural areas,

- **Improved pre-deployment orientation** to better prepare for their roles and the introduction of a rural physician network.

- **Rural doctors network**: to facilitate communication and experience sharing and to advocate for greater political support for rural health issues.

- **Both administrative and clinical skills**: offer more opportunities for clinical updates and rotations into centers of medical excellence.
  - For those that see their future in more managerial roles, the currently offered Masters course in Public Management appears to be a good choice.

Leodardio et al 2012
Negative aspects

Metropolitan professional perspective drive “risk management strategies”: ‘concentrate delivery of these ‘minimum volume’ procedures and treatments within a designated set of “high volume’ centres.

Absence of reference to service downgrade & service closure from a remote & rural perspective and impact on retention

- Personal health outcomes – increased service accessibility: cost, relationships, residency
- Further disadvantage to populations already experiencing an inequitable gap in health status and outcomes, particularly our Indigenous peoples
- Remote and rural communities’ economic risks - absence of individual, family, business impacts employment, business and viability
- State/provincial economic burden:
  - Greater health service cost per capita for remote and rural residents accessing service in larger population centres
  - Opportunity cost of loss of economic development of remote and rural communities
Education/ retention intervention categories

A1. **Use targeted admission policies to enrol students with a rural background in education programmes for various health disciplines, in order to increase the likelihood of graduates choosing to practice in rural areas**
   - **Availability** (measured as % of health workers with a rural background currently practicing in rural area)

A2. **Locate health professional schools, campuses and family medicine residency programmes outside of capitals and other major cities as graduates of these schools and programmes are more likely to work in rural areas**
   - **Availability** (measured as % of health workers graduated from rural school currently practicing in rural area; % of graduates of family medicine residency programmes in rural area now practicing in a rural area)

A3. **Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas.**
   - **Availability** (measured as percentage graduates practicing in rural areas)
   - **Competence** (measured as perception of administrators of the effect on quality of care and knowledge test scores)
A4. Revise undergraduate and postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention

- **Availability** (percentage of graduates from a rural focused curricula school practicing in a rural area)
- **Competence** (comparison of exam results between rural curriculum students and mainstream medical students)

A5. Design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention

- **Availability** (measured as the reported importance of ongoing education and training to retention of primary health workers practicing in rural communities)
- **Competence** (measured as confidence in practicing in rural area)
Regulatory / retention intervention strategies

B1. Introduce and regulate enhanced scopes of practice in rural or remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.
- Competence (measured using health status and a number of quality of care indicators)
- Responsiveness (measured as patient satisfaction)

B2. Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practicing in rural and remote areas
- Availability (percentage of health workers working in rural areas after graduation)
- Competence (measured as health outcomes, change in health behaviour)

B3. Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives so as to increase recruitment and subsequent retention of health professionals in these areas
- Availability (measured as the percent of compulsory service physicians retained after their compulsory period in a rural area)
- Competence (measured as whether found the compulsory service improved competencies, or was professionally rewarding)
- Unintended effects: dissatisfaction over clinical supervision and work environment in rural areas

B4 Provide scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas to increase recruitment of health workers in these areas
- Availability (measured as retention and physician density)
- Responsiveness (measured as satisfaction of participants with their work and personal lives in underserved areas)
Financial incentives

C1. Use a combination of fiscally sustainable financial incentives such as hardship allowances, grants for housing, free transportation, paid vacations etc., sufficient enough to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers, to improve rural retention

- **Availability** (measured as retention; measured as proportion of health workers recruited to rural area; measured as retention rates)

- **Unintended effects** Dissatisfaction over classification of who is entitled to the financial incentive
Support strategies

D1: Improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools etc.) as these factors have a significant influence on a health worker's decision to locate to and remain in rural areas.

D2: Provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive, and thereby increase the recruitment and retention of health workers in remote and rural areas.

D3: Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, use telehealth to provide additional support to health workers in remote and rural areas.

- Availability (measured as perceived/reported impact on attractiveness of rural post)
- Responsiveness (measured as reduction in referral rates, improvement in care received and number of specialist consultations)
Support strategies cont.

