



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

Geneva, 2 – 4 February 2009



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Table of contents

Introduction	1
The big picture	2
Scope of the recommendations	3
What works	4
Methodology issues	4
What are the main evidence gaps.....	6
Next steps	7

Annexes

Annex 1 – Agenda.....	11
Annex 2 – Group work questions and expected outcomes.....	13
Annex 3 – List of presentations.....	15
Annex 4 – List of participants	16



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.

More than 30 international experts on health workforce rural retention (the Expert Group) met in Geneva to map out a plan of action to develop evidence-based recommendations for publication in April 2010.

The main functions of the Expert Group are:

1. to identify and support the collection of evidence
2. to advise on the interpretation of the evidence, with explicit consideration of the overall balance of risks and benefits
3. to advise on the choice of important outcomes for decision making and developing recommendations
4. to formulate recommendations, taking into account diverse values and preferences
5. to contribute to writing sections of the guidelines and other relevant background documentation.

The recommendations will constitute one of three interdependent pillars upon which the new rural retention programme is based. The other two pillars will be to gather and share evidence and to support countries in implementing effective health workforce retention strategies in rural and remote areas.

Opening the meeting, WHO Assistant Director General Carissa Etienne emphasized the importance of developing recommendations that will have a real effect at country level: "This is why, from the very beginning of the process, we are integrating a focus on the eventual implementation of recommended strategies, to ensure maximum impact where it is needed most."

The main objectives of the three-day meeting were:

6. to critically examine the state of the evidence on this issue and identify evidence gaps
7. to identify the key research questions that the guidelines will provide answers for
8. to agree on a categorization/framework for the effective retention strategies
9. to identify methodological challenges and propose solutions
10. to propose next steps in filling the evidence gaps, including specific arrangements for the process of developing the global recommendations.

This report presents a synthesis of the discussions held in plenary and in the working groups. Details about questions and expected outcomes of working groups, as well as the list of presentations, are given in Annex 1 and 2.





The big picture

Recommendations to increase access to health workers in remote and rural areas through improved retention must be developed within the framework of a country's overall national health plan and guided by the values and principles of primary health care. Rural retention is only one component of strategies to strengthen health systems, address the human resources for health crisis, reduce health inequalities, and attain the Millennium Development Goals.

Rural retention is a complex issue with no easy answers. A host of contextual issues – the current state of health, the health workforce, and the health system, as well as political, socio-economic and cultural factors – need to be considered before effective solutions can be designed. Each country needs to develop its own policies and implementation strategies based on national resources and priorities.

Many of the factors that impact rural retention are outside the control of the Ministry of Health and therefore a multisector response is required. No intervention can be seen in isolation. Success in one country, municipality or community will not necessarily translate to the same success in a different place or time.

Moreover, even definitions and terms are difficult to clarify. Access, for example, may be defined in terms of time, distance or cost – there is no single, clear definition. The definitions of rural and remote and underserved vary between and even within countries, as do people's health needs and the skills that health workers require to meet those needs. What does retention mean? Are people considered retained after 3 years or 5 years?

With so much complexity and variation between and within countries, why has WHO decided to develop these global recommendations? The answer is threefold.

First, rural retention is a problem faced by almost every one of WHO's Member States – developed as well as developing. It is not a new problem and many countries have considerable experience trying to find solutions. There is a recognized need to analyse these experiences more thoroughly to get a deeper understanding (especially contextual) of what has worked, what hasn't worked and why, and to actively share what has been learned.

Second, evidence of what can be achieved – of what is possible – is a powerful advocacy tool. It is not the role of WHO to dictate to countries what must be done. However, WHO and its partners, including civil society, can use the evidence-based global recommendations to show political decision makers why there is an urgent need for action to improve retention of health workers in remote and rural areas.

Third, in countries where political commitment already exists, the global recommendations will assist countries in developing effective retention policies and in translating them into actions and results on the ground.

