Developing the WHO Global Policy Recommendations on “Increasing access to health workers in remote and rural areas through improved retention"

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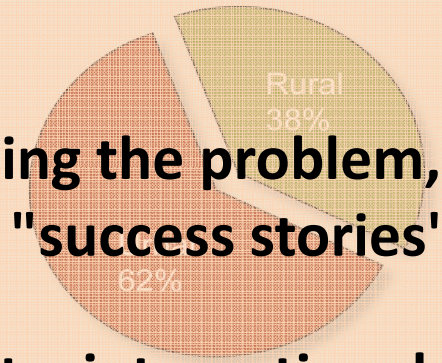
Outline

- Context: why these guidelines?
- Process: how did we go about it?
- Key findings
- Challenges for implementation and next steps (*more on this on Thursday*)

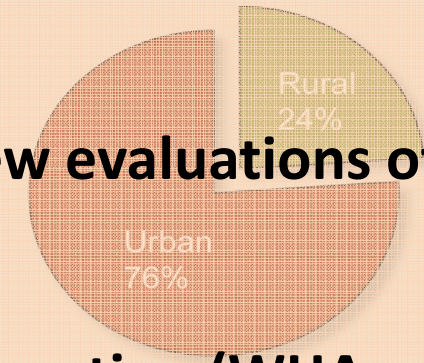
Why does access to health workers in rural areas matter?

- **Having local access to a health worker is critical for health outcomes**
- **Rural/urban imbalances are a matter of concern for both developed and developing countries**
- **Much research on describing the problem, very few evaluations of what works and why, few "success stories"**
- **Increased political interest – international calls for action (WHA resolutions, GHWA Forum/Kampala, G8)**

United Nations, *World Urbanization Prospects - The 2007 revision*



World Health Organization, *The World Health Report 2006 - Working together for health*



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Why "recommendations"? (the WHO Guidelines Review Committee process)

- "Recommendation/guideline" implies that a course of **action** needs to be taken AND that **progress** can be measured against a set baseline
- "Policy option" may remain "optional", not easy to measure success or progress
- **Systematic, explicit, and transparent approaches can help:**
  - **protect against errors,**
  - **resolve disagreements,**
  - **facilitate critical appraisal and**
  - **communicate information**