- **D4:** Develop and support career development programmes and provide senior posts in rural areas so that health workers can move up the career path as a result of experience, education and training, without necessarily leaving rural areas
  - Availability measured as factors that would make a health worker choose a certain job post

- **D5:** Support the development of professional networks, rural health professional associations, rural health journals etc. in order to improve the morale and status of rural providers and reduce feelings of professional isolation
  - Availability measured as number of years in rural post; reduction in number of GPs wanting to leave rural post

- **D6:** Adopt public recognition measures such as rural health days, awards and titles at local, national and international levels to lift the profile of working in rural areas as these create the conditions to improve intrinsic motivation and thereby contribute to the retention of rural health workers
  - Availability measured as reported importance of recognition for health workforce motivation and retention
New issues for Retention research:

- Work disability
- ESL, social & cultural factors; delivering ‘in language’ care
- Task shifting, support, supervision & training
- Primitive living conditions, poverty, privilege & community context
- Lack of high quality staff and impact on teams/ work colleagues
- Corruption – no longer being ‘swept under the carpet’
- Critical incidents that over-ride any intention to stay or retention strategy
- Integrated intervention over the life cycle of HPs in rural & remote – comprehensive framework that everyone commits to use for implementation, evaluation & comparison
Case studies:

• Making doctors serve in underserved areas: Findings from a review of regulatory measures across five Indian states
  
  Dr Dilip Singh Mairembam

• Improving recruitment and retention of medical & nursing staffs in difficult areas: Learning from Rajasthan, India.

  Dr Rajnish Ranjan Prasad

• Implementing a human resources information system in for effective health workforce decision-making at county level.

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Discussion of paradoxes
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- Migration: LIC most in need yet greatest migration out
- Task shifting/role substitution or task sharing?
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- Oversupply: undersupply
- Cost: benefit – can’t afford not to
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Ruth Stewart     Roger Strasser     Pat Stuart     Maree Toombs
George Tucker     Anne Tynan
Increasing access to health workers in underserved areas: a conceptual framework for measuring results

Huicho et al, 2010
Incentives for different cadres

Crowding theory. Frey and Jegan in 2001
“extrinsic goals, coming from outside, can crowd out intrinsic goals where the person receives no apparent rewards except the activity itself”

Volunteer CHWs: the intrinsic motivation received from serving the community may result from a feeling that the work is worthwhile or from the satisfaction gained from achieving goals.

The assumption that an individual’s motivation can be increased simply by increasing the amount of material incentives appears therefore to be wrong.
motivation

• financial rewards,
• career development,
• continuing education,
• hospital infrastructure,
• resource availability,
• hospital management, and
• recognition

Working conditions vs. motivation to work

This work requires a calling. If one bases the work on the salary alone, then one would say ‘why worry with such little pay?’ But if the person is committed wholeheartedly to the serve the patients, then he/she can perform the work well even though the payment is poor. (Nursing Officer, district hospital, IDI)

Somgstad et 2012
“CHW’s are most effective when supported by a clinically skilled health workforce, particularly for maternal health, and deployed within the context of an appropriately financed primary health care system.

However, CHW’s have also notably proven crucial in settings where the overall primary health care system is weak, particularly in improving child and neonatal health. They also represent a strategic solution to address the growing realization that the shortages of highly skilled health workers will not meet the growing demand of the rural population. As a result, the need to systematically and professionally train lay community members to be part of the health workforce has emerged not simply as a stop-gap measure, but as a core component of primary health care systems in low-resource settings.”

Limitations of studies

- Lack of awareness of guidelines; too many frameworks and systematic reviews telling us nothing new; fragmented research
- No baseline data, lack of data, lack of monitoring
- Lack of discussion on impact, awareness raising & comparisons between countries, lack of pulling it altogether making it easier to implement.
- Lack of coherent policy at the national level to enable an equitable set of policy interventions across the different regions.
- Future context may not being addressed:

Broader knowledge required including creative decision making, critical thinking, management, and finances; to deal with a diverse and multicultural workforce and patient population.