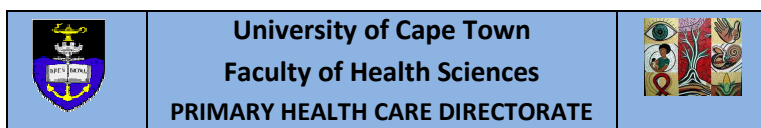
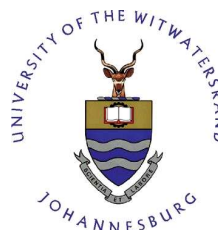


The WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved recruitment and retention:

The South African Context

VERSION 1

DISCUSSION DOCUMENT - JUNE 2011



1. INTRODUCTION

In 2010 the WHO launched its global policy recommendations on increasing access to health workers in remote and rural areas through improved retention¹. The guidelines were launched in partnership with Wits Centre for Rural Health, at Wits Medical School. These contained recommendations in five core categories: Education, Regulatory Strategies, Financial Incentives and Professional and Personal Support. In addition, there was a clear call made to countries with large rural populations to translate the global guidelines to their local context.

The contextualisation of the WHO guidelines to local South African conditions and needs comes at a time when South Africa faces a severe Human Resources for Rural Health (HR4RH) crisis. A new Human Resources for Health plan is currently being developed by the Department of Health and stakeholders have been asked to comment and provide input. The Wits Centre for Rural Health, the Rural Health Advocacy Project, Africa Health Placements, the Rural Doctors Association of Southern Africa, the UKZN Centre for Rural Health and the UCT Primary Health Care Directorate have collaboratively developed this first version of a South African contextualisation of the WHO guidelines².

We welcome input from all health worker categories and other stakeholders. Inputs can be sent to:

Richard.Cooke@wits.ac.za

Marije@rhap.org.za

A summary of the key recommendations can be found in annexure 1.

2. BACKGROUND

Increasing access to health workers in remote and rural areas through improved recruitment and retention is a critical output to achieve the rights of rural communities to comprehensive, quality health care. In South Africa, 46% of the population lives in rural areas, but only 12% of doctors and 19% of nurses work there³.

South Africa is a highly unequal society in terms of access to health care. Over R43bn is spent on private health care annually for 7 million people, compared to R33bn spent in the public health care sector on more than 38 million people⁴. Poor rural communities are the worst off, due to the historical inequities in resource allocation, the highest levels of deprivation, geographical challenges, and past tendencies to develop urban-biased health policies and strategies not easily implementable in rural areas. The lack of a comprehensive rural recruitment and retention strategy has largely contributed to the current staffing crisis. Whereas South Africa as a whole is affected by the HRH crisis in the public sector, failures to access care due to lack of multi-skilled health teams are more difficult to rectify in rural areas. Rural patients do not have the choice of multiple public and private facilities nearby; when

¹ Available from: <http://www.who.int/hrh/retention/guidelines/en/index.html>

² The CRH's Director Prof Ian Couper, and UCT's PHC Chair, Prof Steve Reid also served on the expert panel for the Global WHO guidelines.

³ Hamilton K & Yau J. The global tug-of-war for health care workers. Washington, DC, Migration Policy Institute, 2004

⁴ SAHR 2007

the nearest rural facility is short-staffed, few alternatives are available. Weak outreach support by specialists, coupled with the large distances between facilities and levels of care, and poor emergency transport, patient transport and affordable public transport contribute to poor health outcomes and avoidable deaths.

It is thus not surprising that two of the top 5 priorities for rural health care identified by an expert panel⁵ are “the need to focus on how to recruit, retain and support senior health care professionals in rural hospitals for the long term” (highest priority) and “the need for the development and implementation of a national Human Resource Plan that is relevant to the rural health care context” (3rd priority).

By recruiting and retaining sufficient rural health care workers, good quality health care to rural communities is possible, from primary up to tertiary care.

3. WHO GLOBAL RECOMMENDATIONS - A POLICY TOOL FOR SA

The WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted by member states at the Sixty-third World Health Assembly in May 2010. To complement this initiative, the WHO had already started a parallel process of developing guidelines to help countries recruit and retain local health workers to rural areas. This process led to the set of global policy recommendations published by the WHO⁶.

The WHO recognised, however, that the evidence to support some of the recommendations was limited. This was for two main reasons:

- 1) Each measurable output (such as the percentage of health professionals retained in rural areas) is contributed to by a number of different interventions
- 2) Researching human resources is more suited to case and observational studies, and, to a lesser extent, cohort and case-control studies, but not to randomized controlled trials, the evidence from which carries greater weight.

The panel agreed, therefore, on a more inclusive set of criteria by which an intervention can be adjudged as either recommended or not recommended, in addition to the available evidence. These criteria included:

- group consensus on the absolute magnitude of the benefits and timeframe,
- the presence of negative and/or unintended effects,
- the variability in how stakeholders view the outcomes, and
- the technical prerequisites for implementation.

The resulting recommendations were approved by the WHO Guidelines Review committee.

The above criteria inform the ranking of recommendations, and better guide individual countries using the WHO tool. These criteria are considered in discussing the SA recommendations later in this document.