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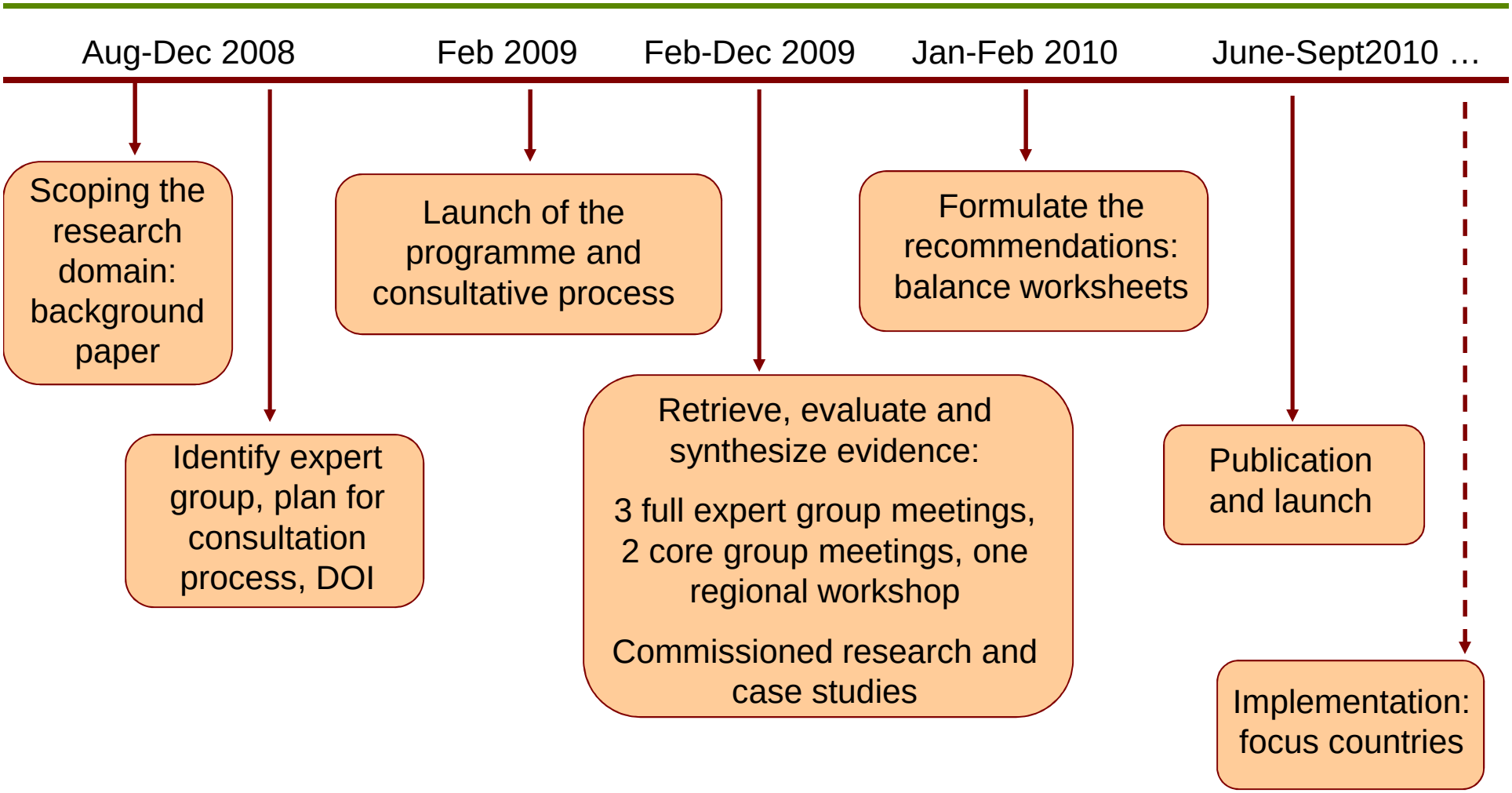
How did we go about it?



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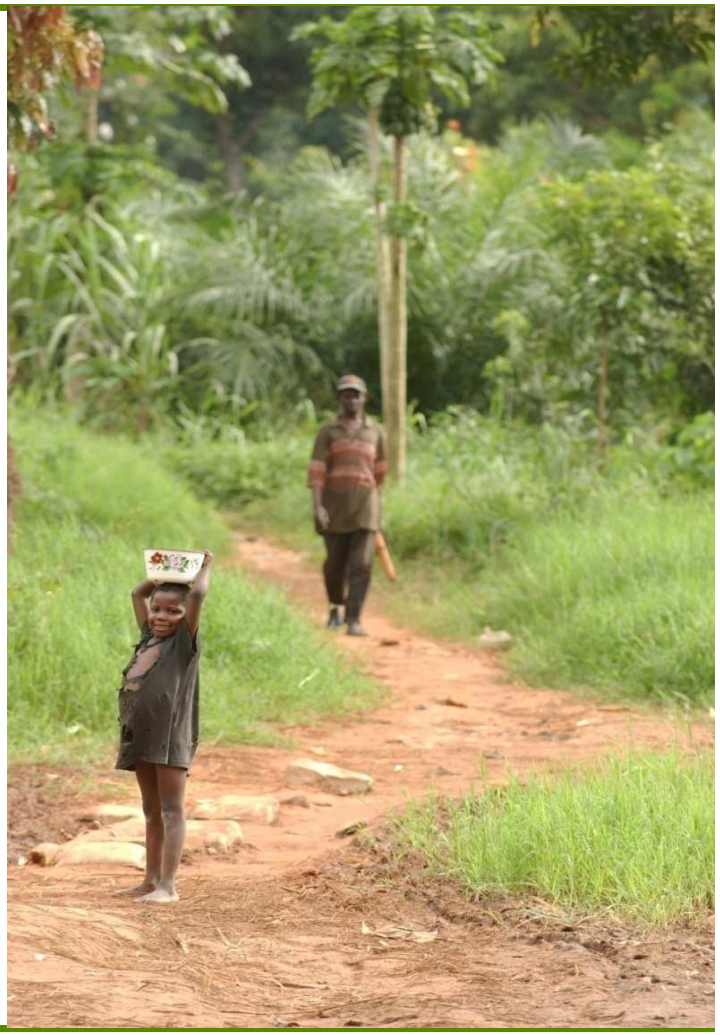
Access to health workers in remote and rural areas depends on two inter-related aspects

