A competent and well-motivated health workforce (HWF) forms the core of a high-quality and efficient health system. However, the HWFs in most countries of the WHO South-East Asia Region are in crisis. The World Health Report 2006, “Working together for health”, revealed that 6 of the 11 countries of the SEA Region had fewer than 23 health workers (doctors, nurses and midwives) per 10,000 population—the “threshold” density of doctors, nurses and midwives below which the coverage of essential interventions, including those necessary to meet the health-related Millennium Development Goals, is likely to be jeopardized.

Member countries are committed to achieving an effective and well-motivated HWF as witnessed in the 2006 Health Ministers’ Dhaka Declaration on Strengthening Health Workforce in the Countries of South-East Asia Region and the Regional Committee resolution on Strengthening the Health Workforce in South-East Asia that it adopted at its Fifty-ninth session in 2006. Consequently, the Regional Strategic Plan for Health Workforce Development in the SEA Region was finalized and disseminated in 2007.

As five years had passed since the Dhaka Declaration, and since the subsequent resolution was adopted and the strategic plan finalized, it was decided to assess the progress made in the implementation of the recommendations that had been made, as well as the lessons learnt. Therefore, the WHO Regional Office for South-East Asia organized a Regional Consultation on Strengthening Management of Human Resources for Health in the South-East Asia Region from 13 to 16 February 2012 in Bali, Indonesia. Seventy participants from all 11 countries of the South-East Asia Region, including regional and global health partners attended the consultation. This publication contains an account of the deliberations and the recommendations made during the consultation.
Strengthening the Management of Human Resources for Health in the South-East Asia Region

Report of a regional consultation
Bali, Indonesia, 13–16 February 2012
## Contents

List of abbreviations ........................................................................................................... vii

1. Introduction....................................................................................................................... 1

2. Objectives ......................................................................................................................... 4
   2.1 General objectives ........................................................................................................ 4
   2.2 Specific objectives ....................................................................................................... 4

3. Inaugural session............................................................................................................... 6
   3.1 Address by the Regional Director ............................................................................. 6
   3.2 Inaugural address by H.E. Health Minister .............................................................. 7

4. The HRH situation in the SEA Region: analysis of country profiles ...... 9
   4.1 Findings ...................................................................................................................... 10
   4.2 Discussion .................................................................................................................. 13

5. Progress in implementation of the Dhaka Declaration, the Regional Committee resolution and the Regional Strategic Plan ........... 14
   5.1 Findings ...................................................................................................................... 15
   5.2 Discussion .................................................................................................................. 18

6. WHO-SEARO initiatives for strengthening the public health workforce.......................... 20

7. Group Work Session I: priority issues and challenges in HRH governance, production and utilization ........................................ 23

8. Global HRH initiatives ................................................................................................... 24
   8.1 Global policy recommendations on increasing the access to health workers in remote and rural areas through improved retention ...... 24
   8.2 WHO initiative on scaling up and transforming health professional education .......................................................... 25
8.3 Global human resources for health observatories..............................26
8.4 The Global Health Workforce Alliance ............................................28

9. Regional HRH initiatives .................................................................29
9.1 The Asia-Pacific Action Alliance on HRH ........................................29
9.2 Network of Medical Councils of the South-East Asia Region ............30
9.3 The South-East Asian Regional Association of Medical Education.....31
9.4 The South-East Asian Public Health Educational Institutes Network ..............................................................................................................32
9.5 The South-East Asian Nursing and Midwifery Educational Institutes Network ..............................................................................................................32

10. National HRH initiatives .................................................................34
10.1 India: HRH management under the National Rural Health Mission .................................................................34
10.2 Indonesia: use of workload indicators of staffing needs to improve HRH distribution/management .................................................................36
10.3 Indonesia: Clinical Performance Development and Management System for nurses and midwives ......................37
10.4 Sri Lanka: re-profiling of the health workforce to meet the emerging health needs .................................................................39
10.5 Bhutan: continuing education for career progression/advancement ..............................................................................................................40
10.6 Nepal: steps to enhance deployment and retention of health workforce in rural and remote areas .................................................................41
10.7 Thailand: measures for retaining the health workforce in difficult and remote areas .................................................................42
10.8 Bangladesh: leadership for universal health coverage – nurturing a new generation of HRH ..............................................................................................................43

11. Group Work Session II: strategic actions to address the identified priority HRH issues and challenges, and country actions to strengthen the public health workforce.................................45
12. The WHO Global Code of Practice on the International Recruitment of Health Personnel .................................................................46
  12.1 Implications of the WHO Global Code of Practice at the country level ..............................................................................................................46
  12.2 Application of the WHO Global Code of Practice: Thailand’s experiences ...................................................................................................48

13. Group Work Session III: country plans for implementation of the WHO Global Code of Practice .........................................................49

14. Recommendations ..................................................................................50
  14.1 Recommendations for countries ..........................................................50
  14.2 Recommendations for WHO ..................................................................51

15. Closing session ........................................................................................53

**Annexes**

1. Agenda ........................................................................................................55
2. List of participants .......................................................................................58
3. Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia .................................................................64
4. Inaugural Address by H.E. Dr Endang Rahayu Sedyaningsih, Minister of Health, Republic of Indonesia ....................................................68
5. Outcome of Group Work Session I .............................................................72
6. Outcome of Group Work Session II ...........................................................79
7. Outcome of Group Work Session III ..........................................................89
## List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAAH</td>
<td>Asia-Pacific Action Alliance on Human Resources for Health</td>
</tr>
<tr>
<td>BANPHEIN</td>
<td>Bangladesh Public Health Educational Institutes Network</td>
</tr>
<tr>
<td>CCF</td>
<td>Country Coordination and Facilitation</td>
</tr>
<tr>
<td>CHW</td>
<td>community health worker</td>
</tr>
<tr>
<td>CPDMS</td>
<td>Clinical Performance Development and Management System</td>
</tr>
<tr>
<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
</tr>
<tr>
<td>HQ</td>
<td>WHO headquarters</td>
</tr>
<tr>
<td>HR</td>
<td>human resource</td>
</tr>
<tr>
<td>HRH</td>
<td>human resources for health</td>
</tr>
<tr>
<td>HWF</td>
<td>health workforce</td>
</tr>
<tr>
<td>INDOPHEIN</td>
<td>Indonesia Public Health Educational Institutes Network</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
</tr>
<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
</tr>
<tr>
<td>SEA</td>
<td>South-East Asia</td>
</tr>
<tr>
<td>SEAPHEIN</td>
<td>South-East Asian Public Health Educational Institutes Network</td>
</tr>
<tr>
<td>SEARAME</td>
<td>South-East Asian Regional Association of Medical Education</td>
</tr>
</tbody>
</table>
SEARO     WHO Regional Office for South-East Asia
THAIPHEIN  Thailand Public Health Educational Institutes Network
WHO        World Health Organization
WISN       workload indicator of staffing needs
WPRO       WHO Regional Office for the Western Pacific
Introduction

The health workforce (HWF) is one of the six important building blocks of the health system. It is well recognized that a competent, motivated HWF forms the core of a high-quality and efficient health system.

However, most countries of the South-East Asia (SEA) Region face problems of HWF shortages, maldistribution, inappropriate mix of skills, limited capacity for human resources for health (HRH) production and ineffective HRH management and deployment. The World Health Report 2006, “Working together for health”, revealed that 6 of the 11 countries of the SEA Region faced a crisis with respect to HRH, and had fewer than 23 health workers (doctors, nurses and midwives) per 10,000 population — the “threshold” density of doctors, nurses and midwives, below which the coverage of essential interventions, including those necessary to meet the health-related Millennium Development Goals (MDGs), is likely to be jeopardized.

Countries are committed to strengthening their HWF management in support of primary health care-based health systems to ensure equitable access to quality health services. At their 24th meeting in 2006, the health ministers of the SEA Region issued the Dhaka Declaration, in which they emphasized the need to strengthen HWF in the countries of the SEA Region and affirmed their commitment for an effective and motivated HWF. This was followed by the Fifty-ninth session of the Regional Committee of the SEA Region, which adopted a resolution on strengthening the HWF in South-East Asia, translating the political commitments of the Dhaka Declaration into action, and endorsed the draft Regional Strategic Plan for HWF Development in the SEA Region. The Regional Strategic Plan was then finalized, published and disseminated in 2007.
Consequently, countries have been taking various initiatives/actions to address their HRH challenges. Five years have passed since the Dhaka Declaration, the subsequent resolution and strategic plan, and it is crucial to assess the progress made in the implementation of the recommendations that had been made. This would enable the countries of the SEA Region to draw lessons and identify measures to further accelerate the strengthening of their HWF management, so that they can ensure the availability of competent, committed and responsive health workers, with an appropriate mix of skills at the right place and the right time.

In light of the above, the WHO Regional Office for South-East Asia (SEARO) organized a Regional Consultation on Strengthening the Management of Human Resources for Health in the South-East Asia Region from 13 to 16 February 2012 in Bali, Indonesia. The participants were key HRH stakeholders, including national HRH focal points, policy-makers in the health and education sectors, representatives of health services, academic institutions, HRH-related networks and WHO collaborating centres, development partners, civil society and nongovernmental organizations. A total of 70 participants, i.e. 32 country participants from all 11 countries of the SEA Region, 14 special invitees (6 from HRH-related networks, 4 from WHO collaborating centres and 4 from development partners), 9 observers, and 14 from the WHO Secretariat (4 from SEARO, 1 each from WHO headquarters [HQ] and the Western Pacific Regional Office and 9 from WHO country offices) attended the meeting. The details of the programme of the meeting and the list of participants are provided in Annexes 1 and 2, respectively.
The meeting was chaired by Mr Debasish Panda, Joint Secretary (Human Resources), Ministry of Health and Family Welfare, India, and the vice-chairperson was Dr Tari Tritarayati, Head, Centre for Health Human Resources Planning and Empowerment, Board of Health Human Resources Development and Empowerment, Ministry of Health, Indonesia. Dr Nonglak Pagaiya, Lecturer, International Health Policy Programme, Bureau of Policy and Strategy, Ministry of Public Health, Thailand and Dr PM Rathnayake, Director of Estate and Urban Health, Ministry of Health, Sri Lanka were the rapporteurs.
2

Objectives

2.1 General objectives

The meeting aimed to gain commitments from key HRH stakeholders and agree on measures for accelerating the strengthening of HRH management in the countries of the Region.

2.2 Specific objectives

The specific objectives of the meeting were:

1. To review critically HRH situations in the Region on the basis of an analysis of the newly prepared HRH country profiles;

2. To assess the progress made in the implementation of the Dhaka Declaration on Strengthening of the HWF in the Countries of the SEA Region (2006), the Regional Committee resolution on strengthening of the HWF in South-East Asia (2006), and the Regional Strategic Plan for HWF Development in the SEA Region (2007);

3. To determine priority issues and challenges in HRH management in the Region, along with strategic actions to address them;

4. To identify actions at the country level to strengthen the public HWF;
(5) To determine actions at the country level to facilitate the application of the voluntary WHO Global Code of Practice for International Recruitment of Health Personnel; and

(6) To propose recommendations for accelerating the strengthening of HRH management in support of primary health care-based health systems in the countries of the Region.
3

Inaugural session

3.1 Address by the Regional Director

Dr Samlee Plianbangchang, the Regional Director, WHO South-East Asia welcomed the participants to the meeting and highlighted the importance of the regional consultation, which aimed to review the progress made in the implementation of the Regional Strategic Plan for Strengthening the HWF in the countries of the SEA Region, developed in 2006. He identified ways and means to face the current challenges more effectively, to enable health systems to equip themselves with adequate human resources who are competent, skilled, socially responsible, dedicated and committed to serving the entire population.

The Regional Director outlined the challenges and issues related to HRH management. These include an overall shortage of health workers, or a shortage in certain categories of health workers, inadequate investment by the government in the production of an overall HWF, or of certain categories, the lack of effective educational and training programmes, and the migration of health staff from rural to urban areas, from the public to the private sector, and out of the country. These issues need to be managed in a systematic manner, within the framework of national health policies, which, in turn, should be reoriented more towards public health interventions and community-based
health services. “For this to happen, we need more public health personnel, including community-based health workers,” he noted.

“The workforce must be capable to effectively develop and implement population-based and community-based health programmes for health promotion, and disease prevention and control,” he added. “The competence and skills of community-based health workers need to be ensured to enable them to run the community-based and public health services and refer very sick people to secondary and tertiary care facilities where they can be treated effectively, whenever required”, Dr Samlee pointed out. “It is also necessary to consider rationalization of the utilization of the health workforce of various categories at various levels, especially in terms of cost-effective use,” he added.

Before concluding, the Regional Director recalled the Regional Committee resolution and the Dhaka Declaration, and reaffirmed the commitment of WHO-SEARO to support the Member States in implementing decisions related to HRH, as well as in implementing the recommendations proposed by the participants of the consultation.

The full text of the Regional Director’s address is given in Annex 3.