⁵ Versteeg M, Couper I. Position Paper: Rural Health - Key to a Healthy Nation. Johannesburg: Rural Health Advocacy Project, 2011. Available at www.rhap.org.za.

⁶ A full discussion of the methodology of the WHO tool is found in section x of the WHO Guidelines.

4. THE GUIDING PRINCIPLES FOR HUMAN RESOURCES FOR HEALTH IN RURAL AREAS

The WHO policy document calls for every country to consider certain guiding principles before starting to design recommendations. Each of these principles takes on a rich significance when considered in the South African context.

Principle 1: The value of the recommendations in the broader South African social, political and economic context

South Africa is a middle-income country which produces poorer health outcomes than some lower income countries. Whereas resources are limited, the available resources could be used more effectively and equitably. South Africa also has one of the highest GINI coefficients in the world, meaning that we are a highly unequal society. This is also reflected in access to health care, and in health outcomes. There is currently strong health leadership in the country, calling for a more equitable health system. This document proposes both short term and long term strategies to address the health workforce inequities.

Principle 2: Understand the workforce

Understanding the workforce, its dynamics, training, distribution and shortages, is an obvious prerequisite for planning suitable workforce strategies. This SA version of the WHO policy guidelines on increasing access to health care workers through rural recruitment and retention has been informed by a broad understanding of the key challenges to rural health workforce recruitment and retention. These have been captured in various documents⁷⁸⁹. Doctor issues, however, are over-represented in this document; due to the availability of evidence, and the expertise of the submitting parties. As called for in the introduction, other health worker categories are invited to comment and expand on the recommendations.

Whilst there is a lack of reliable human resources statistics in the country, there is enough evidence to demonstrate that universities are not training sufficient health care workers to meet the country's needs, and that the most scarce health care professionals are the least likely to work in rural areas. Answers to the staffing crisis however must start with the realization by the Department of Health that the education and training of health professionals is part of its mandate. This is not something that can be left to universities or the Department of Higher Education. Future generations of health professionals need to be developed within the public health service if it is to be adequately staffed in future. To help achieve this goal, all levels of the health service need to be seen and utilized as training facilities.

⁷ NDoH. PLANNING FOR KEY HEALTH PROFESSIONAL CATEGORIES. Towards a health workforce strategy - Improving access to human resources in the South African health system 2011-2015

⁸ Versteeg M, Couper I. Position Paper: Rural Health - Key to a Healthy Nation. Johannesburg: Rural Health Advocacy Project, 2011

⁹ George G, Quinlan T, Reardon C. Human Resources for Health: A needs and gaps analysis of HRH in SA. Durban: UKZN Health Economics and HIV & AIDS Research Division (HEARD), 2009

Principle 3: Ground Policies in the National Health Plan

The WHO global recommendations have been assessed against health priorities and policy developments in South Africa, notably the Revitalisation of Primary Health Care, the introduction of new health cadres including midlevel workers, the development of a new HRH Plan and the preparations for a National Health Insurance.

The success of the future NHI, which aims to provide affordable quality health care for all, is particularly dependent on the availability of sufficient health care workers in rural areas. So is the success of the Primary Health Care Revitalisation strategy.

Principle 4: Address Health Inequities

The main purpose of this document is to inform planning for equal access to quality, affordable health care for those in equal need of health care. With the levels of inequality in our society, this thus requires more resources for specific groups and services: rural health users and rural health care in particular. It also requires a more efficient use of available resources. The RHAP argues as follows in its recently published position paper on rural Health care:

Box 1: The Need for Outreach Guidelines

Besides adequate numbers of health care workers, their efficient use is paramount, even more so in the context of scarce resources. Task-shifting including the use of mid-level workers and outreach support are two fundamental approaches. This requires full support from the professional bodies with the benefit of improved access to health care in mind. In line with the PHC approach, outreach at all levels of the health system is essential, to prevent unnecessary referrals to higher levels of care which is a burden to the patient and to the system, and to support health care workers at the more decentralised levels. It requires:

- Outreach by consultants based at regional and tertiary levels whose main duty is to ensure clinical governance, adequate referral and quality of care at district hospital level;
- Outreach by multi-disciplinary health care teams to community health centres and clinics;
- Outreach by multi-disciplinary community health workers at a household level; and
- Outreach by rural rehabilitation workers to community health centres and clinics and at a household level; the latter applies specifically where rural patients are unable to reach the clinic due to their illness or disability often combined with the inability to pay for transport due to high levels of poverty.

Source: Versteeg M, Couper I. Position Paper: Rural Health - Key to a Healthy Nation. Johannesburg: Rural Health Advocacy Project, 2011

Principle 5: Get into the habit of evaluation and learning

Policy makers obviously look to the evidence of what works in attracting health workers and keeping them where they are required. Where rural health has been disadvantaged, however, is in the lack of resources to carry out research of this kind. When there are few resources to do the job of delivering health care, it is little wonder there are even less to get research of this nature done.

Emphasis is placed on the use of information technology as vital to the evaluation process, but technology must also assist with communication in rural areas in particular. That is

communication not only with patients, but also to build teamwork, to monitor capability, and to ensure continuity of care between facilities, including support of academic and training initiatives across facilities. Information management has wide-ranging benefit, including evaluation of HR strategies.