- **Factors influencing decisions/choices of practice location:**
  - Why people go to, stay in or leave rural and remote areas

- **Health system's responses:**
  - Education interventions
  - Regulatory interventions
  - Direct and indirect financial incentives
  - Management, environment and social support

Source: Lehmann et al, 2008, WHO, 2009



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Key research and policy questions

1. **What is the role of different factors in influencing health workers' choices of location and how best can they be identified?** *(No recommendation, but key principle for implementation - key component of the situation analysis)*
2. **How effective are different interventions in influencing health worker location?** *(all 16 recommendations)*
3. **How should effective retention interventions be designed and implemented to improve staffing of rural health facilities?** *(No recommendation, but chapter 4 on choosing, implementing and monitoring)*
4. **How can the effects of retention strategies be measured and evaluated?** *(No recommendation, but chapter 4 on choosing, implementing and monitoring)*

- What works and why?
- What doesn't work and why?

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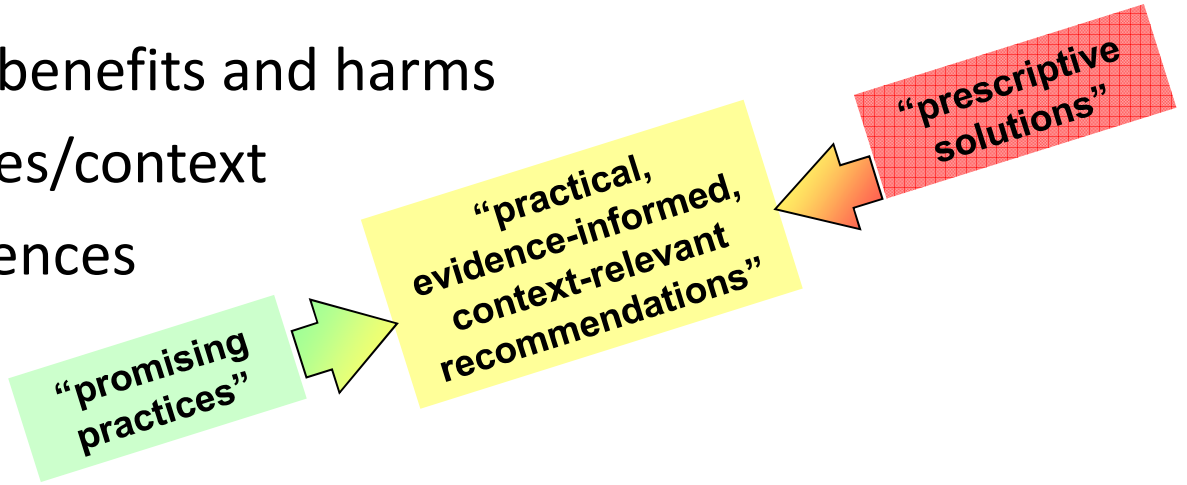
Formulating the recommendations: differences between "evidence" and "recommendations"