3.2 Inaugural address by H.E. Health Minister

H.E. Dr Endang Rahayu Sedyaningsih, Minister of Health of the Republic of Indonesia, welcomed all the distinguished guests and participants of the consultation. She pointed out that HRH development is a key factor in achieving the MDGs and in improving the health status of the people. She stressed the Government of Indonesia’s strong commitment to develop policy and regulations to facilitate the implementation of various action points included in the Dhaka Declaration.

“The revitalizing of PHC and the development, distribution and retention of quality HRH are the two key items in the Health Development Reform Agenda that is being implemented. To ensure the quality of nonmedical health workers, the Ministry of Health has also established the Indonesian Health
Workforce Council at the central level and Provincial Health Workforce Council at the provincial level,” Dr Sedyaningsih added.

Dr Sedyaningsih informed the participants that despite the government’s intensive efforts, Indonesia was still facing several HRH challenges. These are mainly the shortage and maldistribution of qualified health workers and a weak HRH information system. To involve all the stakeholders in the collective efforts to address the challenges, the Government of Indonesia has established the Indonesian Country Coordination and Facilitation (CCF) on HRH. One of the important products of its labour is the National HRH Plan for 2011–2025.

While wishing the organizers and participants success in their deliberations, Dr Sedyaningsih expressed her belief that the regional consultation would provide each country a valuable opportunity to learn from and share other countries’ experiences, and to provide feedback and inputs on how to strengthen HRH management. She promised full support for the implementation of the recommendations of the consultation.

The full text of the Health Minister’s speech is given in Annex 4.
The HRH situation in the SEA Region: analysis of country profiles

Dr Budihardja Singgih, Regional Adviser for HRH, WHO-SEARO gave a presentation on HRH situation in the SEA Region, based on an analysis of the HRH country profiles. He informed the participants that all the countries of the SEA Region had been requested to prepare such a profile in accordance with a SEARO template, which was adapted from a template of the African Health Workforce Observatory (prepared with support from WHO-HQ and the Regional Office for Africa). Countries would need to use only secondary data for this purpose. The profile was meant to assist the countries to build a comprehensive information bank on HRH. The profile would include information on all health workers in all sectors, both public and private, and contain disaggregated data in order to provide inputs for HRH policy dialogue and to facilitate informed decision-making.

The framework used for the analysis of the country profiles for this presentation is illustrated in the figure on page 10.

The analysis of the HRH situation covered all categories of the HFW. It was aimed at assessing whether there were problems of shortage, maldistribution, imbalanced mix of skills, and migration of health workers within and outside the country. Another aim was to assess the workers’ competencies, responsiveness, productivity, passion/commitment and ethics. The analysis for HRH production assessed the adequacy of the country’s training capacity by considering the number and capacity of training institutions and their ownership (public or private), as well as the quality of the training. The analysis for HRH utilization examined the recruitment, deployment and distribution of health workers, and also took account of the work environment in the public sector, as well
as employment of health workers in the private sector. The analysis for HRH governance focused on the status of HRH policy development, planning and management for HRH. There were interlinkages between the HRH situation, production and utilization of HRH, and HRH governance that have an impact on health system performance.

4.1 Findings

An attempt was made to collate the data provided by the countries in their HRH country profiles. Although there were gaps in information, the presentation was intended to stimulate interest of the countries’ in addressing the discrepancies and working on a consolidated plan. The results of the analysis of the HRH situation (including data on the number of key health workers from each country and their geographical and gender distribution), production and utilization and governance are summarized below.

**The HRH situation**

It was revealed that despite some improvement in the HRH situation in a few countries of the SEA Region, countries that had been identified in the *World Health Report 2006* as having a critical shortage in the HWF continued to have an HRH crisis and special efforts were needed to address this situation.
Countries of the Region are still afflicted by maldistribution of HWF. The density of health workers in the urban areas is higher than that in the rural areas in most countries. The density of doctors, nurses and midwives is higher in the rural areas than in the urban areas only in Maldives. In Bangladesh, the density of doctors far exceeds that of nurses and midwives. This gave rise to some concern on the optimal utilization of HRH in the country.

Most countries did not provide gender-disaggregated data. In the case of the few countries that did, HRH gender distribution was skewed in favour of male health workers. An exception was Myanmar, where female health workers, including public health workers, outnumber male health workers.

The information provided on HRH by most countries was incomplete, and focused primarily on medical doctors, nurses and midwives. Information on community-based health workers and other health workers was relatively scanty. Also, information on the migration of health workers within the country and across countries was not available. However, Bangladesh, Indonesia and Thailand reported that migration was a major HWF problem.

**Production of HRH**

In most countries, HRH production is not linked to the service requirements. This calls for greater coordination between the ministries of health and of education, which must make an effort to control the number and quality of health training institutions.

Indonesia and Thailand confirmed that they had the capacity to produce a variety of health workers. They reported the existence of categories of training institutions that were more varied than those in other countries.

Bangladesh, Indonesia and Nepal have more private medical schools than publicly owned ones. However, the Democratic People’s Republic of Korea, Sri Lanka and Thailand have a greater number of publicly-owned educational institutions for health personnel than privately owned ones. It was alarming to note that the number of private nursing schools is in Indonesia is increasing rapidly. The mushrooming of private educational institutes calls for special attention at the country level to ensure the quality of education of health personnel.

Public health education is an area that does not draw much interest from the private sector. Most public health educational institutions in Maldives, Nepal and Thailand, are publicly owned.
Deployment of HRH

In most countries, the recruitment and deployment/distribution of health workers have been entrusted to a particular institution, and guidelines developed for this purpose. However, the linkages between such an institution and other units that are responsible for planning of the HWF, and for pre-service and in-service training are weak. Hence, the recruitment and deployment/distribution do not reflect the quantity, quality and the mix of skills of health workers as they should. They are also not relevant to the diversity of the population and do not reflect the dynamics of the labour market.

In countries that have recently introduced a decentralized health system, authority for recruitment and deployment/distribution having been delegated to the local government, the recruitment and deployment/distribution of health workers is more challenging.

Some countries, such as Indonesia and Thailand, have been taking steps to improve the working environment, especially by offering an incentive package.

The need to establish a proper guiding strategy on HRH has been recognized, as has the need to make effective collaborative arrangements between the public and private sectors. However, most countries have not clearly introduced this guiding strategy in the recruitment process in the private sector.

Governance of HRH

Most countries have special institutions responsible for planning and implementation of HRH policy and strategies. However, the functions of these institutions are still fragmented, being shared either with other units under the Ministry of Health or the sectors related to it. There is a need to have a centralized body at the ministry level to lead, facilitate, coordinate and monitor HRH development activities in the country.

Most countries have professional regulatory bodies to regulate the education of the HWF and the practice of the member professionals.

The HRH information system is fragmented and falls under various units within and outside the health ministry. The information on HRH is mostly uncoordinated. In addition, there is a paucity of research on HRH.
4.2 Discussion

The salient points of the plenary discussion following the presentation were:

**Governance of HRH**

1. The need to identify a key functionary (and nodal department) for all HRH-related issues at the national level was emphasized.
2. Multisectoral planning needs to be encouraged at national and subnational levels.
3. A firm HRH policy addressing production, deployment and retention, as well as the urban–rural gap, needs to be developed in most countries.

**Data on HRH**

1. It is crucial to build a credible database. The database needs to be up-to-date and, to the extent possible, real-time. It might be built through a national HRH observatory or any other similar mechanism.
2. Clear definitions of each category/cadre of health workers (such as nurses, auxiliary nurse-midwives and midwives) are necessary.
3. HRH data should be used for the effective deployment and utilization of the HWF.

**Distribution and deployment**

1. There are critical gaps in the area of equity in deployment, including regional imbalances and skewed urban–rural deployment, and these need to be addressed carefully.
2. Special attention should be given to address certain issues pertaining to retention, including the provision of an optimal work environment.

**Production and training**

1. Significant progress has been made in countries, but gaps in training capacity, as well as the quality and content of training continue to be major challenges.
2. The meeting emphasized the need for instructional reforms to ensure the quality and relevance of education.
3. There is a need to strengthen the regulatory framework for training institutions (including accreditation of institutions).
Progress in implementation of the Dhaka Declaration, the Regional Committee resolution and the Regional Strategic Plan

The Health Ministers of the countries of the SEA Region had issued the Dhaka Declaration at their meeting in 2006, in which they had pledged their commitment to promote an effective and motivated HWF. As mentioned earlier, the Regional Committee session that followed the Health Ministers’ meeting in 2006 adopted a resolution on strengthening the HWF and endorsed the draft Regional Strategic Plan for HWF development in the SEA Region. This strategic plan was then finalized and widely disseminated in 2007.

The actions recommended in the HWF resolution and strategic plan were grouped into seven broad areas: (i) planning and implementation of national HWF strategies and plans; (ii) investment in HRH development; (iii) knowledge generation and management of HRH research and information; (iv) strengthening HWF management; (v) enhancing the capacity and quality of HWF educational institutes; (vi) strengthening community health workers; and (vii) fostering regional partnerships.

The progress in the implementation of actions in these seven broad areas was reported by Bangladesh, Bhutan, India, Indonesia, Sri Lanka, Thailand and Timor-Leste as follows.
5.1 Findings

Progress in planning and implementation of national HWF strategies

Most countries had taken special care to form an HRH team of dedicated multistakeholders to develop national HRH strategies and for planning (Bangladesh, Bhutan, Indonesia, Sri Lanka and Thailand). A strategy/plan related to the HWF had already been developed in six countries (the HR Strategy 2009 in Bangladesh, HR Master Plan 2011–2023 in Bhutan, HRH Plan 2011–2025 in Indonesia, HRH Strategic Plan 2009–2018 in Sri Lanka, and HWF Strategic Plan 2007-2016 in Thailand). Timor-Leste intended to include a development plan for the HWF in the Health Sector Strategic Plan 2011–2030, which is being finalized.

Some countries had high-level teams of multistakeholders to facilitate the implementation of plans for HRH development. These included the Country Coordination and Facilitation Team (Indonesia) and the National HRH Committee under the National Health Commission (Thailand). India proposed to set up a national commission on HRH to reform the regulatory framework and enhance the supply of skilled manpower.

Progress in investment in HRH development

All countries advocated for increased investment in HRH. However, the ability to mobilize the resources required was somewhat limited.

A few countries reported a substantial increase in the quantum of funds available for HRH development. India reported an increase in the number of the members of the HWF under the National Rural Health Mission, and also an increase in the funds provided to state governments to strengthen HWF education. Indonesia had introduced special scholarships for the training of specialists under a bond to serve in rural and remote areas. Sri Lanka had obtained additional funds for piloting a reform of the community health worker (CHW) system to address the epidemiological and demographic transitions. Thailand had allocated special budgets to increase the income of the HWF and for the upgradation of skills of health centre personnel to enable them to cater to the needs of health promoting hospitals. Timor-Leste had “Human Capital Development Funds”, which could be accessed for HRH development.
However, most countries were unaware of the total existing resources available for HWF development in the country, as they did not have a centralized expenditure account/system.

**Progress in knowledge generation and management—HRH research and information**

Limited attention was being given to HRH research and information, as reflected in the analysis of the HRH country profiles.

The database on HWF mostly covered the public sector and did not cover all categories of the national HWF.

Research on HRH was limited or nonexistent in most countries. Countries did have research bodies, but only Thailand had a dedicated office (HRH Research and Development Office) responsible for HRH research. This office, however, was finding it difficult to arouse the interest of researchers in HRH research.

**Progress in strengthening HWF management**

Management of HWF required greater attention in all the reporting countries. Some attempts had been made to attract and retain members of the HWF in rural and underserved areas. Special incentive schemes were in place for this purpose in Indonesia, India, Sri Lanka and Thailand.

Job descriptions had been made available in most countries, but these were not serving their purpose fully. For example, staff members were not oriented to their job descriptions in some circumstances.

A few countries (Indonesia, Sri Lanka, Thailand and Timor-Leste) had carried out an assessment of their HWF work environment. However, the steps taken to improve the work environment were limited. Moreover, there were no national standards for HWF work environment.

**Progress in enhancing the capacity and quality of HWF educational institutes**

All countries reported that special efforts had been made to build the capacity of educational institutes for health personnel. For example, Bangladesh had drafted a national plan for scaling up the production of health technologists.
Bhutan had established the Bhutan Institute of Medical Sciences to produce its own medical graduates. Sri Lanka had established six regional training centres to cater to the training needs of regions. Thailand had implemented a plan under which an additional 3000 nurses had been trained, while Timor-Leste had started training of doctors, nurses and midwives at the National University of Timor-Leste.

All countries, except Democratic People’s Republic of Korea and Timor-Leste, had professional councils to regulate the quality of education and practice of their health professionals.

**Progress in strengthening community health workers**

All countries reported that action had been intensified to diversify the roles of CHWs and build their capacity. For example, Bangladesh had recruited and trained 13,500 community health-care providers for community clinics, while India had trained auxiliary nurse-midwives and staff nurses at periphery health facilities as skilled birth attendants. Sri Lanka had piloted a reform of the CHW system to address the epidemiological and demographic transitions. Thailand had provided incentives in the form of salary to village health volunteers and trained them to offer services in response to the health needs of the population, including those of the elderly and needs related to noncommunicable diseases (NCDs). Timor-Leste had trained family health volunteers at the village level.