The ultimate aim of this process is to make life better for health workers and healthier for the people they serve, who live in remote and rural areas. The challenge for the Expert Group is to make sense of the complexities, to understand the evidence in the context of a much bigger picture, and to find practical solutions.

Guidelines review committee

To ensure its recommendations are evidence based and the process for developing them transparent, the Expert Group will adhere to WHO standards for reports and use of evidence as set out by the Guidelines Review Committee (GRC).

This requires, among other things, a synthesis of all of the available evidence and a formal assessment of the quality of evidence using the GRC's grading process. It also requires a consideration of resource use and costs when formulating recommendations and the articulation of the values and preferences that have gone into the judgements that are made.



Scope of the recommendations

Audience

The audience of the global recommendations are policy- and decision-makers in countries wanting to find effective solutions to address this problem.

The recommendations

The global recommendations will span the passage from evidence to policy and from policy to practice. They will stay focussed on the most pressing issues related to retention of health workers in remote and rural areas, and not be too general.

The expert group will identify a set of critical enabling factors and make recommendations on the process for designing effective policies, not provide a turn-key solution. This is because the choice of one specific intervention over another depends heavily on the country and local context. As such, the focus of the analysis will be on the context in which certain interventions work (or do not work). The analysis will also consider different geographical and cultural contexts, and propose categories of countries with certain similarities.

The global recommendations will not be directive or dictating standard approaches for all countries. Rather they will provide a menu of options, and will address processes and strategic approaches that governments can use to improve rural retention of health workers, starting from the design and piloting of interventions, through to implementation, monitoring and evaluation. It will be important to provide guidance on processes for achieving effective change, particularly for scaling up effective pilot programme that seem to be working only for as long as the support for the pilot is available (such as, for example, to learn from the “Implementing Best Practices” initiative for reproductive health services).

The types of health workers

The scope for intervention includes all public and private sector health workers who are employed on a regular, formal basis, including doctors, nurses, midwives, specialists, managers, dentists and support workers (for example, lab technicians, clinical engineers), where some training is required. It would be too difficult to include volunteer workers since they are not in the regulated workforce. This formal classification could include community and mid-level health workers, traditional health practitioners, health counsellors and other types of health workers, as long as they are officially recognized, trained and regulated, and working in the formal health system.

The importance of health managers and robust HRM systems

The WHO global recommendations need to highlight the importance of health managers in general and effective Human Resource Management (HRM) structures and systems. One set of issues relates to the competency and retention of health managers in remote and rural areas (depending on the situation, managers may or may not also be providing health care services). Another set of issues relates to the role of Human Resource Managers and the structures and systems that are in place (or not) and that are aimed at retaining health workers in remote and rural areas.

Categories of interventions

The Expert Group agreed that the interventions included in the background paper that was prepared for the meeting by WHO’s Health Workforce Migration and Retention Unit are valid (see Table 1).

Criteria for inclusion of interventions in the menu of options

Although there is near universal acceptance of the desired outcomes (see section below), the ways of achieving those outcomes are going to be extraordinarily different from place to place and from time to time. For example, it is well recognized that whatever policies and practices that might be appropriate for countries like China and India might not necessarily be appropriate for small island countries like Jamaica. It is not possible to make universal declarations of best practice that would adequately fit all the countries.

But for any intervention to be included in the menu of options it will have to be relevant, feasible, implementable, evidence-based and applicable for as many countries as possible.

One suggestion was to identify a set of critical success factors and develop a basic package for retaining health workers in remote and rural areas that spans competency-based education, payment, benefits, team work, supervision, working environment and management.

What works

Some examples of interventions that were found effective in the WHO review are given under the next few subheadings.

Education and regulatory interventions

Health professionals from rural background are more likely to practice in rural areas. Adapting curricula to include rural health issues improves competencies and creates more interest to work in rural areas. Loan repayment schemes, direct incentives and medical-resident programmes to encourage rural placement have the highest service completion rates and physician retention rates. The effectiveness of compulsory placement shows mixed results.

