Report on the first core group expert consultation on increasing access to health workers in remote and rural areas through improved

6-7 April 2009
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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 April 2010, are being developed by a group of more than 30 international experts on health workforce rural retention. During their first meeting in Geneva 2-4 February the Expert Group 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: http://www.who.int/entity/hrh/migration/report_core_group_rural_retention.pdf.

A smaller group has emerged from this first meeting, called the “core group” that agreed 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.

The expected outcomes of the core group expert meeting were:

- to refine policy and research questions for which recommendations will be developed
- to agree on templates for:
  - recording existing studies and building the evidence tables
  - conducting new country case studies
- to agree on a draft outline of the recommendations
- to agree on a plan of action for the coming months, including:
  - additional research needs (including methodologist for quality of the evidence)
  - list of countries for new case studies

This report presents a synthesis of the presentations and discussions from the meeting. The provisional agenda, list of presentations, and the list of participants are given in Annex 1, 2 and 3, respectively. In addition, a web-based platform for information exchange has been established by the Health Workforce Migration and Retention Unit, to host information related to the development of the recommendations for increasing access to health workers in remote and rural areas¹. Documentation related to the production of the recommendations, as well as other materials of relevance for the group, including a calendar of events, are posted here.

¹ http://ezcollab.who.int/retention
Key research and policy questions

The big questions for the meeting were: given what is already known about rural retention, what else needs to be known to begin effective implementation at country level? What should the recommendations look like? What is the scope of those interventions? And to what categories of health workers are they addressed?

The desired outcome of having health workers in remote and rural areas depends on two interrelated aspects. The first relates to whether health workers want to be there, and there is a large body of literature on why people go to, stay in or leave a rural location. The second aspect relates to whether the health system creates the conditions for health workers to choose rural areas and for them to stay. A literature search that informed the background paper for the first meeting of the expert group identified three main categories of interventions: education and regulatory interventions; direct and indirect financial incentives; and management, environment and social support (http://www.who.int/hrh/migration/background_paper_draft.pdf).

Broadly speaking, the key research and policy questions are: what works and why? What doesn’t work and why? Additionally, given that the implementation of the policies are dependent on an individual country’s political and social context, we are also examining how policies can be successfully implemented, and what are the critical success factors.

Some more specific questions are:

- What is the role of different factors in influencing health workers’ choices of location and how best can they be identified? How do they vary by category of health worker?
- How should effective retention interventions be designed and implemented to improve staffing of rural health facilities?
- What are the pre-requisites for the design and implementation of retention strategies?
- How effective are different health workforce retention interventions in influencing health worker location?
- How can the effect of retention strategies be measured and evaluated?

It is well understood that there are significant knowledge gaps in this area that will take a long time to fill. According to a systematic review published by the Cochrane Collaboration2, “while some of these strategies have shown promise, this review found no well-designed studies to say whether any of these strategies are effective or not. Rigorous studies are needed to evaluate the true effect of these strategies to increase the number of health care professionals working in underserved areas”.

Given that the quality of the evidence on which to base recommendations is not strong, what can realistically be expected of the recommendations? The aim of the group is to assess in a transparent and systematic manner what exists in terms of evidence, and to use additional information, including from other types of contextual analysis, to produce broad recommendations that can be adapted at country level, as a function of local context and situation. As time progresses, these options can be reviewed, refined and made more robust. There should also be a focus on implementation, on the “how to” elements of setting up and implementing retention schemes that can respond to country needs and expectations.

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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. Each expert responsible for an area of work gave a short update on the status of their work, followed by open discussions.

**HR Management systems and HR managers**

This area may bring confusion in the terms used. Two major aspects were discussed. The first relates to the *competencies required by health managers*. Not enough attention is paid to human resource (HR) management skills even though HR managers play a critical role in creating and implementing retention strategies. Most managers of rural health services are doctors or nurses or non-physician clinicians with no formal training in HR management.

The second area relates to the *HR management system*. Such a system comprises professionally qualified HR managers and staff in effectively supported HRH units that recruit, deploy, implement retention schemes, use workforce data to plan and manage staff, and assist with budgeting and supporting the health workforce. HR management system strengthening work is often confused with general management and leadership development, but should be separate. Both are necessary. At present, the HR management system that supports and sustains retention interventions remains weak and dysfunctional in most countries. Any efforts to improve rural retention – especially when it comes to scale up – that fail to address weaknesses in the HR management system will eventually fail.

**Health workers retention and coverage of disease-specific programmes**

There is a largely untapped, but potentially relevant source of information from disease-specific programmes. All the major vertical programmes are acutely aware that an inadequate health workforce is the most important constraint to better outcomes. For example, poor TB control is intimately linked to workforce issues in general and to rural retention in particular. The most recent global plan of action for TB control calls on countries to develop strategic and operational plans for health workforce development, including plans to improve rural retention. Data from the disease-specific programmes could be examined to better understand why some remote and rural areas have been successful in retaining health workers and why others have not.

**Studies in progress – what is new?**

A few members of the core expert group presented updates on studies in progress that promise to contribute a wealth of timely and relevant information for the development of the recommendations.