**Progress in fostering regional partnerships**

Most countries had been actively involved in building regional partnerships through participation in international meetings. Countries engaged in other activities, too, to foster regional partnerships. These included building an international team to deal with international health matters (Indonesia), participating in South-to-South exchange programmes (Sri Lanka), supporting the Asia-Pacific Action Alliance on Human Resources for Health (AAAH) activities as Secretariat and supporting HRH work in other regional countries (Thailand), and building partnerships with countries within and outside the Region for training (Timor-Leste).

**Some remaining challenges**

Despite the progress made, there are certain challenges that countries still need to address carefully in order to create an HWF that is effective and adequately motivated, as envisaged in the Dhaka Declaration. These include:
• effective implementation of the HWF plans that have been developed;
• ensuring the active engagement of multistakeholders in HRH development;
• building the national capacity for HRH research and for the establishment of an effective HRH information system that provides sound evidence to inform policy and decisions;
• mobilizing resources to bring about desirable improvements in HRH development;
• building HRH management capacity, especially at the local level;
• addressing HWF migration issues, particularly within the country; and
• fostering close coordination between the education and services sectors to ensure that the HWF produced meets the service needs and requirements.

5.2 Discussion

The salient points of the plenary discussion following the presentation were as follows.

• Coordination and communication on the production and utilization of HWF, especially between the ministries of health and education and the academic training institutions, needs to be improved to ensure an adequate number of HWF and quality of its education, and make education relevant to the needs of the community.

• Countries in the greatest need rely on access to professional training opportunities available in other countries. To promote the production of specialist workforces, WHO-SEARO should foster intercountry strategic partnerships, especially between countries in the greatest need and countries with established HWF educational systems.

• It would be beneficial to have region-wide regulation of examinations, including entrance examinations for medical schools, medical and postgraduate degree licensing to maintain uniform and appropriate standards of quality among medical professionals in the Region.
Through their national human resource (HR) policies and the allocation of budgets, countries must pay greater attention to the need for nurses, public health workers and allied health workers, in addition to that for doctors.

Member States should actively follow up on the implementation of various World Health Assembly and Regional Committee resolutions. This should be the responsibility of national government as well as the WHO Secretariat.
WHO-SEARO initiatives for strengthening the public health workforce

The public health workforce comprises individuals whose primary intent is to preserve and promote health by focusing on health promotion and disease prevention. They work mainly at the community level to provide health services. By virtue of the very nature of the work it does, the public health workforce is multidisciplinary. Some examples of public health workers are public health physicians, community nurses, public health midwives, nutritionists, sanitarians, community-based health workers and public health laboratory technicians. The public health workforce constitutes a considerable part of the overall human resources for health.

The public health workforce is the backbone of any health system based on the principles of primary health care. WHO-SEARO gives great importance to strengthening of the public health workforce. The “Calcutta Declaration on Public Health”, which had emanated from the 1999 Regional Conference on Public Health in South-East Asia, had provided the much-needed impetus for efforts to further strengthen public health in the Region. Further, the South-East Asia Public Health Initiative had been launched in 2004 under the leadership of the present Regional Director, Dr Samlee Plianbangchang. One of the most important objectives of this initiative was to strengthen education, training and research in the sphere of public health.

WHO-SEARO had worked for advocacy and more effective policies for strengthening of the public health workforce. Over the years, the WHO Regional Committee for South-East Asia had deliberated upon issues related
to the public health workforce on several occasions. In 2011, the Regional Committee adopted a resolution on strengthening of the community-based health workforce in the context of revitalizing primary health care.

Furthermore, it had developed the *Regional Strategic Plan for Health Workforce Development in the South-East Asia Region (2007)* and the *Strategic Directions for Strengthening Community-based Health Workers and Community Health Volunteers in the South-East Asia Region (2008)*. These documents provided guidance on the strategic actions that countries can take towards strengthening the public health workforce.

In addition to taking several initiatives to strengthen the community-based health workers and community health volunteers, action had been taken to improve the deployment of medical and nursing-midwifery personnel in the community. Health-care providers were urged to lay greater stress on public health interventions and empowering the people in the area of self-care. It had advocated the deployment of health-care workers to perform public health functions at the primary care level. In 2011, a regional meeting on strengthening the deployment of public health nurses in support of the MDGs and a regional consultation on strengthening the role of family/community physicians were organized.

Health systems have to cater to an ever-increasing urban population, which has its own challenges. Further, health systems are being decentralized in many countries. Consultations and meetings have resulted in the identification of strategic actions that need to be taken to address the challenges of capacity-building and the management of HRH, including the public health workforce, in the context of urban health and the decentralization of health systems.

Recognizing the important contribution of HRH in health outcomes, the Member States recommended to WHO that it should assist them with the formation of a regional network to facilitate the optimal use of resources within the Region. SEARO assisted in the establishment of a network of medical councils and educational institutions. The main purpose of these networks is to provide a platform for exchanging information, experiences and resources, and to facilitate working together on common concerns or issues. SEARO provides technical and financial support to the South-East Asian Public Health Education Institutes Network, South-East Asian Nursing and Midwifery Educational Institutions Network, Network of Medical Councils of South-East Asia Region, South-East Asia Regional Association of Medical Education, and South-East Asia Primary Health Care Innovations Network.
SEARO responds to country-specific needs related to strengthening of the public health workforce. In recent years, technical and financial support was provided to Timor-Leste to upgrade public health training of health-care providers through improvement of the curriculum for training of doctors, nurses and midwives. The Bachelor in Public Health programme was established at the Royal Institute of Health Sciences in Bhutan, while the National Institute of Health Sciences, Sri Lanka, received assistance to implement a faculty development programme.

WHO-SEARO is committed at the highest level to continue to work with its Member States, institutions and WHO collaborating centres and partners to strengthen the public health workforce in South-East Asia.
Group Work Session I: priority issues and challenges in HRH governance, production and utilization

For Group Work Session I, the participants were divided into three groups. The list of the different group members is provided in Annex 5. The members of Group 1 were requested to discuss the issues and challenges involved in HRH governance, while Group 2 was requested to discuss HRH production. The topic assigned to Group 3 was HRH utilization. The participants were also requested to identify the causes (hindering factors) of the identified issues and challenges, as well as what worked well (facilitating factors).

The outcomes of the three groups’ deliberations were presented at the plenary session and the presentations were followed by a plenary discussion. The final outcome of Group Work Session I, incorporating the comments and suggestions made in the plenary discussion, are provided in Annex 6.
Global HRH initiatives

8.1 Global policy recommendations on increasing the access to health workers in remote and rural areas through improved retention

In his presentation, Dr Mario Dal Poz, HRH Coordinator, WHO-HQ highlighted the global HWF crisis, focusing on the geographical imbalance. While approximately half of the population lived in rural areas, less than 38% nurses and less than 25% physicians worked in these areas. Bringing health workers to the rural and remote areas and keeping them there was a challenge confronting all countries, and the situation was worse in the 57 countries that had an absolute shortage of health workers.

To help countries address this issue, the WHO Secretariat convened in 2009 a gender-balanced group of experts comprising researchers, policy-makers, funders, representatives of professional associations and programme implementers, drawn from each of the WHO regions. The expert group was asked to examine the existing knowledge and evidence, and to provide up-to-date, practical guidance to policy-makers on how to design, implement and evaluate strategies to attract health workers to rural and remote areas and retain them there.

After a year-long consultative effort, the group developed a document proposing 16 evidence-based recommendations on how to improve the recruitment and retention of health workers in underserved areas in order
to increase access to health care. The document can also serve as a guide for policy-makers in matters such as choosing the most appropriate set of interventions, in implementing and monitoring them, as well as evaluating their impact over time.

The proposed recommendations are related to (i) interventions and policies on education; (ii) regulations; (iii) financial incentives; and (iv) personal and professional support.

The meeting discussed the proposed recommendations for improved retention. It was felt that a country’s choice of interventions should be informed by an in-depth understanding of the HWF. This required, at the minimum, a comprehensive analysis of the situation, an analysis of the labour market, and an analysis of the factors that influence the decision of health workers to relocate to, stay in or leave rural and remote areas. Giving due consideration to the broader social, economic and political factors at national, subnational and community levels that influenced retention would help to ensure that the choice of policy interventions was anchored in and tailored to the specific context of each country.

8.2 WHO initiative on scaling up and transforming health professional education

Dr Mario Dal Poz also briefed the meeting on the ongoing WHO initiative for scaling up and improving the quality and relevance of the education of health professionals. He underscored the fact that the education of HWF is one of the key elements of the working lifespan, and is of particular importance in the production of HWF and in the enhancement of its performance. Several factors related to HRH production that have contributed to the global HWF crisis have been identified. These, among others, are: an inadequate number of educational institutions for health professionals; no system for accreditation or regulation of the educational institutions; migration of faculty members due to poor pay or inadequate support; outdated teaching materials; inadequate investment, and a stagnant or decreased number of enrolments.

To respond to the global crisis in the education of health professionals, WHO introduced in 2009 an initiative entitled “Transforming and Scaling up Health Professional Education”. The initiative was aimed at supporting and improving the performance of country health systems to meet the needs of the population in an equitable and efficient manner.
This initiative envisaged a transformative process of scaling up, encompassing reforms of the education and health systems that would address the quantity, quality and relevance of health professionals with an eye to improving the health outcomes of the population. It was developed on the basis of a survey to assess the values and preferences of the stakeholders and beneficiaries in the matter of transforming and scaling up the education of health professionals, so that it may incorporate the diversity of specific contexts into the global recommendation (“value” referred to the relative importance or worth of the consequences/outcomes of an intervention, and “preference” referred to the relative desirability of a range of interventions). These proposed guidelines would respond to present and future educational needs, and their acceptability and feasibility would be assessed to facilitate and broaden their implementation.

The guidelines being developed would provide a strategic direction to countries. However, they would need to be adapted to the country’s context.

### 8.3 Global human resources for health observatories

In her presentation, Dr Gulin Gedik, HRH team leader, WPRO highlighted the role of the HWF observatories as mechanisms for cooperative initiatives, involving public sector-related ministries and organizations, nongovernmental organizations/civil society, academia, professional associations, global, regional and subregional organizations, and development partners, to improve the development of human resources by promoting and facilitating evidence-based policy-making.

The core functions of HRH observatories are to inform, and sometimes evaluate, HRH policy-making by ensuring that valid and reliable information and evidence is available, and that all the relevant stakeholders are engaged in the process. Human resources for health observatories collect, analyse and disseminate data and information on the HWF and labour market; conduct applied research and generate knowledge; contribute to policy development; and capacity building; and to the understanding of HRH issues, and advocate and facilitate dialogue between stakeholders.

Observatories use a range of strategies and tools to achieve their objectives. These include dedicated websites, HRH databases, technical publications, discussion forums, technical meetings, training activities and policy dialogues.
The way that HRH observatories are organized varies according to the regional and country context. Not all observatories are involved in all the activities mentioned above.

A global meeting of HRH observatories was held in Lisbon, Portugal, in July 2011. The meeting confirmed the aforementioned observations and also developed a plan of action, to be implemented by the stakeholders of the HRH observatories. The plan referred to three levels.

At the country level: It was hoped that WHO and different partners could promote the HRH observatory approach and the core functions of such observatories where they were not yet developed. The plan also envisaged scaling up of the capacity of HRH observatories, investing in HRH information, information systems and technical skills. Finally, it was felt that it was important to demonstrate the HRH observatories’ contribution to the development of policy and improvement in the health of the population.

At the regional and subregional levels: The plan laid emphasis on the transfer of knowledge, standardization of tools, technical support and cooperation, comparative metrics and benchmarking, including examples to support and twine with “young” observatories as part of HRH capacity development.

At the global level: WHO and other international agencies and partners should focus on coordinating efforts by convening virtual and face-to-face meetings, networking, and aligning donor support (aid effectiveness) and policy analysis. Special attention should be given to priority countries, and priority interregional and global HRH issues. “High-level” targeted advocacy and influence should demonstrate the link between improved HRH and better health.

The meeting enquired about the success of the national HRH observatories in other regions. It was pointed out that in countries where this initiative existed, there was enhanced coordination among HRH stakeholders and improvements had been noted in the HRH information system. With the help of the evidence produced by the national observatory, some countries, such as Peru, had been able to effectively ensure the availability of an adequate number of health workers in rural areas, where there had earlier been an acute shortage.

The meeting cautioned against setting up a new structure while establishing a national HRH observatory. The observatories should be built on the existing infrastructure and/or mechanism and the emphasis should be on their functions rather than on setting up new structures.
8.4 The Global Health Workforce Alliance

Dr Mario Dal Poz, on behalf of the Global Health Workforce Alliance (GHWA), informed the participants that the GHWA, comprising more than 300 members, was established by WHO in 2006. It represented health professional organizations, academia, nongovernmental organizations (NGOs) and the private sector, both in the developing and developed countries. Its mission was to mobilize all stakeholders to collaboratively advocate the need to and take appropriate actions to achieve access for all to skilled and motivated health workers, with the focus on the 57 countries in crisis.