Principle 6: Engage stakeholders early

This may be the most-stated principle in any kind of “plan”. In an HR strategy - where the subject of the plan is the stakeholders themselves – this principle takes on a special significance. It is often difficult for rural health care workers to have their voices heard as many work in isolated areas, far from the provincial and national decision-making centres. A conscious effort needs to be made to involve rural health care workers as part of the development of rural recruitment and retention strategies. Whereas the partner organizations that developed this document will aim to obtain further input from other rural health care workers, government is also called upon to make additional efforts in ensuring rural health care workers are heard and consulted in matters relating to the health workforce.

Community engagement in HRH strategy is also important. This is vital, not only because the local community should be a resource for the recruitment of students to study health care (nurses, doctors, therapists, community health workers), but also because communities can play a valuable role in personal support.

A marketing strategy can be devised to highlight the recommendations, as well as canvass input to the entire process of attracting, recruiting and retaining health workers in rural and remote areas.

Principle 7: Ensure HR expertise is strong

Strong and accountable leadership is required not only at national but also at district and facility level to ensure rural recruitment and retention strategies work. All managers need to understand the significance of health professional shortages for achieving national and local targets, and to be involved in addressing these. This understanding must manifest in practical support to the development and operation of strong human resource systems.

The WHO suggests the key component of a strong HR management system is professionally prepared and competent HR managers who are able to perform the following HR functions:

- **Personnel:** Workforce planning, recruitment, hiring and deployment
- **Work environment and conditions:** Employee relations, workplace safety, job satisfaction, career development
- **HR information:** Data and information for decision making
- **Performance management, leadership and staff development:** Performance appraisal, supervision and productivity

The strength of all these functions will determine the success or failure of HR interventions in South African health system. Rural health is especially dependent on strong HR expertise. On an operational level, for example, supervision and retention strategies are closely interlinked. The impact of poor supervision and support to rural health workers can prompt resignations.

It is vital that supervision and authority be decentralized to the facility level as much as possible. Clear lines of authority must be evident in the District Management System, but there must be collective input to retention strategies by all who are affected by it. Collective decision making (but with clear leadership provided when required) allows for work practices to be continually evaluated and reviewed, so improving retention.

In any district (or sub-district, as is often more practical), the District Management Team (DMT) is ultimately responsible for improving the relevant health indicators. Blindly doing so with little thought to how the listed HR functions may impact targets is not sustainable. It is recommended that recruitment targets in the key performance indicators of DMT members are included. The issuance of job offers should be decentralised to hospitals. Oversight monitoring can still continue at a provincial or centralised body.

5. SHORT-TERM STRATEGIES¹⁰

Progressively realising the right to health requires immediate short term interventions as well as longer term strategies. This section proposes a set of short term strategies for rural recruitment and retention.

5.1 Nurture rural Community Service professionals

The majority of community service (CS) health professionals are placed in urban settings, undermining one intention of CS which is addressing the inequitable access to HRH in the system. Research in SA has shown that negative experiences during community service contribute towards the “pushing” health workers to the private health sector and to developed nations¹¹. To address this, the following are required:

- A transparent process for the equitable allocation of community service officers, with preference being given to rural hospitals.
- Mechanisms to encourage CS professionals to opt for rural placements and to stay on thereafter (such as credits when applying for postgraduate positions).
- Improve the orientation and support programmes for new CS professionals to increase their effectiveness early on. Districts should be responsible for the practical orientation of the CS professionals. CS orientation done by some provinces is conducted notoriously late in the year, a situation regarded as unsupportive “out-of-touch”.
- National and Provincial DOH must facilitate communication between CS professionals and senior staff at hospitals in which the former have an interest. Early communication to provide advice and assistance will encourage CS professionals to pursue more rural postings. Creating a central database to profile the relevant hospitals will facilitate this.

¹⁰ Most of these points are based on a letter submitted to the national Minister of Health in April 2010 by a coalition of organisations involved in rural health workforce issues, entitled “Proposal for key measures to address the crisis in human resources for health in South Africa, with a focus on rural health care”.

¹¹ Prof SJ Reid. Personal communication. (Research for National Department of Health.)

5.2 Revise policies on who may work in South African public service

SA needs a policy that, while steering clear of active recruitment from developing countries, would allow suitably skilled doctors from such countries, who apply to work in South Africa *by their own initiative*, as well as actively recruiting doctors and other health professionals from developed countries. To address this, the following are required:

- Review policies that dictate the circumstances under which doctors and nurses may be endorsed to work in South Africa, without compromising standards of patient care.
- Urgently review all applications for endorsement pending with the Foreign Workforce Management Programme (FWMP) of the Department.
- Conduct marketing and recruitment drives in wealthy nations which potentially have excess doctor and nurse capacity. 2011 has witnessed fewer endorsements of foreign doctors by the HPCSA; the professional body correctly claim some applicants have insufficient experience. There are, however, currently many rural hospitals reliant on foreign doctors to fill posts not attracting any South African applicants; these hospitals are now vulnerable to closure. Patient care need not be compromised if a doctor is pre-registered to work under supervision for a set period before full registration is granted.

5.3 Increase support to the nursing profession

Nurses play a vital role in rural health teams. Yet, there are many challenges faced by the profession, including the aging of the nursing workforce. For this reason a Nursing Summit was held in 2011 resulting in the Nursing Compact. Its implementation cannot be delayed.