**Sub-Saharan African Medical Schools Study (SAMSS)**

The objectives of this study are to generate understanding regarding the status, trends, capacity building and retention efforts of medical education in sub-Saharan Africa. The 18-month study is due to be completed by March 2010. The innovations in retention that will be part of the study include: increasing the number of faculty; attracting research funds; acclimatizing students early on to rural service; recruitment from and training in rural areas; regionalization and collaborations (twinning); and presence/absence of retention regulations (e.g. compulsory service).

**Positive Practice Environments Campaign**

The country case studies that are being undertaken as part of the Positive Practice Environments Campaign will have at least one section devoted to retention in rural areas. Positive practice environments are settings that: ensure the health, safety and personal well-being of staff; support the provision of quality patient care; and improve the motivation, productivity and performance of individuals and organizations. The objectives of the campaign are to raise the awareness,
understanding and support of all relevant stakeholders; apply the PPE principles; offer a global platform; stimulate the sustained establishment of PPEs; and recognize PPE settings. The first wave countries include Morocco, Uganda, and Zambia.

**Regional perspectives**

There were presentations on additional evidence from China, India, South America and Australia.

**China**

China has embarked on a national project (co-shared by the Ministry of Health and the Ministry of Finance) with three main objectives. The first is to address the severe shortage of licensed doctors in township hospitals in remote and rural areas. The second is to attract and encourage licensed doctors to work in rural areas, and the third is to explore a long-acting mechanism of attraction and retention for rural health institutions. In 2008 the central government established a fund for the project, which will pay a special compensation to licensed doctors recruited to hospitals in poverty-stricken areas where there was no licensed doctor and an official vacant post. The five-year programme will run until 2013.

**India**

India is well into the implementation phase of the National Rural Health Mission, which is being funded by the central government and not by individual states. In the past three years, more than 75,000 health workers have been added into the public health system. Three factors affect poor densities of public sector health workers in India: not enough facilities have been created; not enough posts have been sanctioned in existing facilities; and not enough candidates have been attracted or retained in posts that have been created. Experience to date has shown limited effect with bonding and compulsory strategies in India. Rural service as pre-qualification for admission to post-graduate training has been effective in most states, but there have been problems with the quality of service delivery and a transient workforce. Other approaches or strategies have been tried with some impact, such as contractual appointments, a simpler process of recruitment, better compensation packages and financial incentives, promotions and cadre restructuring.

**Latin America and Caribbean**

A preliminary assessment of retention strategies in rural and remote areas of Latin America and the Caribbean has been conducted. Several “bundled” and single retention strategies have been implemented or are soon to be implemented in countries in the region. There is sound evidence to support task shifting, but studies on incentives, for example, are urgently needed at country level. In general, there is a scarcity of implementation and evaluation studies. Evaluation of impact of the different strategies must accompany implementation efforts at country level. There is also a need to develop indicators to measure the adequacy of implementation and the impact of different strategies. Moreover, studies should be extended beyond doctors and nurses to include other cadres, such as community health workers.

**Australia**

Australia has a 40-year history of attempting to address the shortage of health workers in rural areas – and not many success stories to share. Its current strategy is to target its programmes and eligibility requirements over the lifespan of the health worker: high school students, university students, registrars and interns, urban general practitioners interested in rural practice; rural general practitioners; and overseas trained doctors. Although considerable support is available to current and future general practitioners in rural areas of Australia, the government has stated that the rural workforce shortage is the number one problem for rolling out primary health care.
Europe – rural doctors professional associations

In addition, there was a presentation about the activities of the Institute Rural Health UK (www.irh.ac.uk), the European Rural and Isolated Practitioners Association (EURIPA) and the Wonca Working Party on Rural Practice. The purpose was to share the European rural health perspective, and to forge links between WHO and Wonca/EURIPA. The Working Party on Rural Practice, which was formed in Vancouver in 1993, includes 20 members from all the regions: Europe, Asia, Africa, North America, South America, and Australasia/Pacific. It has developed a number of policies, statements and declarations as well as an action plan for rural health (www.globalfamilydoctor.com). EURIPA’s mission is “To ensure that all the rural and isolated populations in Europe have access to high quality health care irrespective of location, culture or resource”. Members of this European network of rural practitioners are committed to raising the profile and credibility of rural health issues; identifying and sharing good rural practice; establishing rural research; and establishing rural health as a specific “discipline”. The Rural and Remote Health journal is available at http://rrh.deakin.edu.au.

Interventions and questions

This section highlights some of the interventions and questions from the discussions that followed the three parts of Session I – Update on progress from the core expert group.