Financial incentives

Direct financial incentives to practice in rural areas may encourage rural practice, in particular in developed countries, but reports from developing countries are not all positive.

Management, environment and social support

Professional and community support to rural workers encourages rural practice; it can be achieved by supportive supervision, internet access and community involvement projects, as well as by professional networks. A few countries have implemented large-scale interventions to improve the health facility infrastructure and living conditions, and evaluations of these interventions have been published (Mali, Thailand and Zambia are such examples).

Methodology issues

The conceptual framework on which the recommendations are based holds that the final outcome of having health workers in remote and rural areas depends on two inter-related aspects:

- the factors that influence the decisions of health workers to come to, stay in or leave a rural area, and
- the health systems responses to these factors, through interventions in the categories mentioned above (education and regulation, payment methods, and management, environment and social support interventions)

Research is required to understand both these aspects.

Table 1. Categories of interventions used to improve retention of health workers in remote and rural areas

Category of intervention	Examples
A. Education and regulatory interventions	<ul style="list-style-type: none"> – 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 – Compulsory service requirements (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) – Producing different types of health workers (mid-level cadres, substitution, task shifting) – Recognize overseas qualifications
B. Financial incentives (direct and indirect)	<ul style="list-style-type: none"> – 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
C. Management, environment and social support	<ul style="list-style-type: none"> – 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 – Supportive supervision – Support for continuous professional development, career paths – 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) – Increased opportunities for recruitment to civil service

Source: WHO, 2009. *Increasing access to health workers in remote and rural areas through improved retention*⁹. Background paper for the first expert meeting to develop evidence-based recommendations to increase access to health workers in remote and rural areas through improved retention. Geneva, 2–4 February, 2009

Choices of location

Health workers are unlikely to want to work in environments that are unsafe, that lack essential supplies and equipment, that have no opportunities for career development, that have inadequate or non-existent supportive supervision, and so forth. Attention to these and other non-monetary factors is an essential element of any strategy that aims to encourage health workers to stay in their jobs and to improve their motivation and performance. Health worker motivation, job satisfaction, and performance need to be included in the recommendations because quality of care is directly related to access and is one of the measures of success of rural retention policy interventions.

Methods to identify and understand choices of location have been discussed at length. It appears that a new method, the discrete choice experiment, holds promise for policy makers, both in helping to identify the trade-offs that health workers make in choosing location for practice, and the potential costs associated with various attributes of their jobs. This latter aspect is particularly relevant in the subsequent design of interventions that should take into account these costs.

Evaluating the effectiveness of interventions

Being able to say whether an intervention is effective or not is helpful when making recommendations. However, social science research is not the equivalent of a clinical trial. The realist review approach was presented as a potential instrument to assess the impact of interventions. This approach looks beyond understanding whether an intervention achieved its expected outcome (was effective) and tries to understand why the interventions has worked and how. It puts context at the centre of analysis.

The time dimension

Follow-up studies where work has been undertaken 5 or 10 years ago would be particularly useful (to assess if policies are still working and conclusions remained valid, since policies must be effective over a significant time period).

Outcome measures

There is general agreement among the experts that indicators proposed by the WHO background paper are the right ones:

- human resources for health-related outcomes:
 - changes over time in the rural/urban ratio of health workers to population density
 - percentage of health professionals who choose to work in a rural or underserved community as a consequence of an intervention
 - duration in service of the health workers in remote and rural areas
 - health worker satisfaction about working in rural or remote areas
- health systems-related outcomes:
 - number of outpatient visits at public health facilities in rural facilities before and after an intervention
 - patient satisfaction with care provided by rural providers (in before and after studies)
 - health outcomes indicators (morbidity rates, mortality rates, in particular infant and post-neonatal mortality; these can improve in the long-run, but there is a need to carefully address the potential confounding factors)

These indicators can be used to assess the impact of interventions, and see to what extent they were successful or not. One outstanding question is how to measure whether there is a complete health team to deliver health services in the remote and rural areas.