- **It is possible to make <u>strong recommendations</u> with only <u>low quality of the evidence</u>**

- **Recommendations are judgments, reflecting:**
  - Quality of evidence
  - Balance between benefits and harms
  - Local circumstances/context
  - Values and preferences
  - Resource use
  - Feasibility



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The 16 WHO global policy recommendations

Category of intervention	Examples
A. Education	A1 Students from rural backgrounds
	A2 Health professional schools outside of major cities
	A3 Clinical rotations in rural areas during studies
	A4 Curricula that reflect rural health issues
	A5 Continuous professional development for rural health workers
B. Regulatory	B1 Enhanced scope of practice
	B2 Different types of health workers
	B3 Compulsory service
	B4 Subsidized education for return of service
C. Financial incentives	C1 Appropriate financial incentives
D. Professional and personal support	D1 Better living conditions
	D2 Safe and supportive working environment
	D3 Outreach support
	D4 Career development programmes
	D5 Professional networks
	D6 Public recognition measures

Education interventions: the “rural pipeline”

Support of rural HWs: nurturing the RIGHT ENVIRONMENT

- ✓ Career ladders for rural health workers (D4)

Postgraduate training: creating the RIGHT OPPORTUNITIES

- ✓ Rural residency programmes (A5)

Undergraduate training: getting the RIGHT CONTEXT

- ✓ create schools outside major cities (A2)
- ✓ rural clinical placements in rural areas (A3)
- ✓ changes in curricula (A4)

Student selection: choosing the RIGHT PEOPLE

- ✓ targeting admission of students from a rural background (A1)

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Regulatory interventions: different types of health workers or different contractual arrangements

- Compulsory service: not always effective (needs reinforcement and heavy administration)
- Enhancing the scope of practice for rural health workers: more duties and responsibilities, but not always accompanied with adequate rewards
- Clinical officers are a potentially good solution:

Box 5. "Técnicos de cirurgia" in Mozambique

Mozambique began to educate and train assistant medical officers with surgical skills called "técnicos de cirurgia" in 1987. Twenty years later, a study found that 88% of all the "técnicos" who graduated in 1987, 1988 and 1996 were still working in district hospitals, compared with only 7% of medical officers who were originally assigned to district hospitals after graduation. Considering that these "técnicos" perform 92% of all major obstetrical surgical interventions in rural hospitals, the authors argue that provision of emergency obstetric care in these areas would be "impossible" without them *(60)*.

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Financial incentives: how much is "large enough" and for how long?

- **Australia:** 65% retention rates after five years for a financial support programme for rural doctors
- **Malawi:** 52% salary top-ups for 11 cadres, after 5 years 30% more nurses and 100% increase in number of doctors.
- **Zambia:** after 2 years, 50 new doctors where previously none.
- **Niger:** after two years, no change in the proportion of doctors and rural surgeons choosing rural areas.

- *The appropriate amount of financial incentives should be gauged in relation to the opportunity costs for health workers: labour market analysis and discrete choice experiment studies*

Personal and professional support most likely to work, yet very little done for it

- **Mali's strategy to encourage young doctors to work in rural areas:**
  - Started in 1986: public, private or hybrid contract for young doctors going to rural areas
  - Initial training in rural medicine, accommodation, equipment and transportation means, plus an installation package
  - Encouraged to join the Rural Medical Association and be part of a peer-learning and support network
  - In 2008, 150 new rural doctors, of which 115 have joined the Association
- **WHO Evaluation mission (April 2008) showed encouraging results:**
  - 1.5 million people now having access to a doctor-led health team
  - Increased use of services
  - Increased patient satisfaction
- **Altruism/committed spirit versus personal interest**