- We can acknowledge all of the weaknesses of the existing evidence but that should not prevent us from pursuing our goal – it’s not going to be perfect. We must be modest with our objectives.
- What competencies do managers need in order to improve rural retention?
- Does a formal qualification in HR actually make a difference in improving rural retention? What is the evidence base to support the position that a stronger HRM system improves rural retention?
- How are we going to compile all the information into a database?
- Use a framework across the lifespan of the health worker instead of the three categories of interventions.
- In terms of the categorizations of interventions, there were a few requests to separate education from regulation (at the moment the two are grouped together).
- Given that interventions are so culture and society specific, it is going to be difficult to generalize.
- We will need to look at processes and especially consider the issue of unintended consequences. We do not want to lose sight of the overall implications of what is being recommended.
- Strategies that have been tried and failed should not be abandoned. Instead, they need to be taken apart and put back together in a different way, informed by the knowledge of why they didn’t work in the first place. An intervention that didn’t work in one context may work in a different context.
- We need to go back and re-examine the literature in order to deepen our understanding of both successful and unsuccessful rural retention interventions – at the policy level and in the implementation of the policy.
- Retention starts from recruitment phase and not just at deployment, thus the role of curricula (community-based) and the location of schools (rural) need to be examined.
- The group should survey relevant policies and activities of non-government organizations, faith-based organizations and the private sector, especially in places where one or more of these sectors has been successful, but the state sector has not. Much of their experience in trying to retain rural health workers has not been documented so interviews or workshops may be needed.
Randomized control trials reveal what works but not how or why it works. There is a need for a better way to deal with complex interventions like those related to retaining a health workforce in remote and rural areas where context is important in determining the outcome.

We need standard definitions of terms such as access. And to be clear on what exactly we want to measure.

**Approaches for assessing the evidence**

There appears to be broad support among the core expert group for using the realistic review approach to assessing the evidence, as a tool to build the knowledge base about how and why a given intervention works. Realist inquiry views interventions as a set of complex social and behavioural activities that need to be described and understood. The research question becomes “what is it about this program that works for whom in what circumstances” instead of “what works”.

**The realist review approach**

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. Examples include feeling obliged to change, being motivated, or feeling frustrated.

The suggestion is to first review studies of similar interventions in different contexts and different interventions in similar contexts and then to synthesize the evidence, identifying patterns related to:

- What mechanisms (reactions) were triggered by the interventions and why and what was intended to happen?
- Which contextual factors contribute to success or failures of interventions

Answers to these questions will lead to tailor made/context specific recommendations.

**Systematic approach to develop new case studies and to assess the evidence**

One of the expected outcomes for the meeting is to agree on templates for recording existing studies, building the evidence tables and for conducting new country case studies.

A draft template had been prepared prior to the meeting, but it was agreed that there was not enough time to finalize it during the meeting. Many suggestions were made especially about making it shorter, more focused on rural retention, and more open to qualitative analysis. People were asked to provide additional comments by email by mid April. The revised template is presented in Annex 3. In addition, there are some 35 studies being led by WHO and the World Bank that are focused on comprehensive assessments and evaluations of rural retention interventions. To date, 12 have been completed, 17 are either about to start or are underway, and 6 proposals are being seriously considered. The studies cover 30 countries across the 6 WHO Regions, including 19 countries with an HRH crisis. The protocol for these studies is to work with countries from the beginning, to plan, to undertake the study, to analyse available data, to take a coordinated approach to evidence gathering, and to avoid overlap.

**Draft outline of the recommendations**

Much of the second day of the meeting was spent discussing the draft outline of the recommendations. Members of the core expert group offered many concrete and helpful suggestions on all of the sections. These included the need for a strong statement upfront on the magnitude of the problem and the link to primary healthcare, social justice and equity, as well as a vision statement, a description of objectives, purpose and methods, and definitions. There was general agreement that the headings should change to more accurately reflect the content of the section. Outcomes should include the MDGs. The target audience should be policy makers across government in all relevant sectors, HRH
leaders at all levels, civil society, NGOs, community representatives and researchers. As to the question of whether or not to include community health workers, it was decided that it would depend if there was some amount of formal training involved. It was also agreed that monitoring and evaluation should be part of, and not separate from, the recommendations on implementation. This will reflect the essential need for learning by doing. A revised outline is proposed in Annex 4.

Next steps

Participants were asked to submit their comments on the documents presented, mainly the draft country template and the draft outline of the recommendations. It was mentioned that the exchange platform on EZCollab was available for experts to post documentation, and start discussion groups. Also, specific discussions will take place with various experts to finalize the research work. The next meeting of the full expert group, to be held on 29th June -1st July in Geneva, will discuss the additional research and the revised draft outline of the recommendations, in the light of the current evidence, and taking into account the values, benefits and risks for the proposed recommendations.
## Plan of action for the coming months