The issue of HRH was a multisectoral issue and tackling the underlying challenges thus required multisectoral policy options and solutions. Therefore, all stakeholders and partners need to work together to address the HRH crisis. Incountry partnership for HRH involves key stakeholders such as the ministries of health, education, labour and finance, as well as the private sector, professional associations, regulatory bodies, NGOs, the civil society, and national and international development agencies.

The GHWA had supported countries in the establishment of Country Coordination and Facilitation (CCF), which was a process that brought the key stakeholders on one platform to develop and implement an evidence-based, comprehensive and costed HRH plan. The establishment of CCF would help to make the HRH coordination mechanism more effective, making it easier to identify HRH priorities, promote policy dialogue, advocate HRH as a building block of the health system, develop a comprehensive and costed HRH plan, mobilize resources to finance the HRH plan, and oversee the HRH plan implementation and progress.

The CCF mechanism had been established in several countries in the world including two Member States from the SEA Region (Indonesia and Nepal).
Regional HRH initiatives

9.1 The Asia-Pacific Action Alliance on HRH

In his presentation, Dr Weerasak Putthasri, Coordinator, the Asia-Pacific Action Alliance on Human Resources for Health (AAAAH), informed participants that the AAAAH was the only regional network for HRH. It had 16 members in the South-East Asia and Western Pacific regions. It was managed by a small secretariat under the guidance of a steering committee. The secretariat worked with country coordinators, who coordinated between the AAAAH and in-country agencies to update and monitor data on HRH development. The chairperson of the AAAAH was rotated on an yearly basis. This year, the chairperson was China, while next year (2013), it would be Indonesia.

The AAAAH held annual meetings, and six such meetings had already been organized. Its seventh annual meeting, scheduled to be held in Bangladesh in December 2012, would focus on the theme of national HRH policy and management to improve retention of health professionals in remote and rural areas.

Knowledge-sharing through meetings and the AAAAH website and newsletter, as well as capacity-building, had formed the major focus of the activities of AAAAH. AAAAH was keen to play a greater role in driving the national agenda of countries rather than being a talk-based network. It had received support from various development partners, such as the Rockefeller Foundation and WHO.

AAAAH was working on topics such as rural retention of HRH, HRH information system, strategic planning in HRH production and management, and migration of HRH.
9.2 Network of Medical Councils of the South-East Asia Region

In her presentation, Dr Meera Thapa Upadhyay, member of the secretariat of the Network of Medical Councils, informed the participants that the network, established in 2007, had a current membership of all countries of the SEA Region. Its aim was to ensure quality medical education that enhanced the quality of health services in the country. The Network made efforts to promote close collaboration between the medical councils of the SEA Region to facilitate the exchange of information and sharing of experiences, with an eye to strengthening the standards of medical education so that it is relevant to the emerging needs. The Network also identified and addressed areas of common interest to upgrade standards of professionalism among the countries of the SEA Region. In addition, it promoted closer relations with other international organizations dealing with the upgradation of professional standards for medical practitioners.

The Nepal Medical Council had served as the secretariat to the Council since 2009. During the past four years, the Council had established the secretariat office, finalized the governance structure and organized yearly meetings. The publications of the Council included modules and teaching aids on medical ethics for undergraduates, guidelines for accreditation of medical schools, guidelines and instruments for institutional quality assurance in medical education, and guidelines for continuing medical education/continuing professional development activities and for promoting social accountability of medical schools. Currently, the Council was working on the introduction of skill-based assessment during the licensing examination, integration of the issue of patient safety in the medical curriculum, teaching of communication skills during undergraduate medical training and development of regional guidelines for internship.

Coordination with the Ministry of Health/Ministry of Education for the establishment of medical colleges in remote areas of countries constituted one of the current challenges. There was also the need to work with other stakeholders to strengthen HRH management in order to provide quality health services for all in the Region. The other matters of concern were financial sustainability and seeing to it that all member councils continued to have the same level of enthusiasm.
9.3 The South-East Asian Regional Association of Medical Education

Professor Dr Khunying Kobchitt Limpaphayom, Past President, the South-East Asian Regional Association of Medical Education (SEARAME), stated in her presentation that SEARAME is a part of the World Federal Medical Education, which served as an umbrella organization for six regional organizations with a strategic partnership with WHO. The goal of SEARAME was to improve the quality and relevance of medical education at all levels—undergraduate, postgraduate and continuing professional development—in line with the World Federal Medical Education.

The work of the Association included: (i) developing a shared database that will include up-to-date information on experience in implementing quality-improvement processes in medical schools; (ii) promoting twinning between schools and other institutions to foster innovative education; (iii) updating the management of medical schools; (iv) identifying and analysing, by WHO regions, innovations in medical education to help define appropriate lines of work for each region; (v) assisting institutions or national/regional organizations and agencies in developing and implementing reform programmes and establishing recognition/accreditation systems; (vi) contributing to the setting of standards in medical education to promote good practice in the areas of teaching and assessment, taking special note of the standards developed by the World Federation of Medical Education; (vii) fostering communication among medical educators and medical schools in countries of South-East Asia and beyond; (viii) helping evaluate suitable procedures for training students and medical teachers; (ix) collecting factual evidence on the objectives of and programmes in medical education to help describe, distribute and document methods of medical education in the SEA Region; (x) encouraging the medical educational research being conducted in countries in South-East Asia and supporting research projects exploring aspects of medical education; (xi) promoting collaboration with the other regional associations for medical education under the umbrella of the World Federation for Medical Education; (xii) promoting collaboration and synergy between the health system and medical education in the context of the country, and (xiii) promoting the establishment or making available the information regarding quality accreditation system to the Member States.

The future plans of SEARAME included promoting multinational research in the area of standards for social accountability and the creation of a database on potential academic areas in which collaboration on fellowships could be initiated.
9.4 The South-East Asian Public Health Educational Institutes Network

Dr Phitaya Charupoonphol, President of the South-East AsianPublic Health Educational Institutes Network (SEAPHEIN), said in his presentation that the regional network was established in 2003 and its members take turns in acting as president every two years. Currently, the network covered more than 50 institutes in 11 countries of the SEA Region. The secretariat office was located in the Faculty of Public Health, Mahidol University in Thailand. The network’s latest annual meeting, its sixth one, was held in Kathmandu, Nepal, in November 2011.

The goal of this regional network was to strengthen the capacity of health workers, as well as capacity in public health, through education and advocacy for public health. It also promoted domestic networking in countries of the SEA Region, as a result of which there was a Thailand Public Health Educational Institutes Network (THAIPHEIN), Indonesia Public Health Educational Institutes Network (INDOPHEIN), and the Bangladesh Public Health Educational Institutes Network (BANPHEIN).

SEAPHEIN helped countries of the SEA Region that were in need to establish schools of public health and standardize them. It had supported the establishment of public health schools in Bangladesh, Indonesia and Myanmar. It had also helped the Royal Institute of Health Sciences in Bhutan to develop and implement the Bachelor of Public Health programme for upgrading the capacity and qualification of health assistants.

At present, SEAPHEIN was focusing on matters such as education on and advocacy for harmonization of public health, transformative education and regional training centres for national health planning.

9.5 The South-East Asian Nursing and Midwifery Educational Institutes Network

Dr Jariya Wittayasooporn, Director, WHO Collaborating Centre for Nursing and Midwifery, Department of Nursing, Faculty of Medicine, Ramathibodi Hospital, Mahidol University, Thailand had been the chairperson of the South-East Asian Nursing and Midwifery Educational Institutes Network (SEANMEIN) since 2010. In her presentation, she informed participants that the network was established in 2007 with the goal of strengthening and promoting the standard
and quality of nursing and midwifery through collaboration among the nursing and midwifery educational institutes in the SEA Region.

The first SEANMEIN meeting was held in Chandigarh, India in May 2007, while the second was held in Yangon, Myanmar in April 2009. The meetings touched upon a wide variety of important issues, such as the MDGs, primary health care, and the quality of nursing and midwifery education.

Collaborative activities among the members had been organized through the years. These included fellowships, scholarships, study visits, workshops and training courses.
10
National HRH initiatives

10.1 India: HRH management under the National Rural Health Mission

In his presentation, Mr Debashish Panda, Joint Secretary (Human Resources), Ministry of Health and Family Welfare, India informed participants that the National Rural Health Mission (NRHM) was introduced in 2005 to provide affordable and accessible health care to rural India. An attempt had been made to bring various national health programmes and schemes under one umbrella.

The main areas of focus of the NRHM are: (i) improving the management of programmes through the establishment of management structures at all levels; (ii) flexible financing; (iii) strengthening the community participation for better implementation and monitoring progress through established service standards; (iv) HR reforms, including the provision of additional manpower; (v) institution of village-level functionaries (accredited social health activists); and (vi) skill-based training of HWF.

The NRHM was being monitored continuously through periodic reviews and missions (joint, common and external review missions). A bottom-up approach was used for planning, which involves the development of project implementation plans.

Many focused interventions and strategies to decrease the maternal and infant mortality rates had been implemented under the NRHM. These included
the Janani Suraksha Yojana, a conditional cash transfer scheme for promoting institutional deliveries and strengthening home-based newborn care. Since the introduction of the NRHM, there had been a steady increase in the health budget, which was ₹ 2700 million for the financial year 2011–2012.

Reforms of HRH under the NRHM included employment of contractual staff; continuous upgradation of skills through pre-service and in-service training; and strategies for attracting and retaining skilled professionals in rural areas. These strategies included offering financial and non-financial incentives for working in difficult areas, rotational posting in difficult areas, simplification of the recruitment process, compulsory rural service bonds in various states, and the proposed creation of a mid-level professional cadre—rural medical practitioners. Further, financial assistance was offered for the establishment of new health institutions and the upgradation of the existing ones to promote retention.

The main challenges faced by the NRHM in the area of HR were the shortage of skilled manpower, especially in rural areas, as well as difficulties in retaining health workers in these areas. Inequities in the distribution of health professionals are another cause of concern.

The proposed initiatives to strengthen HRH institutional reforms included:

- establishment of a new overarching regulatory body—the National Commission of Human Resources for Health—to strengthen and reform the current regulatory framework and enhance the supply of skilled manpower in keeping with the need;
- establishment of a credible database on health professionals; and,
- accreditation of health institutions and the establishment of a quality assurance framework.

The main reforms proposed to improve training included the revision and updating of the curriculum, and the incorporation of the right mix of knowledge and skills in training.
10.2 Indonesia: use of workload indicators of staffing needs to improve HRH distribution/management

Dr Tari Tritarayati, Head, Centre for Health Human Resources Planning and Empowerment, Board of Health Human Resources Development and Empowerment, Ministry of Health, Indonesia informed participants that since the decentralization policy had been implemented in Indonesia, the local government had more autonomy in the matters of providing and managing public facilities, including human resources. In the health sector, most human resources (civil servants) were employed by the local government and served public health facilities. The Ministry of Health’s decree numbers 81 (2004) and 922 (2008) provided guidelines on planning with respect to the requirement of HRH, as well as on the roles and responsibilities of HRH at different levels, viz. at central, provincial and district/municipal hospitals.

The workload indicator of staffing needs (WISN) was a new method of calculating the HRH requirement based on the real work done by health workers and was applicable to all categories of health workers. The Ministry of Health had started using this indicator for HRH planning and management.

During 2004–2010, the Ministry of Health disseminated the guidelines on HRH plan on requirements and trainings, garnered commitment from the decision-makers to use the WISN, and facilitated the process of the use of the WISN method by the local health offices and relevant units of the ministry. The ministry also developed tools for the application of the WISN. All provincial health offices and some district hospitals received assistance in the development of HRH plans.

The major findings of the workload calculation exercise included the following:

- Midwives at the community health centres often performed tasks not related to midwifery. This trend varied across regions.
- It was not clear whether the tasks unrelated to midwifery were being performed due to the absence or shortage of health workers from other categories.
The findings emphasized the need to define/redefine the roles and responsibilities of health workers, and to achieve the appropriate and effective “staff mix” at the health facility level. This would also improve staff competencies.

Some of the challenges faced in using the WISN method included inadequate commitment of the stakeholders and the limited number of competent HRH planners. There was also the need to develop a system for job analysis and formulate job descriptions for various categories of health workers employed at health facilities at different levels. WISN results must be utilized to convince local governments and the National Employment Administration Agency to take the necessary action. A point to be noted was that the WHO manual on WISN was found to be difficult to understand. The use of the “calculation formula” in the worksheet had been particularly problematic.

It was encouraging to note that the Ministry of State Apparatus had decided to adopt the WISN method for civil servant planning by 2012–2013.

During the plenary discussion, the meeting was informed that WHO-HQ had reviewed and revised the WISN manual to make it more user-friendly, and that the revised version was available on the WHO website.

10.3 Indonesia: Clinical Performance Development and Management System for nurses and midwives

Mrs Ni Wayan Mulati, Director of Nursing, Sanglah Hospital, Bali, Indonesia reported that a study conducted by the Ministry of Health and WHO (2000–2001) that investigated the role and function of nurses and midwives, as well as issues related to their performance, found that over 50% did not have a job description. There was no system for monitoring their performance and over 70% had received no training during the three preceding years. Studies carried out earlier had also indicated that during the late 1990s, there was a mismatch between the level of education of these personnel and the role they were expected to play in the hospital and community.