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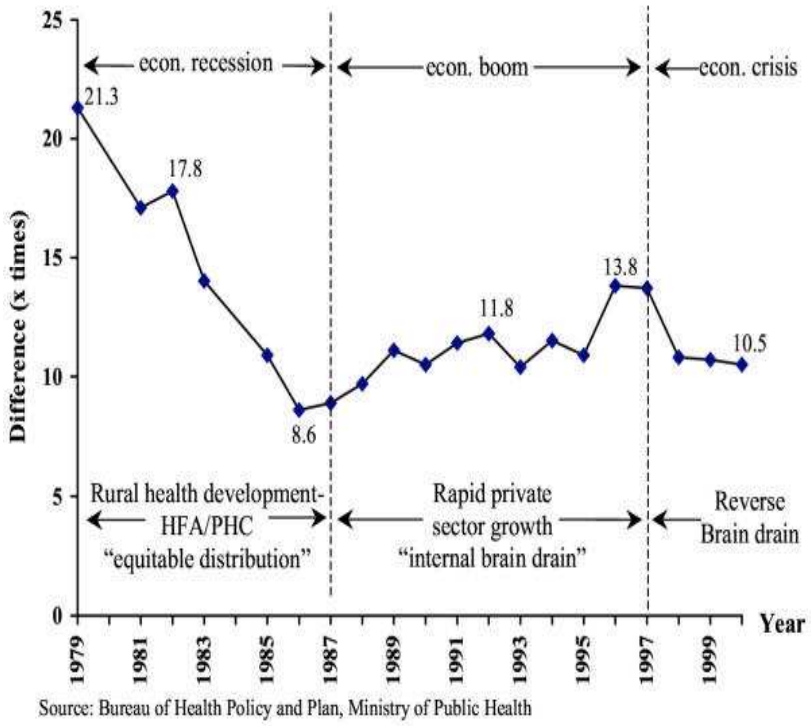
Promoting multiple strategies: the case of Thailand

Significant differences between the Northeast and Bangkok population-to-doctor ratios



Source: Wibulpolprasert S, 2003

Strategies that worked:

- **Regulatory:** compulsory contract of 3 years of public work after graduation
- **Economic:** rural development project and financial incentives
- **Education:** rural recruitment and training in rural health facilities; development of community medicine
- **Managerial:** personnel management
- **Social**: movement for rural development