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<th>Expected product</th>
<th>By when</th>
<th>Area leader and partners</th>
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| **Case studies** | Common template for case studies  
Inventory of current and planned case studies | By April  
By April 2009 | WHO to draft template  
WB and WHO – joint list of country case studies |
| **Expanded and structured database of studies in different languages and for different cadres** | Expanding database (using common template for assessing the evidence)  
Synthesis of existing evidence | End June 2009  
End August 2009 | WHO to draft template  
Luis Huicho (LAC)  
Gilles Dussault (Portuguese papers)  
Junhua Zhang, D.Y., G.Z – China  
Sundararaman – India  
Kim Weber - Australia  
Thinakorn Noree – Thailand  
J. Wynn-Jones – Wonca  
F. El-Jardali – EMRO  
Mireille Kingma (PPE)  
WHO/M. Dieleman, S. Frehywot, T. Sundararaman |
| **Quality and strengths of the existing evidence** | Review the current evidence using the realist inquiry approach | End June 2009 | WHO/M. Dieleman, S. Frehywot, T. Sundararaman |
| **Impact conceptual model and monitoring framework** | Conceptual framework for monitoring and evaluation, including impact and outcome indicators | End April | Luis Huicho, Marjolein Dilelemen, Laurence Codjia, Jim Campbell, WHO |
| **Reinforcing studies in progress and refining some of the research methods** | Africa Medical Schools study  
Trinity College studies  
Toolkit for conducting DCEs | End Nov 2009  
End June 2009 | Seble Frehywot  
Charles Normand  
Marko Vujicic, K Webber (DCE Test) |
| **Fill some evidence gaps** | Review of compulsory service  
Impact of competency based training on practice in rural areas  
Impact of teamwork and supervision on job satisfaction  
Impact of management on HW performance and retention  
Competences needed by health managers to improve retention  
Impact of weak HRM systems on attraction /retention of HW  
Discussion paper on above | End Aug 2009  
September 2009  
End June | Seble Frehywot  
Barbara Stilwell  
Barbara Stilwell  
Joseph Dwyer/Marjolein Dieleman/Fadi El-Jardali/D. Dovlo/G. Allen-Young/Jim McCaffery |
| **Costing of interventions** | Estimates of costs of various interventions | End June 2009 | WHO/K. Webber/ Jim Campbell/WB |
| **Drafting the recommendations** | Second draft outline  
1st Draft recommendations  
1st Draft implementation toolkit | End June 2009  
September 2009  
September 2009 | WHO/WB |

* The “area leader” (in bold in the table) is understood to be the person(s) that have competency in the area, is (are) willing and able to commit personal time to do the work under the specific area, and is willing to coordinate the other members of that area so that the expected products are finalized in time for the upcoming meetings.
## Calendar for the recommendations

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<td>1st Core group expert meeting</td>
<td>2nd full expert group meeting</td>
<td>2nd Core group expert meeting</td>
<td>Thematic Workshop</td>
<td>3rd Full expert group meeting</td>
<td>Launching of recommendations</td>
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**Review plan of action**
- Draft first outline of recommendations
- Assess progress on activities by area of work
- Review the draft outline of recommendations

**Assess progress on areas of work**
- Begin drafting the recommendations

**Exchange country experiences**
- Pre-test draft outline of recommendations/draft recommendations?

**Second draft of recommendations**
- Start peer review process

**More than just launching? Advocacy event?**

| 6-7 April, Geneva | 30 June – 1 July, Geneva | 20-21 October TBD | 17-20/23-26 November TBD | TBD | TBD |
ANNEX 1. Provisional agenda

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

First core expert group meeting
6-7 April 2009
Room M105, World Health Organization, Geneva

Provisional agenda

Monday, 6 April 2009

08:30 Registration

09:00 Welcome and introduction

Welcome and opening remarks
Jean-Marc Braichet, Health Workforce Migration and Retention Unit, WHO

09:10 Review of the plan of action and policy questions
Carmen Dolea, Health Workforce Migration and Retention Unit, WHO

09:30 General discussion

10:00 Session I – Update on progress from the core expert group

Chair: Marko Vujicic, World Bank

Filling of evidence gaps

Impact of management systems on rural health workforce, Jim McCaffery
Competencies required by health managers, Fadi El-Jardali
Priority programmes and rural retention, Karin Bergström

11:00 – Coffee break

11:30 Update on studies in progress

Africa medical schools study, Seble Frehywot
Africa health workforce motivation studies, Charles Normand
Positive Practice Environments Campaign, Mireille Kingma
Update on case studies by WHO and the World Bank, Daniel Shaw

12:10 Moderated discussion

13:00 – Lunch break

14:00 Session I – Update on progress from the core expert group (continued)

Chair: Kim Webber, Rural Health Workforce, Australia

Additional evidence from regions

Guanpeng Zhang, Ministry of Health, China
Thiagarajan Sundararaman, Ministry of Health, India
Luis Huicho, Universidad Peruana Cayetano Heredia, Peru
Kim Webber, Rural Health Workforce, Australia

14:50 Moderated discussion

15:30 – Coffee break
Session II – Templates and approaches for assessing the evidence

Chair: Fadi El-Jardali, American University of Beirut, Lebanon

16:00 Templates for reviewing the evidence and for case studies
Laura Stormont, Health Workforce Migration and Retention Unit, WHO

16:20 Realist Review approach for assessing the evidence
Marjolein Dieleman, Royal Tropical Institute, Amsterdam, the Netherlands