Other urgent actions include:

- Revise current lengthy registration processes, including a revision of the requirements for SANC registration.
- Ensure a speedy process for the appointment of nurses in rural health facilities.
- Improve support structures for nurses working in rural facilities.
- Consider the role of foreign qualified nurses in rural health care delivery. Foreign nurses have shown growing interest to work in South Africa but move to other countries due to a dysfunctional SANC.

5.4. Improve recruitment and retention processes for health care workers

The process for recruiting local and foreign health workers into the system can also be done more efficiently. This would assist greatly in filling vacancies quickly and avoiding losing health care workers to other posts due to delays in appointments. To address this, the following are required:

- Identify and unblock bottlenecks and avoid duplication in the recruitment process of health workers by, amongst others, automating suitable points in the process and facilitating cooperation between players, such as the Foreign Workforce Management Programme, the HPCSA and Provincial Departments of Health. In 2011, the Educational Commission for Foreign Medical Graduates (ECFMG) verification is now required for doctors prior to registration with the HPCSA. While there is logic to this in principle, in reality this lengthens the process of registration by six months. The international market for doctors is extremely competitive, and many foreign doctors will simply apply to work elsewhere. Therefore, it is proposed to the HPCSA to allow foreign candidates to write the qualifying exams in centres elsewhere than only in

South Africa. The HPCSA should hold exams in Europe at least twice a year to allow European doctors the opportunity to sit the exam at a lower cost to themselves. It will greatly increase the number of doctors who can work in SA.

- Ensure rapid turnaround times for advertisements and appointment of key health professional categories, with set, measurable norms for these.
- Reconsider OSD scaling of mid-level medical officers (as agreed in July 2009), who are the backbones of rural health care. Review impact of current OSD for nurses on recruitment and retention of different nursing categories. Adjust salaries adequately to recruit and retain experienced doctors and nurses in the state sector.

5.5 Revisit priorities for cutting costs at a provincial level

In response to health overspending, provincial health departments have cut costs by freezing medical posts in government health facilities. This means that doctors and other health professionals who leave rural facilities are not replaced, which has led to the collapse of entire health teams. To address this, the following are required:

- Place a ban on the freezing of critical clinical posts.
- Do not cut funding to clinical posts in rural areas. Rural communities historically receive support below the critical level required to achieve its intended impact and sustainability; give special attention to prioritising financial resources for all clinical posts in rural areas, whether based at district hospitals or those within the recently-prioritised primary health care arena (CHCs, clinics and community)
- Develop minimum staffing norms on which to base the above.

More detail on staffing norms is provided in box 2.

Box 2: Staffing Norms

Staffing norms need to be set, as an overall guideline for health managers responsible for service delivery. The Rural Doctors Association of Southern Africa argues that a minimum of 6 doctors should apply to smaller rural hospitals of about 60 to 80 beds. RuDASA recommends the following formula for the determination of doctor posts, as an accepted **minimum** level requiring no motivation for filling of posts, regardless of the financial situation, job freezes and budget cuts:

Minimum staffing norms for doctors at DISTRICT HOSPITALS	
1000 uninsured population	1 bed
10 beds	1 doctor
100 beds	= 10 doctors for 100,000 uninsured population

Interns still undergoing training should not be calculated in this pool, and not more than two community service doctors should be part of the minimum doctors/population. The staffing norms take into account leave days, the 24-hour service provided by most district hospitals, the fact that caesarean sections and other surgical operations require at least two doctors in theatre, and the need for outreach to support community health centres and clinics. It must be stressed that this is the minimum that should be available, and areas with high disease burdens and high levels of socio-economic deprivation should be first in line to receive additional doctors. Similar staffing norms for other health professionals need to be established.

(Adapted from RHAP Position Paper, 2011)

6. LONG TERM STRATEGIES

Longer-term strategies are set out according to the framework of the WHO Guidelines on Increasing Access to Health Workers in Rural and Remote Areas¹². High priority recommended interventions are presented below.

A summary of this section is presented in Annexure 1.

6.1 Educational strategies

Educational strategies are critical in long term planning. Without such strategies, the future health workforce cannot be developed. The international evidence is clear that educational strategies targeted towards producing health professionals for rural areas are required in order to impact future numbers of health professionals in such areas^{13,14}. In fact, the educational recommendations have the most evidence behind them out of all those in the WHO guidelines. If implemented successfully, the absolute effect is very big. South Africa already has good, localised examples, but they need to be scaled up. Considering the wider scope, universities need to recruit and train on the basis of their core mandate: producing HRH for health care needs of the entire SA population. Practice has shown that there are no grounds to believe that the HR needs of the 46% of the population who live in rural areas will be addressed by a trickle-down effect, unless targeted interventions are implemented.

- **Targeted admission policies:** Students from rural areas are 2-5 times more likely to work in rural areas¹⁵. Currently less than 30% of all health science students are from rural areas, with most faculties having fewer than 15% of students from rural areas¹⁶. Recruitment of rural students should be a mandatory component of selection policies, and universities should be required report on progress in this regard. However, support for such students from both the faculties and the districts in which these students originate is critical, along with processes to identify such students early on (in high school).