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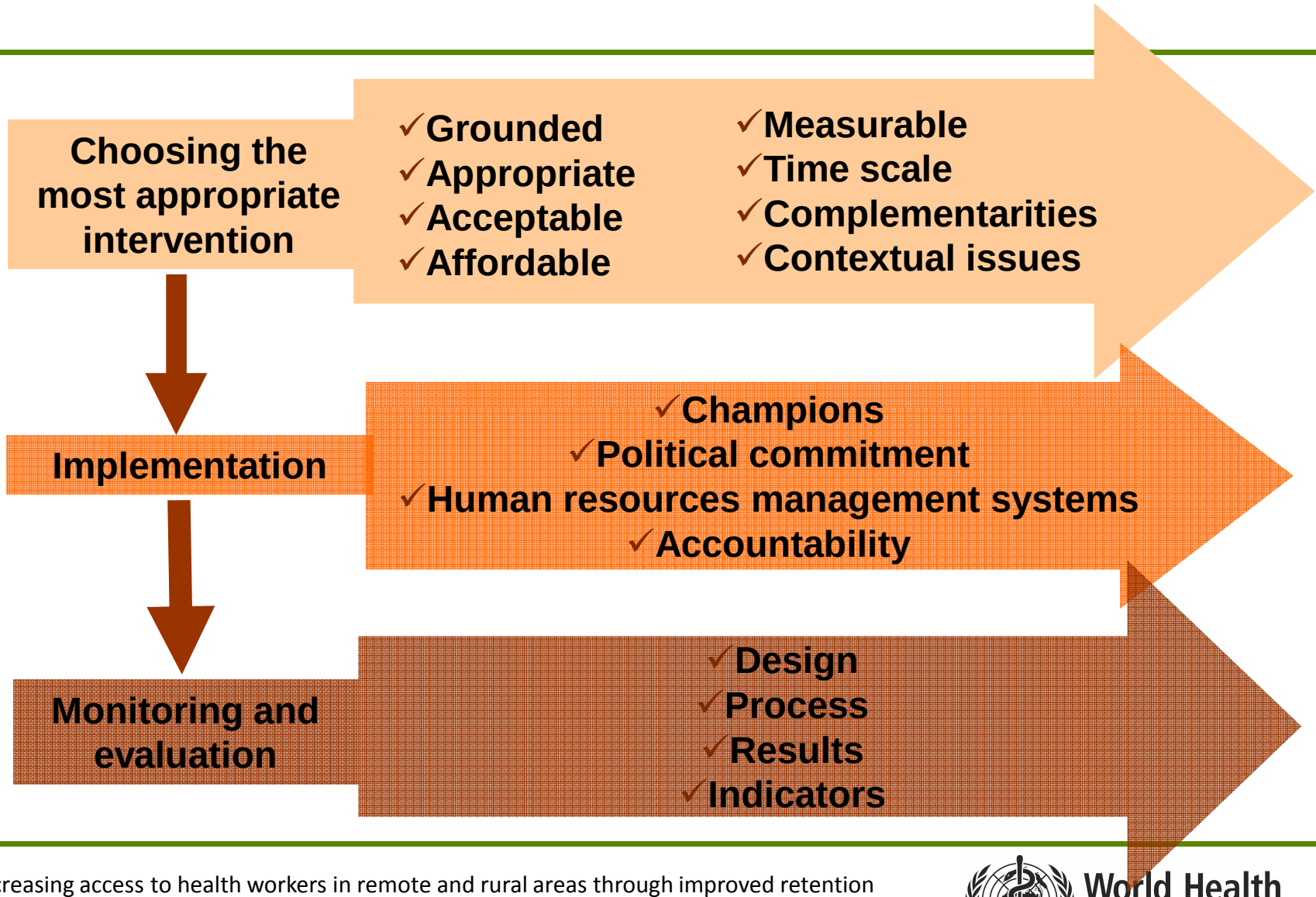
Taking the recommendations into action



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Outcomes of interest

Figure 4. Measuring the results of rural retention interventions

CONTEXT: Social determinants, political situation, stakeholder power and interests, economic issues (fiscal space, fiscal decentralization), individual factors (marital status, gender, age)

LEVEL	INPUTS (design and implementation)	OUTPUTS	OUTCOMES	IMPACT
DIMENSIONS	• Situation analysis, including factors influencing decisions for rural work • Labour market analysis • Organization and management capacity • Choice of relevant interventions • Stakeholder engagement • Resources needed	**Atractiveness** Preferences for rural work ↓ **Recruitment** Effective contracting and posting ↓ **Retention** Health workers remaining in rural areas for certain periods of time	**Workforce performance** - Availability - Competence - Responsiveness - Productivity **Health systems performance** - Accessibility (coverage of interventions) - Productivity - Responsiveness	**Improved health service delivery** **contributing to** **improved health status**

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Situation analysis: measuring the scope of the problem

- **Rural/urban ratios:**
  - Bangladesh: 30% of nurses are located in four metropolitan districts where only 15% of the population lives
- **Vacancy rates:**
  - Tanzania: 60% of posts for personnel with nursing skills vacant
- **Absenteeism:**
  - Peru: 28% absenteeism in Peru's hospitals
- **Unemployment/underemployment:**
  - South Africa: 35,000 unemployed registered nurses, despite 32 000 vacancies
- **Dual employment:**
  - Uruguay: the average number of jobs held by a physician is 2.6
- **Strikes:**
  - Bolivia: Health workers on strike between 4 to 10 weeks per year over the last 5 years