16:40 Moderated discussion

17:30 End of day one

18:00 Cocktail
WHO staff lounge, 8th floor

Tuesday, 7 April 2009

09:00 Session III – Draft outline of the recommendations

Chair: Charles Normand, University of Dublin, Trinity College, Ireland

Summary of Day One
Joanne McManus, Consultant, Oxford, UK

09:15 Typology of countries – producing context-relevant recommendations
Paolo Hartmann, Country Focus, WHO

Draft outline of the recommendations
Carmen Dolea, Health Workforce Migration and Retention Unit, WHO
Christophe Lemiere, World Bank

Moderated discussion

11:00 – Coffee break

11:30 Session III – Draft outline of the recommendations (continued)

Chair: Charles Normand, University of Dublin, Trinity College, Ireland

Moderated discussion on drafting the outline of recommendations (continued)

12:30 – Lunch break

14:00 Session IV – Plan of action and next steps

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

14:00 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

14:15 Moderated discussion

15:30 – Coffee break

16:00 Upcoming meetings and brainstorming
Agenda for expert meeting in July
Thematic workshop in November
Brainstorming for the launch of the recommendations

17:00 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: http://www.who.int/hrh/migration/core_expert_consultation

Day 1

Review of the plan of action and policy questions - Carmen Dolea
http://www.who.int/entity/hrh/migration/hmr_core_expert_dolea.pdf

Impact of management systems on rural health workforce - Jim McCaffery
http://www.who.int/entity/hrh/migration/hmr_core_expert_mccaffery.pdf

Priority programmes and rural retention - Karin Bergström
http://www.who.int/entity/hrh/migration/hmr_core_expert_Bergstrom.pdf

Africa medical schools study - Seble Frehywot
http://www.who.int/entity/hrh/migration/hmr_core_expert_frehywot.pdf

Positive Practice Environments Campaign - Mireille Kingma
http://www.who.int/entity/hrh/migration/hmr_core_expert_positive_practice.pdf

Update on case studies by WHO and the World Bank, Daniel Shaw
http://www.who.int/entity/hrh/migration/hmr_core_expert_shaw.pdf

Recruiting Licensed Doctors for Township Health Centers in Remote & Rural Areas - Guanpeng Zhang
http://www.who.int/entity/hrh/migration/hmr_core_expert_zhang.pdf

Retaining skilled health Human Resources for Rural and Remote areas: a mapping of efforts under NRHM and ongoing studies in this area - Thiagarajan Sundararaman
http://www.who.int/entity/hrh/migration/hmr_core_expert_retaining_skilled_hr.pdf

Retention strategies in Latin America: a preliminary overview - Luis Huicho
http://www.who.int/entity/hrh/migration/hmr_core_expert_huicho.pdf

Realist synthesis of retention interventions: practical application - Marjolein Dieleman
http://www.who.int/entity/hrh/migration/hmr_core_expert_dieleman.pdf

Templates for reviewing the evidence and for case studies - Laura Stormont
http://www.who.int/entity/hrh/migration/hmr_core_expert_stormont.pdf

Day 2

EURIPA & Wonca: European Rural and Isolated Practitioners Association – John Wynn-Jones
http://www.who.int/entity/hrh/migration/hmr_core_expert_dolea_d2.pdf

Plan of Action – Jean-Marc Braichet and Carmen Dolea
http://www.who.int/entity/hrh/migration/hmr_core_expert_euripa_wonca.pdf
ANNEX 3: Provisional list of participants

First core expert group consultation
Increasing access to health workers in remote and rural areas
through improved retention
6-7 April 2009, World Health Organization, Geneva

Technical Advisers

Allen-Young, E. Grace
Permanent Secretary
Ministry of Health and Environment
2-4 King Street
Kingston, W.I.
Jamaica
Tel: +876 967 1078
Fax: +876 967 1303
Email: rupyoung@cwjamaica.com
Email: blairs@moh.gov.jm

Campbell, Jim
Integrare S.L.
Aribau, 69, 2°-1a
08036 Barcelona
Spain
Tel: +34 934 530 788
Fax: +44 (0) 870 763 0263
Email: jim.campbell@integrare.es

Codjia, Laurence
Technical Officer, GHWA
World Health Organization
20 Avenue Appia
Switzerland
Tel: +41 22 79 12360
Email: codjial@who.int
Email: sociosn@yahoo.fr

Dieleman, Marjolein
Royal Tropical Institute
PO Box 95001
Mauritskade 63
1090 HA Amsterdam
The Netherlands
Tel: +31 20 5688658
Tel: +31 71 5137095
Fax: +31 20 568 8677
Email: m.dieleman@kit.nl

Ding, Yang
Tel: +86 10 5993 5224
El-Jardali, Fadi
Assistant Professor and Acting Chair
Department of Health Management and Policy
American University of Beirut
Riad El Solh
1107 2020 - Beirut
Lebanon

Tel: 01-350000 ext. 4692
Email: fe08@aub.edu.lb

Frehywot, Seble Lemma
Assistant Research Professor Health Policy and Global Health
The George Washington University-SPHHS
The Dept of Health Policy & The Dept of Global Health
2021 K Street, NW, Suite 800
2175 K Street, NW, Suite 810
Washington, D.C.
United States of America