Value, timing and ease of Implementation:

This intervention does not require significant resources, and the benefits clearly outweigh the disadvantages. The current inequities in South Africa support this solution to target rural students over others. There is also no real barrier to translating the evidence into practice, as long as proper and effective selection processes are followed. Walter Sisulu University Medical School in the Eastern Cape is an example of a school that considers the rural origin and intent of candidate students.

¹² World Health Organization. Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva: World Health Organization, 2010. Available at <http://www.who.int/hrh/en/> Accessed 28th April 2011.

¹³ Wilson NW, Couper ID, De Vries E, Reid S, Fish T, Marais BJ. A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. *Rural and Remote Health* 9: 1060. (Online), 2009. Available from: <http://www.rrh.org.au> Accessed 28th April 2011.

¹⁴ Grobler L, Marais BJ, Mabunda SA, Marindi PN, Reuter H, Volmink J. Interventions for increasing the proportion of health professionals practising in rural and other underserved areas. *Cochrane Database of Systematic Reviews* 2009, Issue 1. Art. No.: CD005314. DOI: 10.1002/14651858.CD005314.pub2.

¹⁵ De Vries E, Reid SJ. Do South African medical students of rural origin return to rural practice? *South African Medical Journal*. 2003; 93: 789-793.

¹⁶ Tumbo JM, Couper ID, Hugo JFM. Rural-origin health science students at South African universities. *S Afr Med J* 2009; 99(1): 54-56

- **Location of undergraduate clinical training outside of major cities:** There are numerous good examples of the success of locating training outside of major centres^{17,18,19}, and the impact of this on students has been shown to be significant in South Africa²⁰. The department of health should support and facilitate the establishment of regional- and district-based training centres for health professionals, linked to appropriate health facilities, at which students can be accommodated for significant periods. This requires resources in terms of accommodation, travel, adequate infrastructure and clinical support.

Value, timing and ease of Implementation:

While expensive initially, the long-term effects will significantly offset the cost. Policy makers must be wary of political interference in the choice of sites for more district-based training centres. The difficulty of sourcing staff for working in rural areas is significant, but theoretically less difficult than sourcing health professionals for other rural areas with no training facility attached – the difference being the synergy and support the former will have. Quality of care and clinical governance will also improve at rural training sites.

There are existing district-based campuses and nursing schools based in rural areas that should be supported and developed. Far less costly than establishing new facilities from scratch, these facilities prolong the stay of graduates. As members of the multi-disciplinary teams of health care delivery, such students contribute to the job satisfaction and retention of qualified health professionals.

Exposure of students to rural clinical experiences through rotations in existing district health systems is cheaper than establishing purpose-built facilities, but sufficient resources need to be allocated to such programmes, and the rotations need to be of sufficient length to have a positive impact. Not least of the required resources is accommodation for the students. Quick-fix, poor-quality, pre-fabricated accommodation must be avoided, and innovative models must be explored. All the logistics need to be resourced properly as well, including transport and supervision (academic and administrative). Investigating private-public partnerships to meet these objectives is a proven option in South Africa, but the example of the North West Province signing an Memorandum of Agreement to provide accommodation for final year medical students is an example of government commitment worthy of commendation.

- **Location of postgraduate clinical training outside of major cities:** Opportunities for postgraduate training must be established in rural areas. In terms of medicine, all registrar training programmes should include rotations in regional hospitals, and outreach to district hospitals. Other training programmes can be fully placed in rural areas, such as family medicine training.

Value, timing, and ease of Implementation

The value of establishing postgraduate training in rural areas extends beyond the

¹⁷ Couper I D, Hugo JFM, Conradie H, Mfenyana K. Influences on the choice of health professionals to practice in rural areas. S Afr Med J 2007; 97(11): 1082-1086.

¹⁸ World Health Organization. Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva: World Health Organization, 2010. Available at <http://www.who.int/hrh/en/> Accessed 28th April 2011.

¹⁹ Couper I, Worley PS, Strasser R. Rural longitudinal integrated clerkships: lessons from two programs on different continents. Rural and Remote Health 11: 1665. (Online), 2011. Available from: <http://www.rrh.org.au>

²⁰ Reid SJ, Couper ID, Volmink J. Educational factors that influence the urban-rural distribution of health professionals in South Africa: A case-control study. S Afr Med J 2011; 101: 29-33.

retention of trainees alone. A postgraduate Family Medicine training programme, for example, is led by a supervising specialist family physician. Operationally, ALL the health workers under the supervision of this specialist must benefit from the leadership and management the latter is trained and obligated to provide. This contributes to job satisfaction and staff retention.

The urgency of this initiative is underlined by the Department of Health's current focus on the District Health System (DHS) to improve health care delivery. Successful implementation will be far more likely if postgraduate training in rural districts is also urgently supported by the DOH.

- **Continuing education/continuing professional development (CPD) programmes:** Support for appropriate, well-organised and locally-based CPD is an important factor in retention. Good examples exist in South Africa, using innovative training approaches such as facility-based mentoring or web-based learning, and need to be supported to scale up²¹. An appropriately-skilled training coordinator should be appointed to be responsible for this in each district. Career development opportunities are then needed for all professional categories.