To improve the situation, the Clinical Performance Development and Management System (CPDMS), a managerial process to improve the clinical competence and performance of nurses and midwives in the hospital and community, was implemented. The broader objective of the CPDMS was to
improve the delivery of health services and the quality of human resources. The CPDMS framework focuses on three aspects, viz. awareness, management, and improvement of performance. The major components are standards and procedures, job-description performance indicator, reflective case discussion, and monitoring and evaluation based on key performance indicators.

The expected outputs are related to teamwork among all relevant health professionals; quality of nursing care; performance appraisal; operational system, and a reward and punishment system. CPDMS emphasizes continuing education and the effective and efficient utilization of resources. Adult-learning (30% theory and 70% practical exercise) and the provision of greater access to resources are essential for the implementation of the CPDMS, which is currently being implemented in hospitals and health centres.

Evaluations following the implementation of the CPDMS indicated that nursing standard operating procedures (SOPs) were available at all clinical sites, all staff had a job description, 3–5 performance indicators were available for monitoring at regular intervals and reflective case discussions were being held on a monthly basis.

Following the success of CPDMS, the Ministry of Health issued a ministerial decree for its wider implementation in hospitals and clinics. CPDMS had also been included in pre-service nursing and midwifery education. CPDMS had also been incorporated as part of quality assurance in hospitals and community.

The highlights of the CPDMS experience include the following:

- CPDMS had proved to be a unique way to improve the performance of nurses and midwives.
- It had helped to improve the quality of health-care services.
- CPDMS implementation had ensured measurements and procedures to facilitate the achievement of goals, and proved to be sustainable.
- It had the potential for replication by other health professionals.

During the discussion, participants expressed their appreciation of this initiative. It was noted that a similar initiative had yielded positive results in a few health facilities in India. It was suggested that Members States should arrange visits to share experiences in such initiatives.
10.4 Sri Lanka: re-profiling of the health workforce to meet the emerging health needs

Dr PM Rathnayake, Director of Estate and Urban Health, Ministry of Health, Sri Lanka, in his presentation, described the main issues that affected HR management in the country. These included increased globalisation of the economy, rapid expansion of the private sector, technological changes and environmental changes, changing needs of the diverse workforce, need to respond flexibly to current HR issues and problems, increase in litigation related to HR management, and lack of managerial commitment.

The current HRH profile of the public sector could be categorized as:

- **curative**, which comprises the subcategories of medical, nursing, professions supplementary to medicine (e.g. medical laboratory technologist), paramedical (e.g. hospital midwife) and others (e.g. attendants);

- **preventive**, which consists of the subcategories of medical (e.g. medical officer of health), nursing (e.g. public health nursing sister), professions supplementary to medicine (e.g. public health laboratory technologist), paramedical (e.g. public health inspector, public health field officer, public health midwife), and others (e.g. non-medical) employees); and

- **support**, which consists of the subcategories of medical administrators, other civil administrators, finance managers, management assistants, programme and planning officers, statisticians and others.

Apart from these, there are related workforces, such as security, laundry, sanitary and catering services, which had been outsourced by the government.

Some problems related to the current HWF profile were an increase in the demand for costly curative services, changing epidemiology reflected in the increasing number of cases of noncommunicable diseases (NCDs), and equity issues (such as disparities between districts).

The key measures taken to address the HRH challenges were: increasing the recruitment numbers (policy decisions have been taken); enhancing the training capacity (intake of training schools, including medical schools, was increased); expanding the public health cadre to tackle the emerging NCDs, and increasing the number of specialists in subspeciality areas.
10.5 Bhutan: continuing education for career progression/advancement

Ms Yangchen Chhoden, Chief Human Resource Officer, Ministry of Health, Bhutan highlighted that the health policy in Bhutan, in accordance with the Constitution, mandated free access to basic health-care services in both modern and traditional medicines. To fulfil this mandate, the government has developed the HRH Master Plan 2011-2023. The objective of the plan was “to ensure adequate and equitable distribution of appropriately motivated and skilled health workers to provide quality services”. It was a living document that aimed to: (i) develop adequate HRH to provide standard services; (ii) ensure equity in the distribution of the available HR in the health facilities across the country; (iii) ensure that the right people are in the right place at the right time; (iv) align the HR policy and management with the objectives of the Ministry of Health; (v) enhance the skills and competence of health professionals in keeping with the changing disease pattern and advancement of medical technology; (vi) ensure optimum utilization of available resources for intended purposes; (vii) promote transparency, accountability and equity in all HR actions; and (viii) promote self-reliance in the matter of skilled health professionals in the country.

HRH management in the country was faced with several challenges. These included difficulty in arranging for postgraduate training for medical doctors; need for continual training to keep up with advancements in health technologies and to deal with the rapidly changing disease pattern; funding constraints; and the deployment and retention of staff in the face of migration.

The focus of HRH activities was to overcome the existing HRH shortages and continuing education of existing staff. The government had been taking short-term and long-term measures to overcome shortages. Short-term measures included recruitment on contract (including government retirees and non-Bhutanese health professionals); utilizing health volunteers from overseas; and imparting training under the Accelerated Nursing Programme and Advanced Nursing Training Programme. The Bhutan Institute of Medical Science was being planned as a long-term measure to meet shortages. The new institution was expected to have five faculties, viz. medicine, traditional medicine, nursing, dentistry and public health.

The health policy laid emphasis on in-service training and continuing education. The Bhutan Medical and Health Council’s regulations (2005) required all registered medical and health professionals to undertake a minimum of 30 credits (or 90 hours) of continuing medical education every five years. In-service training programmes, conducted in the country and abroad, were linked to career advancement.
**10.6 Nepal: steps to enhance deployment and retention of health workforce in rural and remote areas**

Dr Kabiraj Khanal, Undersecretary, Ministry of Health and Population, Nepal, in his presentation, highlighted the following key HRH issues:

- fragmented approach to HR planning, management and development
- continuing shortage of HRH in the public sector despite increased production
- unequal distribution of HRH, especially affecting rural and remote areas, and inability to attract and retain the HWF in these areas
- inappropriate mix of skills
- Poor staff performance (in terms of productivity, quality and availability)
- Inadequate HRH financing.

In order to improve the HR situation, the Health Ministry introduced both financial and non-financial incentives (such as opportunities for career advancement and higher education), decentralization of HRH management (such as local contracts for health professionals), and mandatory rural service for medical graduates supported by scholarships.

In addition, academic institutions had taken initiatives to pilot various models of partnership with the district health system with the aim of strengthening district hospitals to enable them to function as teaching hospitals, improving the population’s access to health services, creating evidence through research activities at the community level, linking undergraduate training with exposure to community needs, and encouraging rural service by giving priority to those with rural service for enrolment into postgraduate programmes.

The Ministry of Health and Population, which accorded high priority to the strengthening of HRH development and management, had made special efforts to strengthen the partnership with academic institutions by making community- and district hospital-based training mandatory for undergraduate and postgraduate medical education programmes. This would foster positive attitudes toward rural employment. It aimed to develop HWF in accordance with the projection for HRH needs by effective local recruitment, and policies and practices to facilitate the retention of the HWF. The ministry would intensify its dialogue with the National Planning Commission and Ministry of Finance to increase resource allocation for HR development.
10.7 Thailand: measures for retaining the health workforce in difficult and remote areas

Dr Nonglak Pagaiya, Lecturer, International Health Policy Programme, Ministry of Health, Thailand presented the measures taken by Thailand to address the geographical maldistribution of HWF. Health workforce maldistribution problem was one of the main HRH problems severely affecting the Thai health system for a very long time. The case of physicians was used as an example to illustrate the measures that Thailand had taken to address the issue.

Thailand had implemented a package of measures to increase the number of physicians in rural areas. These measures had been successful to some degree, judging from the improvement in some relevant indicators, for example the improvement in the doctor–population ratio in the north-eastern region of the country during 1993–2010.

The measures designed to improve the work environment to attract and retain HWF in difficult and remote areas consisted of:

- developing rural health infrastructure;
- planning educational strategies to increase production and curricula reform;
- evolving strategies for compulsory rural service;
- giving financial incentives (e.g. hardship allowance, nonpractice allowance, and special allowance for long service in difficult area);
- giving non-financial incentives (e.g. career advancement measures, rural doctor award, rural doctors’ society, continuing education/specialist training, and job substitution).

Dr Pagaiya concluded that HRH issues were handled by several stakeholders, including the Ministry of Health, other ministries and professional councils. A national HRH committee and a national HRH plan that envisages long-term investment in building capacity for HRH research and management could contribute greatly in addressing the HRH issues.
10.8 Bangladesh: leadership for universal health coverage – nurturing a new generation of HRH

Dr Khaled Shamsul Islam, Senior Assistant Chief, Ministry of Health and Family Welfare, Bangladesh, presented the example of the Chowgacha model district health system. He highlighted the fact that HWF in this district had already achieved all the MDG targets for Bangladesh. In fact, all the relevant service performance indicators for the district, measured by the Demographic and Health Survey and other national surveys, exceeded the national average values by a large margin.

The following factors had contributed to this success story:

- ownership and commitment of the entire HWF
- strong stewardship provided by the civil surgeon (district health office)
- whole-hearted involvement of the following entities in planning, financing and implementation:
  - local government bodies
  - community leaders
  - NGOs
  - entrepreneurs/private business.

The Government of Bangladesh had requested the Ministry of Health and Family Welfare to scale up the success factors of Chowgacha as a national model.

Discussions on national HRH initiatives

The salient points that emerged from the plenary discussions following the country presentations were as follows:

- Countries were unique in the matter of developing initiatives to address their HRH challenges. It was beneficial to have a forum or platform to facilitate exchanging of information and sharing of experiences between countries.
• It was crucial that the HRH plan and production support the national health policy and health system plan.

• An effective HRH information system was needed to support HRH planning and development.

• To address HRH issues effectively, each country would need a strong leadership at the national level to facilitate, coordinate and drive HRH development in the country. The capacity of HRH leaders/managers would need to be developed.

• WHO could provide technical advice on best practices in HRH development and management, platforms for the exchange of experiences, assistance in capacity-building, and help in the reviewing, assessment and monitoring of the progress in HRH development in countries.
Group Work Session II: strategic actions to address the identified priority HRH issues and challenges, and country actions to strengthen the public health workforce

The participants were requested to take into account effective approaches and practices for HRH development and management from global, regional and national initiatives, and deliberate further on the issues and challenges in HRH governance, production and utilization that were identified in Session I to determine the strategic actions to address them. The groups were also requested to identify specific actions to be carried out at the country level to strengthen the public health workforce.

The outcomes of the groups’ deliberations were presented in the plenary session and were followed by a plenary discussion. The comments and suggestions from the plenary discussion were incorporated in the final outcome of Group Work Session II. The final outcome is provided in Annex 7.
12.1 Implications of the WHO Global Code of Practice at the country level

Dr Mario Dal Poz, HRH Coordinator, WHO-HQ, highlighted in his presentation the background and the process of developing the WHO Global Code of Practice on the International Recruitment of Health Personnel. The Code aimed to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel and to facilitate the strengthening of health systems. It was designed by Member States and was adopted by the World Health Assembly in 2010 to serve as a continuous and dynamic framework for global dialogue and cooperation.

The guiding principles and main recommendations of the Code covered the following areas:

- ethical international recruitment
- developing the HWF and promoting the sustainability of health systems
- fair treatment of migrant health personnel
- international cooperation
• support to developing countries
• gathering of data and research
• exchange of information.

The Code spelt out the responsibilities of WHO, the Member States and international agencies in supporting its voluntary implementation. The Member States were expected, among other things, to designate an authority for the implementation of the Code. The designated authority was expected to organize advocacy and communication to publicize the Code among all stakeholders, and to incorporate it into applicable laws and policies, as appropriate. The Member States were expected to report to the WHO Secretariat (the first report is due in May 2012), while the WHO Director-General is to report to the 2013 World Health Assembly on the related progress. So far, in the SEA Region, Maldives, Myanmar and Thailand had designated authorities.

The professional regulatory bodies could play an important role in providing information about international recruitment through the credentialing and licensing process. In addition, special efforts were needed to obtain information from the licensed recruiting agencies.

During the plenary discussion, it was suggested that the spirit of the Code could be used to work out bilateral agreements between countries and to formulate the related regulations and policies. The Code was not a law and did not have a mandate for its enforcement. The process of its development was very lengthy; it took six years of discussion and consultations and three days at the 2010 World Health Assembly. However, it could be amended.

The huge shortage of HWF in the developing countries was partly due to international migration. Therefore, the source/recipient countries should be responsible to alleviate the situation. In the case of the SEA Region, however, Bhutan, Maldives and Timor-Leste, which were the recipient countries, were not in a position to pay compensation.