Tel: +1 (202) 994-4311
Email: seblelf@gwu.edu

Huicho, Luis
Universidad Peruana Cayetano Heredia
Batallon Libres de Trujillo 227
L133 Lima
Peru

Tel: +51 1 993481121
Fax: +51 1 4314013
Email: lhuicho@gmail.com

Kingma, Mireille
International Council of Nurses
Consultant, Nursing and Health Policy
3, place Jean Marteau

Tel: +41 22 908 0100
Fax: +41 22 908 0101
Email: canedo@icn.ch
Lemièrè, Christophe
Health Specialist
The World Bank
1818H St. N.W.
20433 - Washington, D.C.
United States of America
Tel: +1202 473 1000
Email: clemiere@worldbank.org

McCaffery, James
Senior Advisor for Technical Resources
The Capacity Project/TRG
Chapel Hill and Washington
United States of America
Email: jmccaffery@capacityproject.org

McManus, Joanne
Consultant
105 Howard Street
Oxford
OX4 3AZ
United Kingdom
Tel: +44 (0) 1865 722880
Fax: +44 (0) 1865 727602
Email: joanne.mcmanus@yahoo.co.uk

Noree, Thinakorn
Researcher
International Health Policy Program
Ministry of Public Health
Tiwanon Road
Nonthaburi 11000
Thailand
Tel: +66-2 5902396
Fax: +66-2 5902385
Email: thinakorn@ihpp.thaigov.net

Normand, Charles
Edward Kennedy Professor of Health Policy and Management
University of Dublin
Trinity College
Email: charles.normand@tcd.ie
3-4 Foster Place
Dublin 2
Ireland

**Sundararaman, Thiagarajan**
Executive Director
National Health Systems Resource Centre
I/II Taj Apartments,
Rao Tula Ram Marg, Moti Bagh,
New Delhi 110022
India

Tel: +91 0995831755
Email: sundararaman.t@gmail.com

**Vujicic, Marko**
Health Economist
The World Bank
1818H St. N.W.
20433 - Washington, D.C.
United States of America

Tel: +1202 473 1000
Email: mvujicic@worldbank.org

**Webber, Kim**
CEO, Rural Health Workforce Australia
Rural Health Workforce Australia
Suite 1, Level 6
10 Queens Road
Melbourne Vic 3004
Australia

Email: kim.webber@rhwa.org.au

**Wynn-Jones John**
President EURIPA
Life President Institue of Rural Health
Gregynog Hall
Tregynon
Newton
Powys, SY16 3PW
United Kingdom

Tel: +44 168 66 50 800
Fax: +44 168 66 50 300
Email: johnwj@irh.ac.uk

**Zhang, Guangpeng**

Email: mht@moh.gov.cn
Division Director
Health Human Resources Development Centre
Ministry of Health
3 Huoqiying Road, Haidian District
Beijing, 100097
China

WHO Technical Resources

Bergstrom, Karin
TB Strategy and Operations
World Health Organization
20 Avenue Appia
Switzerland
Tel: +41 22 791 4715
Email: bergstromk@who.int

Braichet, Jean-Marc
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland
Tel: +41 22 791 2391
Email: braichetj@who.int

Celletti, Francesca
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland
Tel: +41 22 79 14403
Email: cellettif@who.int

Chaouachi, Amel
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland
Tel: +41 22 79 14240
Email: chaouachia@who.int
Dal Poz, Mario R.    
Human Resources for Health  
World Health Organization  
20 Avenue Appia  
Switzerland  
Tel:+41 22 791 3599  
Email:dalpozm@who.int

Dolea, Carmen  
Human Resources for Health  
World Health Organization  
20 Avenue Appia  
Switzerland  
Tel:+41 22 791 4540  
Email:Doleac@who.int

Dovlo, Delanyo  
Health Policy, Development and Services  
World Health Organization  
20 Avenue Appia  
Switzerland  
Tel:+41 22 791 1465  
Email:dovlod@who.int

Hartmann, Paolo  
Country Focus  
World Health Organization  
20 Avenue Appia  
Switzerland  
Tel:+41 22 791 2735  
Email: hartmannp@who.int

Kabra, Rita  
Consultant  
Human Resources for Health  
World Health Organization  
20 Avenue Appia  
Switzerland  
Tel:  
Email: rita.kabra@gmail.com

McLellan, Faith  
Research Policy and Cooperation  
World Health Organization  
20 Avenue Appia  
Switzerland  
Tel: +41 22 791 3522  
Email: mclellanf@who.int
Mercer, Hugo
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland

Tel:+41 22 791 3749
Email:mercerh@who.int

Nkowane, Mwansa
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland

Tel:+41 22 791 4314
Email:nkowanemwansa@who.int

Novarina, Valérie
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland

Tel:+41 22 791 5836
Email: novarinav@who.int

Samb, Badara
Health Systems and Services
World Health Organization
20 Avenue Appia
Switzerland

Tel: +41 22 791 4452
Email: sambb@who.int

Schmets, Gerard
Health Policy, Development and Services
World Health Organization
20 Avenue Appia
Switzerland