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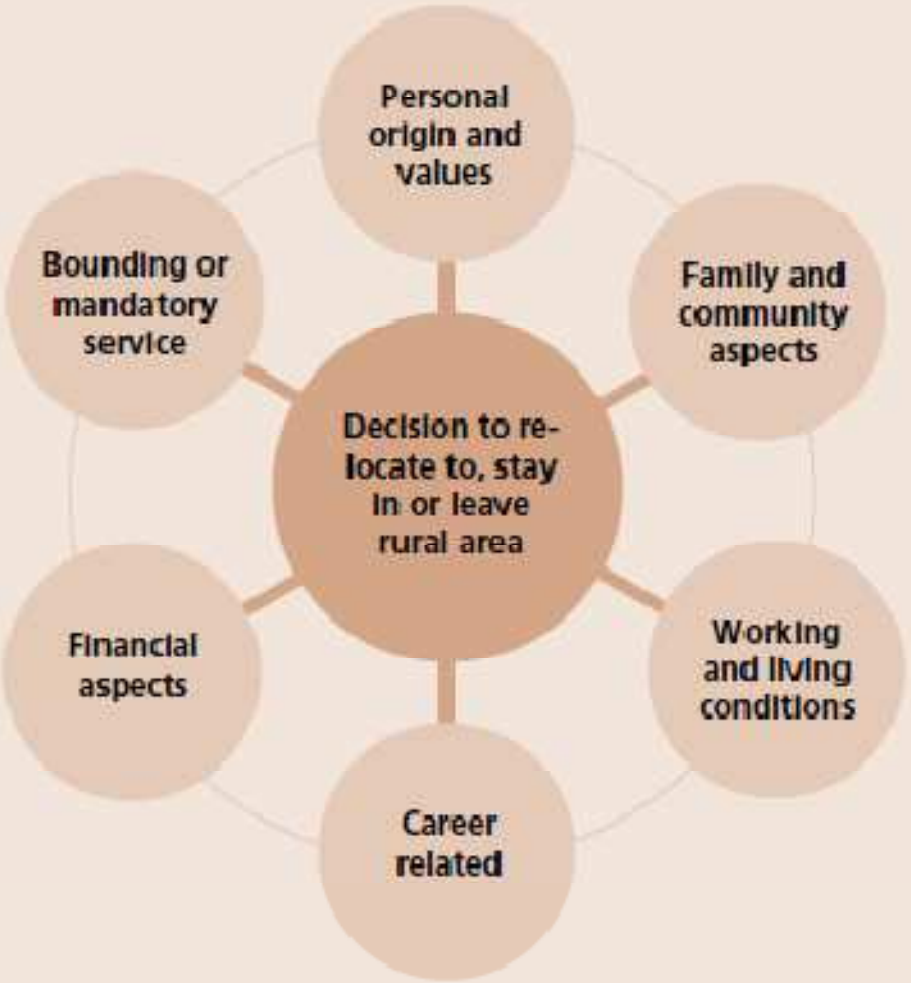
Understanding the health workers: factors affecting the decisions for practice location



Personal
Rural background (origin), values, altruism

Family and community
Provision of schooling for children, sense of community spirit, community facilities available

Financial aspects
Benefits, allowances, salaries, payment system

Career related
Access to continuing education opportunities, supervision, professional development courses/ workshops etc, senior posts in rural areas

Working and living conditions
Infrastructure, working environment, access to technology/medicines, housing conditions etc

Bonding or mandatory service:
Whether obligated to serve there

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Challenges for implementation and future revisions

- **Choice of most appropriate strategies:**
  - Political will and leadership, coordination, health system strengthening
  - Relevance of strategies, contextual issues, bundles, costs and benefits
- **Implementation at country level:**
  - Time effect, sustainability, coordination
- **Evaluations and impact assessment:**
  - How do we know there is a “success”:
    - indicators, outcome measures, information systems
    - attribution of effects