What are the main evidence gaps

The following is a list of the main evidence gaps identified by the Expert Group:

- Very limited evidence was found for the Eastern Mediterranean Region, and to a certain extent for the Latin America and Caribbean countries.
- There is very limited information for some cadres – including ancillary workers, dentists, pharmacists and health managers, including human resources managers.
- The impacts of different fiscal and other interventions are rarely clear, and few had been analysed in detail.

- Evaluations of compulsory bonding or mandatory community service are required, including the impact on the quality of services.
- The costs of implementing rural retention strategies and incentive schemes are also unclear.
- The importance of context needs further consideration and analysis.
- There are knowledge gaps in how to implement retention interventions.
- In many countries even more basic data, such as, for example, on workforce composition, still remain inadequate.
- Knowledge gaps were identified in the area of management, such as for example: the impact of teamwork and supervision on job satisfaction; the impact of management on health workers performance and retention; and competences needed by health managers to improve retention

Next steps

During the third day, the experts agreed on a plan of action for the coming months, which covered the following areas of work: enlarging the number of case studies, using commonly agreed templates for assessing the evidence and for conducting specific case studies; expanding the evidence base from regions not yet covered; assessing the quality of the evidence; filling some evidence gaps; capturing opportunities of on-going research; and beginning to draft the recommendations, with a view to focus on implementation.

One of the Expert Group's main objectives is to give to decision makers practical tools and to show that its suggestions are based on good evidence. The group will need to begin to think about how best to package this information to have the greatest impact.

From research to policy to practice

There is a need to develop a knowledge translation and a knowledge management strategy (or a policy to practice track), perhaps working with groups of countries that have common characteristics. Reaching and engaging key stakeholders, including decision makers, civil society, the private sector and affected communities, must be at the centre of the effort. A participatory research process may have the best chance of triggering a process of change that will eventually produce the desired results.

Engage with decision makers and communities

Any research that is undertaken such as case studies or surveys needs to engage all stakeholders involved in health policy and health practice, including civil society and community representatives, in order that the studies and eventually the policies have realistic objectives and clear links to the goals of local communities, their aspirations, and their needs.

Capture opportunities

Link up with other groups pursuing similar objectives in order to share knowledge, identify synergies, reduce transaction costs and avoid duplication. This includes partnerships hosted by WHO such as the Alliance on Health Systems and Policy Research and the Global Health Workforce Alliance. Another potential partner is USAID, which is one of the key implementers of a major PEPFAR programme that is underway to strengthen the health workforce in Sub-Saharan African countries. Similarly, synergies should be forged with other on-going initiatives, such as the Positive Practice Environment campaign launched by six health professional associations at global level, with support from GHWA. As part of this initiative, the "Guidelines: Retention of Health Professionals" was mentioned as a useful background document to consider as the initiative develops.

Map out ongoing related initiatives and activities, identify opportunities for working together, and make contact with investigators of ongoing relevant studies. Build on recommendations that have already been made by other taskforces and initiatives for rural retention or for retention in general that can apply to rural areas. Forging synergies with on-going initiatives related to the area of health workforce retention, such as for example the Positive Practice Environments campaign launched by six global health professional associations.

Learn more from country experiences

Strengthen the knowledge base of effective interventions and improve understanding of important contextual factors that impact on retention through a deeper analysis of existing studies – especially non-English and grey literature – from all regions of the world.

Brazil, Canada, Cuba, Indonesia, Iran, Thailand, and the United States are examples of countries that have been grappling with rural retention for decades. Other countries, including China, Ethiopia, India, and Mali, have recently launched major efforts to increase the number of health workers in remote and rural areas. Some countries have good sets of data from pilot studies and are ready to scale up (Kenya).

The literature on retention in general provides good insights for retention in rural and remote areas. In addition, the relevance of successful interventions that have been used in sectors other than health, such as incentives for teachers working in remote and rural areas, also needs to be studied.