Tel: +41 22 791 13420
Email: schmetsg@who.int

Shaw, Daniel
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland

Tel:+41 22 791 1458
Email:shawd@who.int
**Stormont, Laura**
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland

Tel:+41 22 791 2940
Email: stormontl@who.int

**Straume, Karin**
Consultant
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland

Email: straumek@who.int

**Yan, Jean**
Human Resources for Health
World Health Organization
20 Avenue Appia
Switzerland

Tel:+41 22 791 1049
Email: yanj@who.int

**Zurn, Pascal**
Human Resources for Health
World Health Organization
20, Avenue Appia
Switzerland

Tel: +41 22 7913776
Email: zurnp@who.int
ANNEX 4: Revised draft template for country case studies

19/05/2009

Introduction
This template can be used either as a draft outline for any new country case studies, or, in another format, as a tool to record existing (published/unpublished) papers, articles, or reports into a larger database, that will eventually form the basis for the recommendations (the “evidence tables”). Its main purpose is to facilitate the collection of information on contextual factors and on mechanisms used for the design, implementation and evaluation of an intervention, so that an informed statement can be made about the success/failure of such intervention. And so that users in others countries have sufficient data about an intervention(s) to determine whether or how it might work in their own context. It can also help arrive at a categorization of countries, based on different characteristics proposed below, so that the eventual recommendations are made in relation to the category of country, and not as a general “fit-for-all” solution.

The content of this template can be adapted then both for data collection instruments for new studies, and for data extraction sheets for constructing the evidence tables. The evidence tables are requested by the WHO Guidelines Review Committee (GRC), as a proof of the fact that the process to get the evidence was transparent, systematic and comprehensive.

In addition to the information below, and to respond to the requests of the GRC, an intervention should also be described according to the four characteristics below (PICO):

\[ P \_ = \text{target population of an intervention} \]
\[ I = \text{intervention} \]
\[ C = \text{comparison} \]
\[ O = \text{outcomes} \]
A. Country overview (concise)

a. Country socio-economic and political context, focusing on rural/urban disparities
   
i. Country characteristics:
   1. geographical (small island states [multi or few], land-locked, mountainous, etc)
   2. socio-political (federal state, post-conflict state, (ex)colonial status, etc), focusing on rural geography
   3. languages and ethnic groups
   
ii. GDP per capita in urban and rural areas
   
iii. Poverty rate (urban and rural if available)

b. Demographics and major health indicators
   
i. Total population and rural-urban population ratios
   
ii. Life expectancy at birth and other indicators of health status, by rural and urban if possible

B. Health systems overview

a. Priority health problems as identified by the national health policy and/or health sector strategic plan (in particular related to the MDGs), particularly identifying any rural/urban differentials
   
i. HIV/AIDS prevalence, TB, etc
   
ii. Maternal mortality ratio
   
iii. Infant mortality rate
   
iv. Chronic disease incidence

b. Major policy drivers of the national health policy
   
i. Primary health care
   
ii. Millennium Development Goals

c. Financing of the health system
   
i. Models: tax-based/social insurance
   
ii. Measures:
   1. Total health expenditure per capita – rural vs urban
   2. Total health expenditure as % of GDP
   
iii. Out-of-pocket / private financing

d. Decentralization policy
   
i. Administrative
   
ii. Financial

e. Policy on public/private health care

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3 In case where intervention focuses on a particular state/district, this information should be filled in again also for state/district, when relevant.
C. Human resources overview

a. National HRH strategic plan and policy
   i. What are the most recent policy documents in relation to HRH? Documents are owned by/involved which stakeholders?
   ii. Does an HRH strategic plan/policy exist? Is it being used, and if so, to what extent? Does it have rural specific sections or initiatives to specifically tackle rural and remote retention?
   iii. When was it developed/revised?
   iv. Does a rural health policy/plan exist? Does it focus on health workforce?
   v. How was it developed (multi-stakeholder process, inclusion of different actors, decentralisation policy, HRH Unit in MoH)?
   vi. What influenced its creation and how it was produced? Is there consensus or is there any significant alternative proposed
   vii. Highlight leadership and management qualifications / bring out training.
   viii. Does it cover main elements of
        1. planning,
        2. education/production and training
        3. recruitment/retention,
        4. monitoring and evaluation of the plan
        5. management and leadership.
   ix. Has it been costed? Using which methodology?
   x. Who is responsible for the governance and leadership of HRH?

b. Situation analysis
   i. What is the current capacity and status of HR information systems in rural and remote areas?
   ii. Total number of health workers and health worker density by
        1. cadre/speciality in rural vs urban;
        2. urban/rural rural vs urban
        3. public/private; age in rural vs urban
        4. gender;
   iii. What are the main HRH problems regarding the planning, education, retention, management of health workers in rural and remote areas etc
   iv. Health labour market indicators related to retention (by urban/rural and public/private if possible) (explained how are they defined)
        1. Vacancy rates
        2. Turn-over rate
        3. Stability rates
        4. Attrition rates
        5. Absenteeism
        6. Unemployment rates (specifically highlight if there is a surplus in urban areas)
        7. Salaries/relative salaries