It was also felt that in the SEA Region, internal migration of health workers from the public to the private sector was more relevant than international migration. Furthermore, data on international migration was not easy to obtain, particularly from the recruitment agencies. Professional bodies could play an important role in this matter by obtaining information from their members about their current place of practice and the reason for changing, if any, in the course of their annual registration and/or renewal of registration/licence.
12.2 Application of the WHO Global Code of Practice: Thailand’s experiences

Dr Krisada Sawaengdee, Registered Nurse, International Health Policy Programme, Ministry of Public Health, Thailand, shared the experiences of Thailand in implementing the Code. She noted that the Code was endorsed in the Sixty Third World Health Assembly after a wait of six years.

Thailand had already taken steps to implement the Code. In July 2010, the national authorities concerned reported to the National HRH Committee on the World Health Assembly resolution, the Code and the fact that Member States were required to submit their first report in May 2012 (The HRH Committee was appointed by the Prime Minister and is under the National Health Commission, which is an independent agency outside the Ministry of Public Health). The Committee then appointed the National Subcommittee on the Implementation of the Code comprising representatives from the ministries of public health, labour, and foreign affairs, professional bodies, Private Hospitals’ Association and universities. It ensured full buy-in and actions were taken by all relevant partners.

The subcommittee first met in February 2011 and translated the Code into Thai. After translation, content validation and back translation, a bilingual (English and Thai) version of the Code was published and widely distributed. The International Health Policy Programme of the Ministry of Public Health was designated as the National Authority for the Code and WHO was informed accordingly. An action plan 2011–2013 for the implementation of the Code was developed and endorsed by the National Health Committee. Measures were taken using domestic resources from the Ministry of Public Health, National Health Commission and International Health Policy Programme.

The main activities charted out in the action plan included communication and advocacy among stakeholders and health professionals, establishment and use of an HRH information system to monitor the movement of HWF, fostering collaboration with recruiters, and providing evidence for the formulation of a national policy.

It was pointed out that the successful implementation of the action plan was made possible by the availability of a multistakeholder forum with adequate domestic resources. The challenges included achieving positive engagement with private recruiters within the weak legal framework. It was noted that the strategic approaches and workplans would be modified in keeping with the changing situation.
In this session, the participants were requested to determine the steps to be taken at the country level to implement the WHO Global Code of Practice. They were also requested to identify how these measures should be carried out, the time frame and the person and/or organization who/that would be responsible, and the support required from WHO and other agencies, if any.

The outcomes of the groups’ deliberations were presented in the plenary and were followed by a plenary discussion. The comments and suggestions from the plenary discussion were incorporated into the final outcome of the session and have been provided in Annex 8.

The meeting was of the view that national authorities concerned should be fully aware of the Code and action taken for its implementation/adaption, as well as of the preparation for submission of the first report in May 2012. Nepal had already formulated a draft plan of action for implementation.

It was stressed that research should be an integral part of the action plan to guide and monitor the implementation of the Code. Countries should use the Code as an advocacy document to address the HRH issue. Further, the source countries should develop comprehensive strategies to cope with the problem of migration of their HWF.
14

Recommendations

On the basis of the deliberations at the meeting, the participants made the following recommendations.

14.1 Recommendations for countries

Countries should take the following strategic measures to address the priority HRH issues and challenges:

1. develop, review and update HRH policies, strategies and plans by engaging relevant stakeholders, with special attention to the public health workforce;

2. advocate for increasing investment, and mobilize resources for the implementation of HRH strategies and plans;

3. create and strengthen HRH governance capacities for the effective implementation of HRH policies, strategies and plans;

4. advocate for the development of an HRH information system and for conducting research, and build capacity for the same;

5. establish mechanisms, such as an HRH observatory, to generate an up-to-date HRH country profile and to facilitate evidence-based policy dialogue for HRH development;

6. strengthen educational institutions to augment the training capacity in terms of quantity and quality, and reorient the curriculum to meet the evolving health needs of the country;
(7) enhance public–private partnerships to strengthen HRH production capacity with the appropriate regulatory framework and mechanism;

(8) address the issue of inequitable distribution of the HWF and educational institutions for health personnel;

(9) develop partnerships between educational institutions and the health-care delivery system to make the educational system more responsive to the health needs of the community;

(10) develop a mechanism and take effective measures to attract, deploy and retain the HWF in remote, inaccessible, underserved and hardship areas;

(11) develop and implement strategies to improve the working environment and conditions of health workers, including remuneration, continuing education, career path and work safety;

(12) establish a mechanism for the periodic monitoring and evaluation of the progress of implementation of interventions and initiatives for HRH development and management, and

(13) consider the application of the voluntary WHO Code within the country context.

14.2 Recommendations for WHO

WHO at all levels should:

(1) facilitate the implementation of national HRH strategies and plans;

(2) provide technical assistance to build capacity for HRH governance and research and conduct operational research in HRH;

(3) facilitate the development and strengthening of the HRH information system;

(4) support the establishment of mechanisms, such as an HRH observatory, to generate up-to-date HRH country profiles and to facilitate evidence-based policy dialogue for HRH development;

(5) foster networking and sharing of information and experiences within and between countries, and within and outside the WHO SEA Region;
(6) assist countries in the application of the voluntary WHO Code, and

(7) organize periodic follow-up meetings to assess the progress, learn about effective strategies/practices and determine measures to further strengthen HRH development and management in countries of the SEA Region.
Two representatives from among the participants were invited to express their views on the meeting. They expressed their appreciation for having had the opportunity to participate in the meeting. They felt that it had been beneficial for them to learn about the effective approaches adopted by other countries to strengthen their HRH development and management and added that they would share the outcomes of the meeting with their colleagues back home.

Dr Budihardja Singgih and Dr Duangvadee Sungkhobol thanked the WHO Representative to Indonesia and the Government of Indonesia for agreeing to host the meeting in Bali. They also thanked all participants, special invitees and observers for their active participation and valuable contributions to the meeting. They expressed appreciation for the cooperation and support extended by all the members of the WHO Secretariat and the administrative support staff. They conveyed their special thanks to the chairperson, Mr Debasish Panda, for conducting the meeting successfully. They also appreciated the roles of Dr Tari Triratayati, Vice-Chairperson; and Dr Nonglak Pagaiya and Dr P.M. Rathnayake, Rapporteurs. They expressed WHO-SEARO’s commitment to collaborating with Member States and providing the required technical assistance to strengthen the HRH development and management in the Region. They hoped that participants would facilitate the implementation of the follow-up actions recommended at the meeting after returning to their countries.

Dr Khanchit Limpakanjanarat, WHO Representative to Indonesia, expressed his appreciation of the fact that all 11 Member States of the SEA Region participated fully in the proceedings of the meeting. This, he said, happened rarely at regional meetings. Commenting on the recommendations
of the meeting, he hoped that participants would ensure that the follow-up actions recommended were implemented in their respective countries.

The Chairperson, Mr Debasish Panda, in his closing remarks, thanked WHO-SEARO for organizing the meeting and expressed the need to hold such meetings on a regular basis to review the progress made and discuss effective approaches and/or best practices to address specific HRH issues of common interest to Member States. WHO-SEARO could draw up a list of issues to be discussed at each meeting and circulate the list among participants for their suggestions and comments before finalizing the agenda for the meeting.

Mr Panda said that WHO-SEARO could work closely with countries to review the progress made in HRH development and to promote HRH advocacy, as well as information and research on HRH. He was also of the opinion that it was crucial to pay special attention to regulatory reform to ensure quality and relevance of education and training of health workers.

He concluded that the Government of India would be willing to collaborate with other countries for HRH development and urged all participants to take initiative to implement the recommendations of the meeting in their respective countries.
Annex 1

Agenda

(1) Inaugural session

(2) HRH situations in the South-East Asia Region: An analysis of HRH country profiles

(3) Progress in the implementation of:
   - Dhaka Declaration on Strengthening health workforce in countries of South-East Asia Region 2006
   - Regional Committee Resolution (SEA/RC59/R6) on Strengthening the health workforce in South-East Asia
   - Regional Strategic Plan for Health Workforce Development in the South-East Asia Region 2007

(4) SEARO initiatives for the strengthening of public health workforce

(5) **Group work session I:** Priority issues and challenges in HRH governance, production and utilization

(6) **Global HRH initiatives:**
   - Global Policy Recommendations on Increasing Access to Health Workers in Remote and Rural Areas through Improved Retention
   - WHO initiative on scaling up and transforming health professional education
   - Global HRH Observatories
   - Global Health Workforce Alliance (GWHA)
(7) **Regional HRH initiatives:**
- Asia Pacific Action Alliance on HRH (AAAH)
- Network of Medical Councils of the South-East Asia Region
- South-East Asian Regional Association of Medical Education (SEARAME)
- South-East Asian Public Health Educational Institutes Network (SEAPHEIN)
- South-East Asian Nursing and Midwifery Educational Institutes Network (SEANMEIN)

(8) **Country HRH initiatives:**
- **Bangladesh:** leadership for universal health coverage – nurturing a new generation of HRH
- **Bhutan:** continuing education for career progression/advancement
- **India:** HRH management under the Rural Health Mission for increasing access to health care
- **Indonesia:**
  - use of workload indicators of staffing need (WISN) for improving HRH distribution/management
  - Clinical Performance Development and Management System for nurses and midwives
- **Nepal:** steps to enhance deployment and retention of health workforce in rural and remote areas
- **Sri Lanka:** re-profiling of health workforce to meet emerging health needs
- **Thailand:** measures for retaining of health workforce in difficult and remote areas

(9) **Group work session II:** Strategic actions to address the identified priority HRH issues and challenges and specific country actions to strengthen the public health workforce
(10) **WHO Global Code of Practice on the International Recruitment of Health Personnel:**
- WHO Global Code of Practice on the International Recruitment of Health Personnel and its implications at the country level
- Application of the WHO Global Code of Practice on the International Recruitment of Health Personnel: Thailand’s experiences

(11) **Group work session III:** Country plans for implementation of the voluntary WHO Global Code of Practice on the International Recruitment of Health Personnel

(12) Drafting and adoption of recommendations for accelerating the strengthening of the HRH management in support of Primary Health Care-based health systems in countries of the Region

(13) Closing session
Annex 2

List of participants

**Bangladesh**

Mr Md Humayun Kabir  
Deputy Secretary (Personnel)  
Ministry of Health and Family Welfare  
Government of the People’s Republic of Bangladesh  
Dhaka

Dr Khaled Shamsul Islam  
Senior Assistant Chief  
Ministry of Health and Family Welfare  
Government of the People’s Republic of Bangladesh  
Dhaka

Dr Mansur Ahmed Khan  
Training Coordinator  
Bangladesh Rural Advancement Committee (BRAC) Health Programme  
BRAC Centre (16th Floor)  
75 Mohakhali, Dhaka 1212

**Bhutan**

Dr Ugen Dophu  
Director  
Department of Medical Services  
Ministry of Health  
Thimphu

Ms Yangchen Chhoedon  
Chief Human Resource Officer  
Ministry of Health  
Thimphu

**DPR Korea**

Dr O Ryong Chol  
Director  
Labour Department  
Ministry of Public Health  
Pyongyang

Mr Ri Su Nam  
Interpreter  
Ministry of Public Health  
Pyongyang

**India**

Mr Debasish Panda  
Joint Secretary (Human Resources)  
Room No. 149-A  
Ministry of Health and Family Welfare  
Nirman Bhawan, New Delhi

Mr Amit Srivastava  
Section Officer (Medical Education Policy)  
Room no. 537 ‘B’ Wing  
Ministry of Health and Family Welfare  
Nirman Bhawan, New Delhi

Dr M Prakasamma  
Director  
Academy for Nursing Studies and Women’s Empowerment Research Studies (ANSWERS)  
215, Amruthaville Apartments, Rajbhavan Road  
Somajiguda, Hyderabad
Indonesia
Dr Tari Tritarayati
Head, Centre for Health Human Resources Planning and Empowerment
Board of Health Human Resources Development and Empowerment
Ministry of Health
Jl HR Rasuna Said Blok X5
Kavling No. 4-9
Jakarta

Dr Elizabeth Jane Soepardi
Head, Centre for Data and Information
Secretariat General
Ministry of Health
Jl HR Rasuna Said, Blok X5
Kavling No. 4-9
Jakarta

Mrs Anna Kurniati
Head of Subdivision, Centre for Planning and Management of HRH
Ministry of Health
Jl HR Rasuna Said Blok X5
Kavling No. 4-9
Jakarta

Maldives
Ms Geela Ali
Permanent Secretary
Ministry of Health and Family
Malé

Ms Sofeenaz Hassan
Director
Ministry of Health and Family
Malé

Myanmar
Dr Tin Tin Lay
Deputy Director-General
Department of Medical Science
Ministry of Health
Naypyitaw

Prof Dr Mya Thu
Director,
WHO Collaborating Centre for Nursing and Midwifery Development Rector,
University of Nursing
677/709 Bogyoke Aung San Street
Lanmadaw Township, P.O. 11131
Yangon

Nepal
Mr Kabiraj Khanal
Under Secretary
Ministry of Health and Population
Kathmandu

Ms Laxmi Pandey Gautam
Under Secretary
Ministry of Health and Population
Kathmandu

Dr Arjun Karki
Professor and Founding Vice Chancellor
Patan Academy of Health Sciences
P.O. Box No. 26500
Kathmandu, Nepal