Re-examine the evidence

Do further analysis of studies that have already been completed in order to develop a superior template for policy intervention and to better understand the factors that influence the impact of interventions. This includes examining what is known about scaling up interventions and looking retrospectively at policies that have been implemented in earlier years for the long-term utility; and undertaking further studies in such places where it is not clear what the medium/long-term practical outcomes were.

Re-examine existing evidence to better understand why so many policies have failed. Is it something to do with the policy analysis, a failure to identify the bottlenecks, a flaw in the programme design, serious problems with the process of implementation, inadequate HRM systems in place to support and sustain scale-up? In those rare cases where a policy has worked, what were the enabling conditions that allowed it to become operational?

Building the evidence base over the long term

Advocate for the adequate monitoring and evaluation of policy interventions that are in the process of being implemented to ensure that the evidence base is built as quickly as possible and that stakeholders across the world can access evidence from other countries' experiences.

Work on primary data collection in a limited number of areas – for example, new positions created such as mid-level cadres and private sector participation – where there seems to be a lack of information.

Identify other priority research that will take longer than the Expert Group's timeframe to complete (for example, study retention over time at different stages of a health worker's career – how do choices change with age? Does gender impact on these choices?)

Draft an outline of the final report

Develop an outline for the final recommendations that will be published in spring 2010. It was suggested that already the WHO background paper contains the elements of this outline. Further refinements will be carried out by a smaller group (the core expert group), including suggestions made during the meeting.

Plan of action for the coming months

Area of work	Expected product	Area leader * & partners	Deadline
Documenting progress of the expert meeting	Meeting report	WHO Joanne McManus WG Rapporteurs	2 March 2009
Case studies	<ul style="list-style-type: none"> • Common template for case studies • Criteria for developing future case studies 	WHO Laurence Codjia Junhua Zhang	Mid-March 2009
	<ul style="list-style-type: none"> • Inventory of current and planned case studies 	T. Sundararaman Charles Normand Kim Webber Francoise Jabot	April 2009
Expanded and structured database of studies in different languages and for different cadres	<ul style="list-style-type: none"> • Template for assessing the evidence 	For template and final database: WHO	March 2009
	<ul style="list-style-type: none"> • Database 	For collection of additional evidence: Estelle Quain (LAC) Gilles Dussault (Brazil, Portuguese language) T. Sundararaman (India) Junhua Zhang (China, SEARO, WPRO/AAAH) Kim Webber (Australia) Julia Seyer (PPE)	June 2009
	<ul style="list-style-type: none"> • Synthesis of existing evidence 	For the synthesis – same experts as above	September 2009
Quality and strengths of the existing evidence	Review the current evidence using the realistic review approach	Marjolein Dieleman/WHO	June 2009
Reinforcing studies in progress and refining some of the research methods (<i>be opportunistic with regards to other on-going work</i>)	<ul style="list-style-type: none"> • Africa Medical Schools study • Trinity College studies • Toolkit for conducting DCEs • AHSPR proposals 	Seble Frehywot Charles Normand Marko Vujicic Taghreed Adam	June 2009
Fill some evidence gaps	<ul style="list-style-type: none"> • Detailed review of compulsory service (bonding interventions) 	Seble Frehywot	Depending on the amount of work required, some papers could be ready by June 2009 or by September 2009
	<ul style="list-style-type: none"> • Impact of competency based training on practice in rural areas • Impact of teamwork and supervision on job satisfaction 	Barbara Stilwell	
	<ul style="list-style-type: none"> • Impact of management on HW performance and retention • Competences needed by health managers to improve retention 	Marjolein Dieleman Joseph Dwyer Fadi El-Jardali	
	<ul style="list-style-type: none"> • impact of weak HRM systems on attraction and retention of HCWs 	Jim McCafferey	
Drafting the recommendations	First draft outline	WHO+WB	March-April 2009

* 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.