Value, timing and ease of Implementation:

Educational strategies are rarely implemented in isolation and not well advertised. It is clear that intervention “bundles” must be considered for scale-up in South Africa to realize the objective of increased retention of health workers in these areas.

The evidence provided above is particularly relevant when these recommendations combine together; this “rural pipeline” in medical education and training is now beyond doubt. This “pipeline” involves recruiting students from rural backgrounds, delivering training in the regions, rural curriculum providing repeated rural exposures, and building regionally based postgraduate training pathways²².

6.2 Regulatory Strategies

- **Enhanced scope of practice:** The skills mix required in urban district hospitals is different from the skills mix in rural district hospitals; the definition of an appropriate skills mix for rural hospitals is urgently needed. Furthermore, restrictive narrowing of the scope of practice that occurs in urban areas must not impact negatively on rural areas, which need multi-skilled generalists more than specialists. One example is the need for generic midlevel rehabilitation assistants in rural areas as opposed to discipline-specific assistants in order to provide a comprehensive level of primary health care amidst staffing shortages. The scope of practice must be flexible in rural areas, with protection for this.
- **Different type of health workers:** The optimum range of health workers required for rural district hospitals and health services must be determined as a matter of urgency. The appropriate skills of such worker must be determined, and job descriptions should be based on need rather than professional protection.

²¹ One such example is a distance-based perinatal education programme first published: D.L.Woods G.B Theron The impact of the Perinatal Education Programme on cognitive knowledge in midwives VII/le 85 No. 3 March 1995 SAMJ

²² Curran V, Bornstein S, Jong M, Fleet L. Rural Medical Education: A Review of the Literature. Canadian Institutes of Health Research, 2004. <http://www.cranhr.ca/literature.html>

- **Clinical associates:** This is given special separate attention because they are a new category of health worker, but could be included under educational strategies as well. Training of this midlevel medical worker cadre must be scaled up urgently, with the appropriate resources being give to the institutions engaged in training, and adequate numbers of posts need to be created in the public service to ensure district hospitals can employ sufficient numbers of these. In the short-term, increased funding to the 3 existing training institutions and regulation of community service for clinical associates should be a priority.
- **Community service:** This has been mentioned under 5.1. To enhance retention, good accommodation in rural areas will be required. While almost all health professionals are currently required to complete CS for full registration, further resources are needed to ensure return on the investment, as detailed under the educational strategies. Underserved, often rural, areas need to be favoured when students are allocated, as is the original intention of CS. This is currently not happening although the UKZN DoH has adopted an innovative rural-friendly CSMO policy in 2010 which serves as an example to other rural provinces.
- **Incentives for return of service:** Rural scholarship schemes abound internationally and have had good success. Two South African schemes, Umthombo Youth in KZN and the Wits Initiative for Rural Health Education (WIRHE) in North West have shown these can work here^{23,24}. Critical to their success are local involvement in student selection, facilitation of an ongoing relationship with the district during training through vacation service and regular contact, educational mentoring and service posting back to the district of origin. Extension of such programmes will assist the targeted admission referred to above (under A).

Value, timing and ease of Implementation

Some of the regulatory strategies may meet with resistance from professional bodies and students who may wish to avoid rural placements. However, it is the country's health needs that should inform the strategies and this requires stakeholders to look beyond professional boundaries and personal interests. Some of the recommendations, such as the training of new cadres, will take time but this cannot be avoided. The training of mid-lever workers is a cost-efficient strategy, although the need for additional supervision needs to be considered. The value of implementing these recommendations is enhanced because these health workers may be less inclined to leave rural areas compared to doctors. Enhancing their scope of practice can then reduce the shortage gap while scaling-up the supply of higher-trained health workers. Staffing norms (See Box 2) need to be introduced in the meantime to ensure the equitable allocation of HRH and the required supervisory support.

²³ Ross AJ, Couper ID. Rural Scholarship Schemes: A solution to the human resource crisis in rural district hospitals. (Open forum) SA Fam Pract 2004; 46(1): 5-6

²⁴ Ross AJ. Success of a scholarship scheme for rural students. S Afr Med J. 2007 Nov; 97(11):1087-90.

6.3 Financial incentives

There is a need to:

- evaluate **OSD** to ensure it favours rural careers²⁵;
- evaluate the **rural allowance** to ensure appropriate facilities attract rural allowance;
- investigate the possibility of **sabbatical leave** for rural health professionals; and
- consider **increased leave days** for rural health professionals e.g. 30 instead of 22, and/or increasing by 1 day per year after each leave cycle for 2 years served. (The latter carries very little direct cost, increases the quality of life for rural health workers and may prevent burn-out.)

Value, timing and ease of Implementation

Whereas some of the above incentives are costly to the State, not reviewing OSD and rural allowance means forfeiting their original purposes. OSD has been declared anti-rural by RuDASA and RHAP, whereas there are health care workers at urban-based facilities that receive rural allowances. Sabbatical leave and additional leave days are low-cost measures with a potentially large impact. The financial incentives can only be successful within a broader package of interventions.