Mr Sita Ram Chaudhary
Dean
National Academy of Medical Sciences
Bir Hospital
Kathmandu

Dr Jagdish Prasad Agrawal
Executive Director
National Centre for Health Professional Education
Institute of Medicine,
Tribhuvan University
Maharajgunj, P.O. Box: 1524
Kathmandu

Professor Paras K. Pokharel
Chief, School of Public Health and Community Medicine
BP Koirala Institute of Health Sciences
Dharan

Sri Lanka
Dr RRMLR Siyambalagoda
Deputy Director-General (PHS II)
Ministry of Health
Colombo

Dr PM Rathnayake
Director, Estate and Urban Health
Ministry of Health
Colombo
Thailand
Dr Krisada Sawaengdee
Secretary,
Subcommittee on Application of the WHO
Global Code of Practice on International
Recruitment of Health Personnel,
National Committee on Human Resources
for Health
Registered Nurse, Senior Professional Level
International Health Policy Programme
Bureau of Policy and Strategy
Office of the Permanent Secretary
Ministry of Public Health
Tiwanon Road, Nonthaburi
Dr Nonglak Pagaiya
Lecturer, Senior Professional Level
International Health Policy Programme
Bureau of Policy and Strategy
Office of the Permanent Secretary
Ministry of Public Health
Tiwanon Road, Nonthaburi
Dr Sophon Napathorn
Dean, Faculty of Medicine
Chulalongkorn University
Bangkok
[Note: Medical Education Unit, Faculty of Medicine,
Chulalongkorn University is the WHO CC for Medical
Education]
Associate Professor Dr Nuntavarn Vichit-Vadakan
Dean, Faculty of Public Health
Thammasat University
Piychart Building 10th Floor
Klong Luang, Rangsit
Pathumthani
Associate Professor Dr Sathirakorn Pongpanich
Deputy Dean,
College of Public Health Sciences
Chulalongkorn University
Soi Chulalongkorn 62
Phayathai Road, Pathumwan
Bangkok
Timor-Leste
Mr Duarte Ximenes
Director, Human Resources Department
Ministry of Health
Dili
Mr Basilio Martins Pinto
Head, Office for Health Policy
Ministry of Health
Dili
Special invitees
Networks
Network of the Medical Councils of
South-East Asia Region
Dr Meera Thapa Upadhyay
Member, Secretariat,
Network of the Medical Councils of
South-East Asia Region, and
Member, Nepal Medical Council
Kathmandu
Nepal
South-East Asian Nursing and Midwifery
Educational Institution Network
(SEANMEIN)
Dr Jariya Wittayasoporn
Chairperson, SEANMEIN
Ramathibodi School of Nursing
Faculty of Medicine,
Ramathobodi Hospital
Mahidol University
Bangkok
Thailand
South-East Asian Public Health
Educational Institutes Network
(SEAPHEIN)
Associate Professor Dr Phitaya Charupoonphol
President, SEAPHEIN, and
Dean, Faculty of Public Health
Mahidol University
420/1 Rajchavithi Road, Rajthevee
Bangkok
Thailand
Associate Professor Prayoon Fongsatitkul
Deputy Dean for Services and
Asset Management
Faculty of Public Health
Mahidol University
420/1 Rajchavithi Road, Rajthevee
Bangkok
Thailand
Strengthening the Management of Human Resources for Health in the South-East Asia Region

South-East Asian Regional Association for Medical Education (SEARAME)
Professor Dr Khunying Kobchitt Limpapahayom
Past President, SEARAME
Fifth Floor, Anandhamahidol Building
Faculty of Medicine
Chulalongkorn University
Bangkok
Thailand

Asia-Pacific Action Alliance on Human Resources for Health (AAAH)
Dr Weerasak Putthasri
Coordinator, AAAH
Ministry of Public Health
Tiwanon Road, Nonthaburi 11000
Thailand

WHO collaborating centres (WHO CC)
Professor Saroj Kumar Mazumder
Director, National Institute of Preventive and Social Medicine, and
Director, WHO CC for Public Health Workforce Development and Training
Mohakhali, Dhaka
Bangladesh

Assistant Professor Dr Thitinut Akkadechanunt
Associate Dean for International Relations
Faculty of Nursing, Chiang Mai University, and
WHO CC for Nursing and Midwifery Development
110 Inthavaroros Road
Sriphum District, Chiang Mai
Thailand

Assistant Professor Dr Acharaporn Sripusanapan
Associate Dean for Human Resources Management
Faculty of Nursing, Chiang Mai University, and
WHO CC for Nursing and Midwifery Development
110 Inthavaroros Road
Sriphum District, Chiang Mai
Thailand

Dr Nantiya Watthayu
Assistant Dean for Academic Services
Faculty of Nursing, Mahidol University, and
WHO CC for Nursing and Midwifery Development
2 Prannok Road
Bangkok, Thailand

Development partners

AusAID
Mrs Armandina Gusmao-Amaral
Senior Officer, Health
Australian Agency for International Development
Avenida dos Martires da Patria,
Dili, Timor-Leste

JICA
Dr Yuriko Egami
Adviser for Health
Japan International Cooperation Agency
Jakarta
Indonesia

UNFPA
Dr Domingas Bernardo
Assistant Representative
United Nations Population Fund
UN House, Caicoli Street,
Dili, Timor-Leste

UNICEF
Dr Monjur Hossain
Chief, Health and Nutrition, UNICEF
UN House, Caicoli Street
Dili, Timor-Leste

Observers

Prof AA Gde Muninjaya
Head,
Centre for Health Service Management
Faculty of Medicine, Udayana University,
Jln P. B. Sudirman
Denpasar – Bali

Mrs Ni Wayan Mulati
Director of Nursing
Sanglah Hospital
Bali
Dr Abdurachman
Consultant,
Board of Development and Evaluation of
Human Resources for Health, and
Vice-Chairman,
Technical Team on Health Workforce
Planning and Management
Country Coordination and Facilitation
(CCF) Secretariat
Ministry of Health
Jakarta

Dr Sri Henni Setiawati
Assistant Deputy,
Coordinating Ministry of People’s Welfare,
and
Vice-Chairman,
Technical Team on Health Workforce
Development and Supervision
CCF Secretariat
Ministry of Health
Jakarta

Dr Sri Wahyuni, M.Sc
Head, Subdivision of Multilateral Health
Cooperation
Centre for International Cooperation,
Secretariat-General
MoH, Indonesia

Ms Rika Rianty, SKM
Staff, Subdivision of Foreign Cooperation
Administration
Centre for International Cooperation,
Secretariat-General
MoH, Indonesia

Ms Risma Susilawati
Staff, Subdivision of Regional Health
Cooperation
Centre for International Cooperation,
Secretariat-General
MoH, Indonesia

Dr Girindro Andi Swasono
Staff, Subdivision of Regional Health
Cooperation
Centre for International Cooperation,
Secretariat-General
MoH, Indonesia

Dr Mohammad Elvinoreza Hutagalung
Staff, Subdivision of Multilateral Health
Cooperation
Centre for International Cooperation,
Secretariat-General
MoH, Indonesia

Ms Khairani
Centre for Data and Information
Secretariat-General, MoH, Indonesia

Dr Mohammad Shahjahan
Technical Officer (District Health System)
WCO, Indonesia

Dr Mohammad Elvinoreza Hutagalung
Staff, Subdivision of Multilateral Health
Cooperation
Centre for International Cooperation,
Secretariat-General
MoH, Indonesia

Ms Khairani
Centre for Data and Information
Secretariat-General, MoH, Indonesia

**Secretariat**

**WHO-SEARO, New Delhi, India**

Dr Budhhardja Singgih
Regional Adviser for Human Resources
for Health

Dr Duangvadee Sungkhobol
Consultant for Human Resources
for Health

Dr Prakin Suchaxaya
Regional Adviser for Nursing and
Midwifery

Dr Sudhansh Malhotra
Regional Adviser for Primary and
Community Health Care

**WHO-WPRO, Manila, Philippines**

Dr Gulin Gedik
Team Leader for Human Resources
for Health

**WHO-HQ, Geneva, Switzerland**

Dr Mario Dal Poz
Coordinator, Human Resources for Health

**WHO country offices (WCOs)**

Dr Khaled Hassan
Medical Officer for Human Resources
for Health
WCO, Bangladesh

Dr Paul Prabhakar Francis
National Professional Officer
(Medical Epidemiology/IVD)
WCO, India

Dr Mohammad Shahjahan
Technical Officer (District Health System)
WCO, Indonesia
Mr Masfuri
National Professional Officer
WCO, Indonesia

Dr Frank H. Paulin
Public Health Administrator
(Health Systems)
WCO, Nepal

Dr R. Kesavan
National Professional Officer
(Health System Development)
WCO, Sri Lanka

Dr Somchai Peerapakorn
National Professional Officer (Programme)
WCO, Thailand

Dr Yuwono Sidharta
Scientist
WCO, Timor-Leste

Administrative support staff
Ms Shalini Sabharwal
WHO-SEARO

Ms Diyah Herawati
WCO, Indonesia

Ms Maulidia Istiqfani Santoso
WCO, Indonesia
Address by Dr Samlee Plianbangchang, Regional Director, WHO South-East Asia

Excellency, Dr Endang Rahayu Sedyaningsih, Minister of Health, the Government of the Republic of Indonesia, distinguished participants, special invitees, and guests, ladies and gentlemen,

It is my pleasure to welcome you all to the Regional Consultation on Strengthening Management of Human Resources for Health in the SEA Region. I thank all participants for sparing their valuable time to attend the meeting. I thank the Government of the Republic of Indonesia for agreeing to host this meeting. I gratefully thank Her Excellency, Dr Sedyaningsih, for her consent to grace the inauguration of the meeting.

Ladies and gentlemen,

In Bali in 2006 we were here to finalize the Regional Strategic Plan for Strengthening the Health Workforce in the SEA Region. Now, we will review the progress in implementing that Strategic Plan and identify ways and means to face the current challenges more effectively in the management of human resources for health in the SEA Region. Health workforce is the most important component of our health systems. To function efficiently and effectively, health systems need adequate numbers of human resources with a good balance in their categories.

Health systems need human resources who are competent, skilled, socially responsible, dedicated, and committed to serving the entire population. In managing human resources for health, we have always faced several challenges. These are the overall shortage, or shortage in certain categories of health workers, inadequate investment by the government in the production of overall health workforce, or of certain categories, lack of effective educational and
training programmes, migration of health staff from rural to urban areas, from public to private sector, and out from countries.

The issues of HR management are normally confined to four main areas: production, deployment, utilization, and career development. The issues in these broad areas need to be managed in a systematic and planned manner. They need to be tackled within the framework of “national health policies”, which should form the basis for the development of the national HR plans for health.

HR must be developed to fully support the implementation of national health policies.

Ladies and gentlemen,

In the management of national health systems in light of the current health challenges, there is a need to reorient our national health policies more towards public health interventions and community-based health services. A bigger proportion of national resources has been invested in building health facilities to serve the sick people compared with that allocated for promotive and preventive care, which is to keep people healthy.

This strategy, to put promotive and preventive care at least at par with curative care, will have an important implication on health-care systems, especially health-care costs. Now, it is time to think of a more effective approach to investment in health — investment that can ensure well-balanced development between preventive and curative care.

Adequate preventive interventions in health care and services will lead to better growth and development, better protection of health, and better health maintenance. If there is inadequate preventive care, people will get sick more often, and with more severe conditions, a situation that leads to an increasing use of treatment facilities. This in turn will result in an overburdening of health-care systems requiring an increased supply of medicines and medical devices.

Health-care costs are increasing and skyrocketing. However, promotive and preventive care through public health interventions will help relieve these burdens, in both the short and the long term.

For this to happen, we need more public health personnel, including community-based health workers. The workforce must be capable to effectively develop and implement population-based and community-based health programmes for health promotion, and disease prevention and control.
The competence and skills of community-based health workers need to be ensured and their status at the professional level may be recognized, whenever justified. We need community-based health workers who are able to effectively develop and run primary care facilities. These health workers are required as the main force to meet today’s health challenges, such as mitigation of health impacts from climate change, implementation of health programmes towards achieving MDGs, prevention and control of emerging infectious diseases, and prevention and control of NCDs. Community-based and public health services need secondary and tertiary care whereby the very sick people can be referred to and treated effectively, whenever required.

For providing referral services, HR also need to be adequately developed in both quantity and quality. In the management of HR, it is also necessary to consider rationalization of the utilization of health workforce of various categories at various levels especially in terms of cost-effective use.

In order to derive the best results of care and services at reasonable cost, services at the secondary and tertiary levels require specialized medical personnel — they must be cost-effectively utilized. Community- and population-based services generally need more generalists with a mix of skills. In other words, they need a multidisciplinary health team.

The drain from the public to the private sector needs to be tackled through public-private partnerships (PPP). Proper rationalization of the utilization of health staff can contribute to alleviation of the problem of migration from rural to urban areas.