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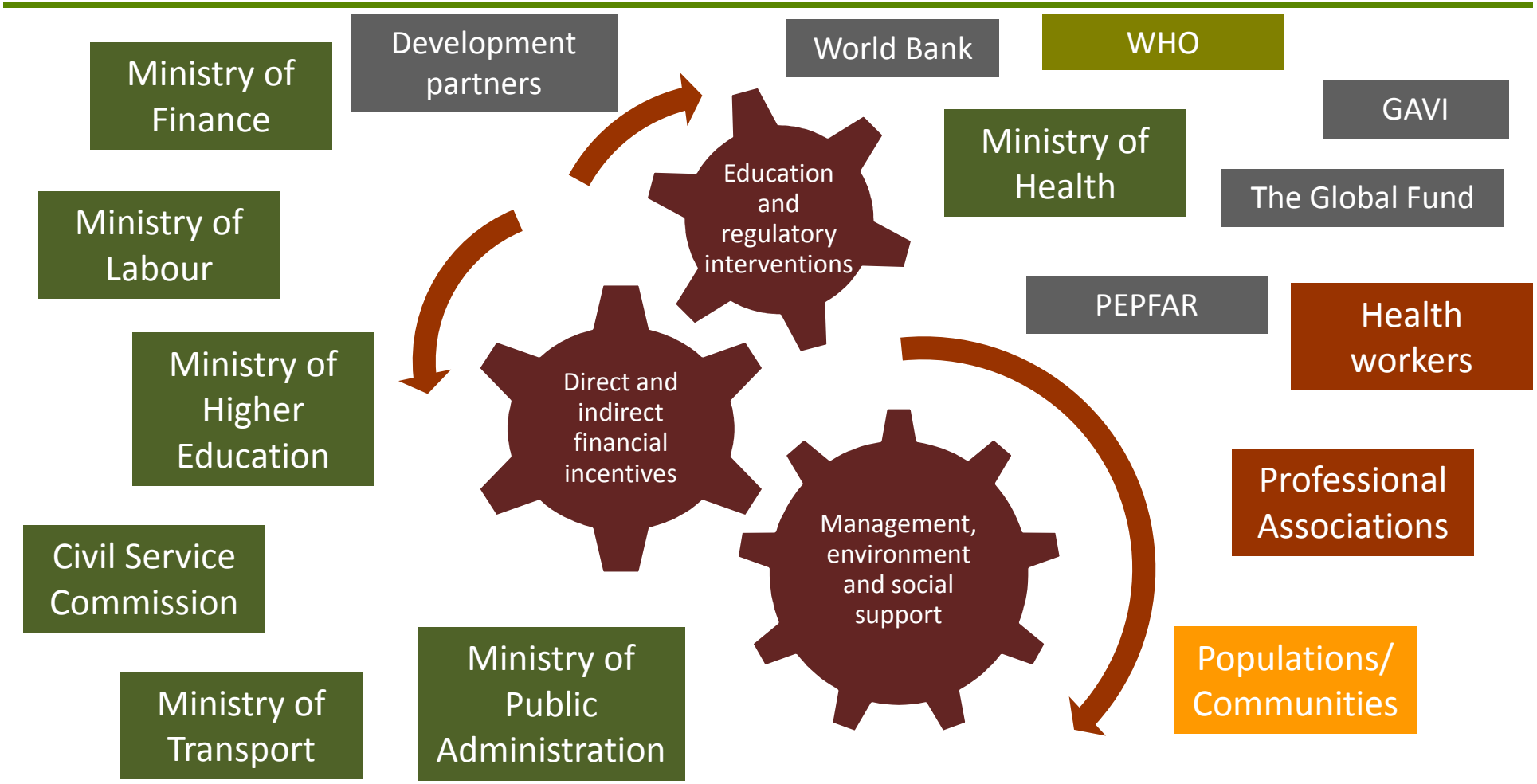
A complex issue in a complex environment



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Thank you for your attention !

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