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4 In case where intervention focuses on a particular state/district, this information should be filled in again also for state/district, when relevant.
D. Recruitment and Retention overview

a. Situation analysis of factors affecting motivation and retention of health workers in rural and remote areas
   i. Methods used for the factor analysis (discrete choice experiments, focus groups, key informant interviews, semi-structured questionnaires etc)
   ii. Main factors affecting choices of location (intention to go to, stay in or leave remote and rural areas)
   iii. Main factors affecting motivation of health workers in remote and rural areas

b. Description of the existing rural and remote recruitment and retention policy/policies:
   i. Which category (education/regulatory, financial, management and environment support)
   ii. When introduced (year)
   iii. At what level was it introduced (National, rural and remote only district or facility etc)?
   iv. Why and how was it introduced (government initiative, donor initiative, civil society push, response to strikes, part of general HRH strategy etc)
   v. Who is implementing it (government/nationwide or district level, private sector, NGOs, FBOs)
   vi. What was the source(s) for design and implementation of the policy (internal working group, evidence review, etc)
   vii. What cadre(s) are covered by the intervention
   viii. Short description of the intervention(s) and of its expected outcomes
   ix. Stakeholder mapping (Who are the stakeholders and what are their views?)
   x. What are the associated costs of the intervention and how are these costs being met by the government/development agencies etc?

c. Implementation issues
   v. Has it been implemented (where, to what extent)
   vi. Was there a baseline assessed? prepared before the evaluation?
   vii. What are the challenges for implementation/enforcement?
   viii. Is there a monitoring and evaluation component included
   ix. What do professions/unions/government/implementers think of this intervention?
   x. Have there been any negative aspects of this intervention?
   xi. Have there been any unexpected/unintended consequences of implementation
   xii. If done on a pilot or limited basis, what is the potential (and challenges) for scale up?

d. Evaluation issues
   xiii. Evaluation methods
      1. when was the evaluation conducted (in relation to completion of intervention) and by whom (were they independent from those implementing the policy?)
      2. study design: cross-sectional study, before and after survey
      3. data sources: documents review, satisfaction surveys for health workers and patients, semi-structured questionnaires health workers; analysis of routine HRH data
xiv. **Outcome measured**:  
1. vacancy rates before and after the intervention  
2. changes in the density of health workers per population before and after the intervention  
3. % health workers remaining in the areas as a consequence of the intervention  
4. increase in average length of stay of workers (e.g., increase in stability index)  
5. utilization rates in the areas of the intervention compared with non-intervention (or before and after the intervention)  
6. satisfaction of health workers within the strategy compared with those colleagues not included or of the same workers before and after the strategy  
7. patient satisfaction surveys before and after the intervention  
8. increase in entrants to rural and remote health workforce  
9. decrease in exits from rural and remote health workforce  
10. increase in length of stay of rural and remote health workforce  

**e. Results**  
Provide a summary of the main results of the evaluation / intervention (including unintended effects of the HRH policy, covering both positive and negative aspects etc)  

**f. Conclusions**  
Provide a summary of the main conclusions of the evaluation / intervention  

**g. Recommendations**  
Highlight the main recommendations made in the evaluation / study  

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5 This section will be revised once the impact evaluation framework will be finalized
ANNEX 5: Revised draft outline of the recommendations

Global recommendations on
Increasing access to health workers in remote and rural areas
through improved retention
Annotated Draft Outline, 19/05/2009

. Executive summary
. Summary of recommendations

A. Introduction and objectives
a. Health workers are key to deliver good quality health services that can improve health outcomes. But there are often insufficient numbers and types where most needed, which is in remote and rural areas, both in developed as well as in developing countries. The need for specific strategies to target the remote and rural areas is due to the need for health workers to be based in geographically isolated rural and remote areas. 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.
b. 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 (WHA57.19 and WHA59.23) requested Member States to put in place mechanisms to address the issue of retention of health workers. In March 2008, the Kampala Declaration 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 Communiqué 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
c. 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.

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8 http://www.who.int/workforcealliance/Kampala%20Declaration%20and%20Agenda%20web%20file.%20FINAL.pdf
9 http://www.g8summit.go.jp/eng/doc/doc080714__en.html
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, provider groups etc. HRH leaders and practitioners, 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, 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 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 describe and measure the problem

NOTE: 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.

[Outcome measures/measuring retention

a. 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—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)

b. 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.

a. 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)

b. 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

c. introduce a **categorization of countries/contexts** based on a series of criteria
   (geographical, economic or political aspects, health systems characteristics etc). Be
careful though on the potential negative implications of categorizing countries

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

<table>
<thead>
<tr>
<th>Category of intervention</th>
<th>Examples</th>
</tr>
</thead>
</table>
| **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) |
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 (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)
   The time dimension needs to be considered. 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
   a. Methods for evaluation – outcome measures. This section will be informed by the work of the small group looking into this issue
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)
- ….

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)