ANNEX 1

Agenda

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

2–4 February 2009, World Health Organization, Geneva

Monday, 2 February 2009

08:30 Registration of participants

09:00 **Session I – Welcome and introduction**

Co-chairs: Manuel M. Dayrit, Director, Department of Human Resources for Health, WHO
Armando Guerra Vilanova, Ministry of Health, Cuba

Welcome and opening remarks from the co-chairs

Address by Carissa F. Etienne, Assistant Director-General, Cluster of Health Systems and Services, WHO

09:20 **Health workforce development – WHO perspectives**

Manuel M. Dayrit, Director, Department of Human Resources for Health, WHO

09:35 **WHO programme of work on health workforce retention**

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

09:50 **General discussion**

10:15 – *Coffee break*

10:45 **Session II – Scope of the global recommendations and mapping of interventions**

Co-chairs: Charles Normand, Trinity College, Dublin, Ireland
Carmen Dolea, Health Workforce Migration and Retention Unit, WHO

Presentation from the WHO Guidelines Review Committee

Faith McLellan, WHO Guidelines Review Committee, WHO

11:00 **Increasing access to health workers in remote and rural areas: issues, challenges and potential solutions. Background paper and introduction to the work of the expert group.**
Carmen Dolea

11:30 **Moderated discussion – Scope of the global recommendations and mapping of interventions**

12:00 – *Lunch break*

13:00 **Moderated discussion (continued)**

Working groups: mapping of current evidence

Working group 1 (suggested theme: education and regulatory related interventions)

Working group 2 (suggested theme: monetary compensation – direct and indirect financial incentives)

Working group 3 (suggested theme: management, environment and social support)

16:00 – *Coffee break*

16:30 **Feedback from working groups on mapping of current evidence**

17:30 End of Day One

18:00 – *Cocktail, WHO main restaurant*

Tuesday, 3 February 2009

09:00 **Session III – Evidence gaps, methodological challenges and potential solutions**

Co-chairs: Charles Normand, Trinity College, Dublin, Ireland
Taghreed Adam, Alliance for Health Policy and Systems Research, Geneva, Switzerland

Summary of Day One

09:15 **Challenges and innovative research approaches for health system policy analysis – panel**

Gilles Dussault, Instituto de Higiene e Medicina Tropical, Lisbon, Portugal
Laurence Codjia, Human Resources Specialist, Dakar, Senegal
Françoise Jabot, Ecole des Hautes Etudes en Santé Publique, Rennes, France
Marjolein Dieleman, Royal Tropical Institute, Amsterdam, the Netherlands
Tim Martineau, Liverpool School of Tropical Medicine, Liverpool, United Kingdom

10:30 – *Coffee break*

11:00 **Working groups - evidence gaps, methodological challenges and potential solutions**

12:00 – *Lunch break*

13:30 **Feedback from working groups on evidence gaps, methodological challenges and potential solutions**

14:30 **Session IV – Challenges for country level implementation**

Co-chairs: Grace Allen-Young, Ministry of Health, Jamaica
Shambu Acharya, Country Focus, WHO

Challenges for country level implementation – country presentations and global perspectives

Country 1 – Romania
Country 2 – Canada
Country 3 – Mali / Madagascar / Benin
Country 4 – Niger
Global Perspectives -- Global Health Workforce Alliance

16:00 – *Coffee break*

16:30 **Working groups – challenges and lessons learned for country level implementation**

17:30 End of Day Two

Wednesday, 4 February 2009

09:00 **Session IV – Challenges for country level implementation (continued)**

Summary of Day Two

09:15 **Feedback from working groups on challenges for country level implementation**

10:30 – *Coffee break*

11:00 **Session V – Plan of action for the coming months**

Co-chairs: Estelle Quain, USAID
Jean-Marc Braichet, Health Workforce Migration and Retention Unit, WHO

Working groups - Plan of action for the coming months

12:00 – *Lunch break*

13:30 **Feedback from working groups and moderated discussion - Plan of action for the coming months**