6.4 Personal and professional support

- **Outreach support:** There is a need to change the mindset of clinicians and managers in order to re-orientate the whole health service towards outreach and support, so that each level is supporting and taking responsibility for those that refer to it. It is more reliable and cost-effective for health professionals to move to where the patients are, then for patients to be referred, and this allows for appropriate skills transfer. Outreach should be included in the performance management agreements of all doctors in tertiary, regional and district hospitals. Appropriate transport resources will need to be provided for this. (See also Box 1.)
- **Improve living conditions:** Priority should be given to improving accommodation (which is often not available in small towns and villages) for health professionals and providing good internet access not only for work but also private purposes.
- **Safe and supportive working environment:** This requires good leadership, and functional health care teams, which require a critical mass or minimum number of health professionals.
- **Career development programmes:** As noted above, study opportunities must be provided with appropriate recognition and rewards.
- **Managerial and administrative support:** Management teams and administrators need to take cognizance of the vulnerability of small rural health teams and need to make replacement of health professionals that leave a major priority

²⁵ See Joint Press Statement by Rural Health Advocacy Project, Rural Doctors Association of Southern Africa, SECTION27 and Wits Centre for Rural Health, Current OSD offer still disadvantages rural communities, 9 June 2010

Value, timing and ease of Implementation

The above recommendations are not difficult to implement and are a low- or medium-cost burden, but the expected outcomes are high. Private-public partnership proposals exist for the accommodation need. Good leadership, a feeling of appreciation and a strong support system within the formal health system is valued highly by rural health care workers, as several studies confirm. This does not cost much. The challenging part in relation to the above recommendations is the change of mindsets which requires high-level leadership, managers that lead by example, and, in the case of outreach support, guidelines. (See Box 1).

7. CONCLUSION

In conclusion, it should be noted that none of these strategies can work in isolation. A comprehensive package of interventions is required in order to achieve the long-term goal of a better staffed rural health care service.

It cannot be assumed that addressing human resources generally will sort out the problem for rural and remote areas of South Africa. International experience and evidence has shown that specific interventions are required to achieve equity for rural areas²⁶. Ironically, whether the interventions relate to improving human resources or not, each intervention requires the commitment of individuals as stakeholders to the process. As the evidence shows, individuals and organisations are actively trying to implement some of these recommendations. They are not yet wholly successful, nor make the desired impacts. What is now needed is the universal commitment of everyone involved in rural health care, including the Department of Health. To progress from the outputs to the intended impacts of improved health service delivery and health status of South Africans requires determination and enthusiasm that no set of recommendations will achieve alone. These recommendations will go a long way, however, to create the environment in which to nurture this determination amongst our health professionals and other stakeholders.

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²⁶ Wilson NW, Couper ID, De Vries E, Reid S, Fish T, Marais BJ. A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. *Rural and Remote Health* 9: 1060. (Online), 2009. Available from: <http://www.rrh.org.au>.

Annexure 1. Summary of Recommendations. The WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention: The South African Context

CATEGORY	RECOMMENDATION BY WHO	DONE IN SA?	OUTPUTS ACHIEVED?	SPECIFIC SA RECOMMENDATIONS	SA EXAMPLES (Note: this is not an exhaustive list of practices nationwide.)
EDUCATIONAL	Targeted admission policies	Yes	Limited	<ul style="list-style-type: none"> - Support programmes to help potential rural high school students of disadvantages backgrounds meeting entry requirements - Rural intent to be part of university selection criterion - Rural origin to be considered favourable selection criterion 	<ul style="list-style-type: none"> - WSU: looks at rural origin/rural intent of candidate students - Medunsa: known to provide lot of mentoring and support - Umthombo Youth Foundation, KZN: rural bursaries for health science training - Wits WIRHE: bursary programmes for rural students, Rural Careers Days (target Grade 10-12)
	Location of undergraduate clinical training outside of major cities	Yes	Limited	<ul style="list-style-type: none"> - Support to and expansion of District Education Campuses - Re-opening and support to nursing schools in rural areas to be prioritized 	<ul style="list-style-type: none"> - Lehurutshe and Kopanong District Education Campuses (University of Witwatersrand) - Ukwanda Rural Clinical School (University of Stellenbosch) - Mpumalanga Health Sciences College (University of Pretoria)
	Exposure of students to rural clinical experience	Yes	Limited	Rural rotation to be integrated into the mainstream training programmes across health disciplines, including e.g. dentistry and pharmacy	<p>US – Worcester, Hermanus, Paarl, Madwaleni hospital in EC</p> <p>Wits – Tintswalo (Mpumalanga), Mafikeng, Taung, Zeerust (examples in North West), Kopanong (Gauteng), 2-wk rural public health block in 5th yr, Integrated Primary Care(IPC) block for final-yr medical students; occupational therapy: 3 rural placements (2 in Limpopo, 1 in Mpumalanga, physiotherapy: 3 rural placements in Limpopo</p>

