Rural retention strategies in the South-East Asia Region: evidence to guide effective implementation

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The availability of a functioning primary health-care system for populations in rural and underserved areas is crucial for reducing morbidity and mortality, and improving health indicators. A fully functioning primary health-care system is also a precondition to achieving universal health coverage (UHC).[1]

The health workforce is the backbone of primary health-care systems.[2] Sufficient, well trained, competent and motivated primary health-care workers in rural and underserved areas are particularly important to provide quality primary health-care services and enhance equity as these services become accessible to more people.[3,4]

However, many countries across the world experience challenges in recruiting and retaining health-care workers where they are most needed, that is, in rural and underserved areas.[5] Workforce shortages, geographical maldistribution, suboptimal skill mix, low motivation and high absenteeism contribute to poor primary health-care performance in rural and underserved areas.[4,5] Improving rural retention of the health workforce is vital to the functioning of primary health care – and therefore to achieving UHC.[3]

The protracted challenges in rural recruitment and retention of health-care workers are not new. In 2010, the World Health Organization (WHO) launched the guidelines *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. The guidelines recommend 16 policy interventions grouped in four main categories of intervention: education; regulation; financial incentives; and professional and personal support.[4] While the framework has been widely used to design and implement policy interventions by countries, its monitoring framework and indicators have not been widely applied to monitor progress and assess the impact of policy interventions.[5] Other public health actors have proposed alternative monitoring frameworks, but policy-makers have not widely adopted them.[6]

The 2010 WHO guidelines on rural retention are in the process of being updated, including a new evidence review and an effectiveness assessment of the recommendations; the guidelines should be published in late 2020.

Rural retention in South-East Asia

All Member States in the South-East Asia Region, except for Democratic People's Republic of Korea and Maldives, report health workforce shortages as measured by WHO's benchmark of 44.5 professional staff per 10 000 population. Maldistribution of health-care workers in rural areas,[7] where 66% of the 2 billion population of South-East Asia live, is a common challenge across all countries in this region.[8] To mitigate these challenges, the WHO South-East Asia Region committed to the objectives of *Decade for health workforce strengthening in the South-East Asia Region 2015–2024*, which identified improved rural retention as one of four key goals.[7]

To assess in more detail the health workforce retention challenges and country policy responses, in 2019 six country case studies (Bhutan, Chhattisgarh State in India, Indonesia, Myanmar, Sri Lanka and Thailand) were conducted. The case studies aimed at better understanding what rural retention policies had been implemented, how these policies were implemented and the impact of those interventions. The WHO 2010 framework was used to assess retention policy implementation.[4]

Findings showed that the six countries had implemented many of the 16 interventions of the WHO 2010 guidelines,[4] usually as interlinked or bundled interventions. These countries most commonly used education strategies and regulatory interventions, but examples of financial incentives and personal and professional support were also found.[9]

Unfortunately, countries usually implemented retention policies without collecting baseline information for tracking progress and for rigorous assessment of outcomes. Moreover, monitoring, which could have informed policy adjustment, was reportedly lacking.

In these countries, the use of either routine statistics or special surveys on human resources for health outputs, outcome and impact of retention policy implementation was very limited, and attributing causality of the few impact results obtained was difficult.

However, a few examples of evaluation were available. Thailand conducted primary surveys that enabled assessment of the impact of policy interventions related to the Collaborative Project to Increase the Production of Rural Doctors, which was based on a special recruitment track of medical

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