15:00 **Next steps and programme of work**

16:00 **Closure of the meeting**
Carissa F. Etienne, Assistant Director-General, Cluster of Health Systems and Services, WHO



ANNEX 2

Group work questions and expected outcomes

Working groups Day 1 – Session II: Scope of recommendations, type of recommendations, and mapping of current evidence

Questions to be addressed by the group:

- Which scope of recommendations should be considered (which professions, specific or general, should it be different by geographical areas, socio-economic region?)
- What interventions to include in the scope of the recommendations? Is the proposed categorization meaningful?
- What criteria for inclusion or exclusion of intervention we should be using?
- Is the current evidence sufficient to begin to make recommendations? What else we want to know better?
- How to expand the pool of knowledge to regions where we don't have information yet?

Expected outputs from the group:

- Agreement on the scope of the recommendations.
- Criteria to include/exclude interventions
- List of agreed upon interventions for the specified category
- Initial proposals to expand the knowledge base

Working groups Day 2 - Session III: Evidence gaps, methodology challenges and potential solutions

Questions to be addressed by the group:

- What are the main evidence gaps regarding research on retention interventions?
- What guidance can you offer on the **mix of most appropriate methods** that should be used in research on retention interventions:
 - With regards to analysis of **factors affecting choices of location**
 - Considering the need for consistency in **measuring effects and outcomes**
 - Considering what additional reporting needs to be done on the **context and background** when evaluating interventions
- Given the mix of methods proposed above, how best to describe the quality of the evidence?

Expected outputs from the group discussion:

- Listing of the main evidence gaps regarding retention interventions.
- Suggestions for a common methodological approach for research in retention interventions
 - Methods for factor analysis
 - Main outcome measures for the effects of interventions
 - Reporting on context
- Framework for assessing the quality of the evidence



Working groups Day 2 - Session IV: Country level implementation

Questions to be addressed by the group:

- From which countries do we have already useful and helpful evidence?
- Which lessons did we already learn from these experiences?
- How to improve for the next country cases studies or implementation? How to use in the best way the evidence on the concerned country and the country case study to implement retention strategies in the country?
- How to work in a good way and in synergy with other partners in the countries?

Expected outputs from the group:

- Regional classification of countries where we have or we will have evidence, to be sure we have enough diversity of approaches
- Identify the steps before the implementation, during it and afterwards
- Identify potential partners in the foreseen countries

Working groups Day 3 - Session V: Plan of action for the coming months

Questions to be addressed by the group:

- Which are the next actions and steps in the coming weeks (particularly before the next expert meeting) to start the process of building recommendations
- Identify clearly these actions and build groups of experts in charge of the identified actions to be done

Expected outputs from the group:

- Establish a list of actions to do (researches to fill the identified gaps in evidence, literature reviews, country case studies, resources mobilization etc.)
- Design one or two leaders (person or institution or both) in charge to lead actions in each area determined and the calendar
- How to communicate with WHO? Who will be the focal point(s) in WHO and for what?



ANNEX 3

List of presentations

The following background papers and presentations from the meeting are available at http://www.who.int/hrh/migration/expert_meeting/en/index.html

Day 1

Human resources for health development - WHO perspectives – Manuel M. Dayrit
http://www.who.int/hrh/migration/hmr_expert_meeting_dayrit.pdf

WHO programme on increasing access to health workers in remote and rural areas through improved retention – Jean-Marc Braichet
http://www.who.int/hrh/migration/hmr_expert_meeting_braichet.pdf

WHO guidelines and the Guidelines Review Committee – Faith McLellan
http://www.who.int/hrh/migration/hmr_expert_meeting_mclellan.pdf

Increasing access to health workers in remote and rural areas through improved retention – Carmen Dolea
http://www.who.int/hrh/migration/hmr_expert_meeting_dolea.pdf

WHO, 2009. Increasing access to health workers in remote and rural areas through improved retention. Background paper for the first expert meeting
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