				<p>UCT – Vredenburg rural site, Rural Student Network</p> <p>UP – district block rotation for medical students</p> <p>WSU – rural blocks at St Barnabas, Holy Cross hospitals</p> <p>Nursing and pharmacy students from different faculties rotate as resources assisting on the Phelophepa Health Train</p>
Revise curricula for rurally relevant issues	Yes	Limited	Specialist qualifications to include a rural rotation to instil the principle of outreach support	<p>US undergrad medicine – full 5th yr spent at Ukwanda Rural Clinical School</p> <p>UP – longitudinal PHC exposure in successive training blocks</p> <p>Wits – Community-oriented Primary Care (COPC) / “Adopt a community” in 3rd/4th yr;</p> <p>Occupational Therapy: comprehensive community appraisal; Physiotherapy: design of community-based management programmes</p>
Continuing education programmes accessible from place of work/home	Yes	Limited	Online distance-based education courses to be more broadly offered, Specialist outreach from regional hospitals to support course learning	<ul style="list-style-type: none"> - MMed (FamMed) and College of Medicine of South Africa (CMSA) Diplomas - Effective Management and Leadership Courses in EC - Africa Health Placements programme supporting rural CPD sessions in Eastern Cape - UCT/UWC long distance Perinatal Education Programme with rural study groups - Foundation for Professional Development courses in rural areas
<p>Overall educational recommendation: Universities need to recruit and train on basis of their core mandate: producing HRH for health care needs of the SA population, including the 43,6% of rural population. Resourcing the “rural pipeline” involves recruiting students from rural backgrounds, delivering training in the regions, rural curriculum providing repeated rural exposures, and building regionally based postgraduate training pathways</p>				

REGULATORY	Enhanced scope of practice to increase the potential for job satisfaction	No	Limited	<ul style="list-style-type: none"> - Rural health teams need multi-skilled generalists - Training to enhance scope of practice should be rural-friendly: brief and locally based - Pharmacy assistants increased scope of practice 	Nurse Initiation Management of ART growing nationwide, but any such changes are disease-specific; strategy should be focused on job descriptions/competencies; multidisciplinary synergistic approach
	Introduce different types of health workers with training for rural practice	No	N/A	<ul style="list-style-type: none"> - Enhance the understanding in academic and policy domains that the rural skills mix is different from the urban skills mix - Expand clinical associates training output - Accelerate staff nursing training output - Accelerate pharmacy assistant output 	- Clinical associates training at Wits, UP, WSU
	Ensure compulsory service requirements with appropriate support and incentives	Yes	Limited	<ul style="list-style-type: none"> - Effectiveness of current CSMO policies and practices to be reviewed and National and Provinces to adopt rural-biased CSMO policies with norms for rural placements - Community service to include clinical associates 	<p>KZN DoH has adopted a best practice rural-friendly CSMO policy. Critical elements of the policy are:</p> <ul style="list-style-type: none"> - Rural underserved areas to be favoured - Supervisors to be appointed at facility level - Accommodation to be provided - Outreach, under supervision, from district hospitals to be conducted - CSMO policies for rehabilitation personnel are rural-friendly
	Provide scholarships and financial incentives in exchange of return of service	Yes	To some extent	<ul style="list-style-type: none"> - Expand and ensure provincial capacity to enforce “exchange of service” 	Limited provincial and military bursaries provided

FINANCIAL	Use a combination of sustainable financial incentives to improve rural retention	Yes	Limited	<ul style="list-style-type: none"> - Rural careers to be incentivised by OSD as opposed to rewarding urban-based specialisation - Rural Allowance to be reviewed to reward work in inhospitable areas - Provide Sabbatical Leave for rural health care workers as a retention tool 	OSD declared anti-rural by RuDASA and RHAP
PROFESSIONAL / PERSONAL SUPPORT	Provide a safe and supportive working environment	Yes	Limited	<ul style="list-style-type: none"> - Provide adequate equipment - Provide accommodation to health care workers and students in rural areas - Recruit health leaders, e.g. hospital CEOs on basis of skills and experience to ensure supportive work environment -HR Norms to be implemented for equitable distribution of scarce HRH and to ensure senior support to CSMOs. -Appointment moratoriums to be banned in places that do not meet the minimal norm 	<ul style="list-style-type: none"> - AHP proposal public-private sector accommodation project - NWDoH MOA with Wits for student accommodation - AHP Rural Doctors Support Programme in EC (District Practice Managers visits to hospitals)
	Implement outreach support activities from better-served areas	Yes	Limited	<ul style="list-style-type: none"> - Outreach guidelines to be implemented across levels from tertiary to community health to ensure supervisory support, e.g. NIMART trained nurses - Introduce cell phone policy: 24 hours access to rotating specialists by district hospital teams 	<p>Best practice examples in different provinces, but not done routinely</p> <ul style="list-style-type: none"> - Long history of Wits outreach to Tintswalo (in the past) - Wits-specialists going out to Klerksdorp-Tshepong (KT) Hospital Complex on a regular basis

	Develop and support career development programmes	No	N/A	- Introduce policy to earn points for years worked in rural areas when applying for registrar and or training opportunities	- Weak HR systems, no government ownership - Planned strategy in EC: minimum of 3 years work in rural area earns preference for registrar post - Wits registrars (range of specialist disciplines) rotate through KT
	Support the development of professional networks	Yes	Limited	As Global WHO recommendation	- Very useful web-based listserves build network around management of clinical cases presented (e.g. paed HIV, ethics), no rural focus - RuDASA and RHAP facilitate the growth of professional networks in rural areas
	Adopt public health recognition measures such as rural health days, awards and titles at local, national and international level	Yes	Limited	As Global WHO recommendation	- The Discovery Foundation has 5 yr history of providing this recognition (not only rural) - RuDASA Rural Doctor of the Year Award