Ladies and gentlemen,

Issues relating to human resources for health (HRH) in the SEA Region require urgent attention. It is an area of high priority for WHO. The Member States in the Region have committed to dealing with these issues in a coordinated manner. The Ministers of Health at their 24th meeting in 2006 adopted the “Dhaka Declaration” on Strengthening the Health Workforce in the Region.

The WHO Regional Committee for SEA in the same year passed a resolution on the same subject and as already mentioned, the SEA Regional Strategic Plan for Health Workforce Development was formulated for guiding implementation of the Regional Committee resolution and the Health Ministers’ Declaration.
Distinguished participants,

The health challenges that have emerged during the past years necessitate significant changes in national health policies. Reorientation of HRH is indeed needed to effectively realize such policy changes in the most cost-efficient and cost-effective manner.

I hope that this meeting will review the state of HRH in the Region in light of the current health challenges being faced by the Member States. To repeat, HR are the critical part of our health systems, and our health workforce must be developed and deployed in a manner that enables them to face today’s and tomorrow’s health challenges effectively.

With these words, ladies and gentlemen, I wish you all fruitful deliberations. I also wish the meeting all success and an enjoyable stay for you all in Bali.

Thank you.
Inaugural Address by
H.E. Dr Endang Rahayu Sedyaningsih,
Minister of Health, Republic of Indonesia

Your Excellency Dr Samlee Plianbangchang, Regional Director, World Health Organization, South-East Asia Region; Dr Bambang Giatno - Head of the Health Human Resource Development Agency of the Ministry of Health; Dr Nyoman Sutedja, Head of the Health Services of the Province of Bali; Dr Khanchit Limpakarnjanarat, WHO Representative to Indonesia; distinguished participants, ladies and gentlemen,

It is a great pleasure for me to address this important regional consultation on strengthening of the management of human resources for health in the South-East Asia Region. On this occasion, let me welcome all the distinguished guests and participants who have travelled all the way from South-East Asia and other regions to Bali. I hope that all of you will have a pleasant and enjoyable stay in Bali, which is commonly referred to as the Island of Paradise.

Ladies and gentlemen,

The important factor in providing quality health services is the human resources for health or HRH. Therefore, HRH development is the key factor in achieving the Millennium Development Goals or MDGs and in improving the health status of the people. We all know that the purposes of achieving MDGs are among others to control various health problems in order to achieve a better quality of life of the people.

As stated in the Dhaka Declaration on Strengthening the Health Workforce, we have strong commitment to develop policy and regulation to improve the availability of health workforce through various actions, namely (i) to develop and implement the national HRH strategic plan; (ii) to increase
the training, educational and research capacity in the area of human resources; (iii) to strengthen the human resource planning and management capacity; (iv) to mobilize adequate resources; (v) to invest in the development of human resources for health; (vi) to actively participate in the work of the existing global and regional networks; and (vii) to take further actions on international migration of health personnel. I am sure, each country in the South-East Asia Region has done its best to carry out these actions.

Ladies and gentlemen,

At present, Indonesia is still facing the challenge of disparity in community access to quality health care among geographical areas and community groups, and at socioeconomic levels. Therefore, the focus of health development during the period 2010-2014 is to improve community access to quality health care and realize the vision of the Ministry of Health to produce “self-reliant healthy people within a just health care system”.

To materialize this vision, a “health development reform” is needed. Such reform will consist of seven efforts namely: (i) revitalization of primary health care; (ii) provision, distribution and retention of quality HRH all over Indonesia; (iii) provision and distribution of sufficient medicines and medical devices in all health facilities in the country; (iv) affirmative action for areas with health problems and the least-developed, border and frontier archipelagic areas; (v) achieving universal coverage in social health insurance; (vi) implementation of the health bureaucratic reform; and (vii) development of world-class health care. The “health development reform” is also meant to strengthen the efforts to achieve the MDGs. The success of the implementation of these efforts needs the support of qualified HRH.

The implementation of a systematic and continuous health development in Indonesia during the last six decades has successfully improved the health status of the Indonesian people. On the HRH side, the Government of Indonesia has increased the number and the quality of the health workers and improved their distribution throughout the country. Some special programmes to improve HRH distribution are the deployment of contracted non-civil servant health workers to remote, very remote, underserved areas, least developed, border, frontier archipelagic areas, and the provision of special incentives for health workers serving at government health facilities in those areas. Additionally, to improve community access to quality health care - mobile hospitals, mobile health centres using four-wheel-drive cars, floating health centres, and flying health-care teams are being operated in remote areas. To enable the health
centres all over Indonesia to carry out better outreach activities, additional funds in the form of “health operational aid” have been provided by the Ministry of Health. The funds are also meant to strengthen the promotive and preventive activities of health centres and to accelerate the achievement of MDGs.

Moreover, an internship programme has been conducted by some faculties of medicine in cooperation with the Ministry of Health for newly-graduated doctors – before the doctors obtained their licences to practise. The programme is meant to lend more experience to the newly-graduated doctors in clinical practice by working in health centres in rural areas. The programme also helps in improving the community access to quality health care.

To provide better community access to specialist medical care in remote areas, the Ministry of Health provides a scholarship programme for the training of doctors and dentists to earn a specialist diploma. Additionally, under the senior resident programme, doctors and dentists who are working on their final stage of specialist training — prior to earning their diplomas — are assigned to work in hospitals located in remote areas, which lack specialists. Moreover, the Ministry of Health also carries out the “doctor with additional competence programme” where general practitioners are trained on the basic competency required for certain types of specialist medical care. To ensure the quality of non-medical health workers, the Ministry of Health also established the Indonesian Health Workforce Council at the central level and Provincial Health Workforce Council at the provincial level.

In 2011, the law on Social Security Management Agency was passed by the House of Representatives. Consequently, on 1 January 2014, universal coverage of social health insurance will be started in Indonesia. At present, preparation is still in progress to provide all necessities, such as the legal framework, management system, health facilities, HRH, and logistics. During the preparation phase, the capacity of health facilities should be improved, among others, by providing more health centres with admission facilities, improving the capacity of third-class wards in hospitals, and providing more hospitals with no class differentiation in its wards.

Ladies and gentlemen,

Despite many efforts by the Government of Indonesia for HRH development, it still has some weaknesses, such as inadequate number and maldistribution of qualified health workers, and an inadequate HRH information system.
At present there are 71 faculties of medicine, 25 faculties of dentistry, 143 faculties of public health, 38 health poly-techniques, and various institutions for health professional education in Indonesia. These institutions are very sources of HRH supply for health care and health development in Indonesia.

It should be borne in mind that HRH development in Indonesia is not solely the responsibility of the Ministry of Health, but it requires the participation and support of all stakeholders. Therefore, the Government of Indonesia has established the Indonesian Country Coordination and Facilitation (CCF) team on human resources for health under the leadership of the Coordinating Minister for People’s Welfare. The Indonesian CCF team comprises representatives from the relevant ministries, national agencies, international agencies operating in Indonesia, health worker councils, professional organizations, health facilities, associations, and health workforce educational institutes’ associations - both from public and private sectors.

One important output of the Indonesian CCF is the National HRH Plan for 2011-2025. The plan is aimed at providing a comprehensive direction and reference for all stakeholders in developing HRH. The plan has six strategies, which include strengthening of the HRH regulations and improving HRH planning, HRH production, and HRH management.

Ladies and gentlemen,

I believe that this regional consultation will give us an opportunity to learn and share each country’s experience and to provide feedbacks and inputs on how to strengthen HRH management. The results of this meeting will help us to better improve the HRH situation at the country, regional and global levels. As health professionals we are all privileged to provide health services to our people and make the key health assets universally available.

Let me end my speech by wishing all participants and the organizers of this meeting to have a productive deliberation that will yield fruitful results to improve HRH development in the South-East Asia Region.

During your free time, I hope that you have the opportunity to experience the beauty of Bali and the hospitality, culture and tradition of its people. Finally, by asking the grace of God the Benevolent and the Most Merciful, I hereby declare the Regional Consultation on Strengthening of the Management of Human Resources for Health In the South-East Asia Region officially open. Thank you.
### Annex 5

#### Outcome of Group Work Session I

**Issues and challenges that impact HRH governance, production and utilization**

1. **Issues and challenges that impact HRH governance**

<table>
<thead>
<tr>
<th>S1 No.</th>
<th>Issues/ challenges</th>
<th>Causes/hindering factors</th>
<th>What worked well/facilitating factors</th>
</tr>
</thead>
</table>
| 1.     | Policies often not evidence based | • Inadequate political will and commitment  
        |                    | • Inadequate funding for HRH research | • Strong political will/commitment  
        |                    |                                         | • Strong leadership |
| 2.     | Policy on dual employment to compromise the public sector employment | • Limited resources and capacity | |
| 3.     | Lack of a costed HRH strategic plan | • Limited resources and capacity | • Strong capacity for strategic planning  
        |                    |                                         | • Adequate resource mobilization |
| 4.     | Inadequate capacity (quantity and quality) in implementing the HRH policy and plan | | • Engagement of multistakeholders including civil society and professional associations to advocate for increased attention in HRH development and management |
| 5.     | Weak HRH database and information systems | • Fragmentation of HRH information and reporting systems | • Minimal dataset, country HRH data profile  
<pre><code>    |                    |                                         | • HRH observatories |
</code></pre>
<table>
<thead>
<tr>
<th>SI No.</th>
<th>Issues/ challenges</th>
<th>Causes/hindering factors</th>
<th>What worked well/facilitating factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Lack of/inadequate HRH structure and staffing in place</td>
<td>• Poorly organized structure</td>
<td>• Appropriate structure and competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Availability of multidisciplinary teams</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Geographical imbalance, as well as imbalance in the mix of skills of health</td>
<td>• Ineffective HRH management</td>
<td>• Effective HRH management</td>
</tr>
<tr>
<td></td>
<td>workforce</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mismatch in the number of professionals produced and employed</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imbalance between competency and job responsibilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Absent/Ineffective regulatory mechanisms of health professionals</td>
<td>• Weak regulation/enforcement</td>
<td>• Strengthen regulatory body, role and responsibility</td>
</tr>
<tr>
<td>9.</td>
<td>Unclear local government accountability in HRH management</td>
<td>• Lack of understanding on the role of local government in HRH</td>
<td>• Inform and involve local government in HRH planning and management to increase their understanding of the situation/problems/priority and their role and responsibility</td>
</tr>
</tbody>
</table>
2. Issues and challenges that impact HRH production

<table>
<thead>
<tr>
<th>No.</th>
<th>Issues/challenges</th>
<th>Causes/hindering factors</th>
<th>What worked well/facilitating factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lack of HRH production policy and plan; mismatch of production and demand</td>
<td>• Insufficient standards and regulations</td>
<td>• Formulation of HRH production policy and plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lack of coordination between Ministry of Education and Ministry of Health</td>
<td>• Effective implementation of the HRH plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2.</td>
<td>Shortage of competent teaching staff</td>
<td>• Being a teacher is not attractive, low financial incentives</td>
<td>• Policy on quality of education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Limited resources and opportunities for advanced education and training</td>
<td>• Allocation of adequate budget for staff development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Regional preference, not willing to be transferred to other areas</td>
<td>• Bilateral agreement/collaboration with experienced educational institutions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Competitive with expansion of labour market</td>
<td>• Incentives, both financial and non-financial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Requirement of high qualification for recruitment of new staff</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lack of comprehensive career planning</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>No.</td>
<td>Issues/challenges</td>
<td>Causes/hindering factors</td>
<td>What worked well/facilitating factors</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 3.  | Inadequate financial allocation that affects quantity and quality of teachers and infrastructure | • Not enough public spending, resource constraint  
• Increased demand of health workforce  
• Policy to improve the ratio of health personnel to population  
• Lack of institutional quality control framework  
• Does not attract private sector to invest | • Need strong commitment from policymakers on investment in education of workforce  
• Costed HRH production plan  
• QA for educational institution  
• Accreditation of educational institution  
• Training of teachers in pedagogy and areas of speciality |
| 4.  | Education does not provide adequate knowledge, attitude and skills required to meet the health challenges and health service requirement.  
Inadequate/inappropriate field/clinical sites that meet teaching standards  
Insufficient attention given to teaching of health ethics in professional curriculum | • Curriculum not updated/ineffective teaching  
• Lack of field/clinical sites | • Competency-based curriculum  
• Transformative education  
• Involvement of utilization/service in education planning and management  
• Periodic review and evaluation of graduates and curriculum |
| 5.  | Mal-distribution of educational institutions | • Insufficient regulation  
• Geographical preference | • Policy on distribution of educational institutions especially in disadvantaged areas  
• Regulation and reinforcement |
### 6. Mushrooming of new educational institutions without any control, plan and coordination

<table>
<thead>
<tr>
<th>Issues/challenges</th>
<th>Causes/hindering factors</th>
<th>What worked well/facilitating factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of HRH plan</td>
<td></td>
<td>• Strong professional regulatory body in implementing its authority</td>
</tr>
<tr>
<td>Ineffective regulatory body</td>
<td></td>
<td>• Regulation on the opening of new schools</td>
</tr>
<tr>
<td>Lack of regulation on the opening of new schools</td>
<td></td>
<td>• Accreditation</td>
</tr>
</tbody>
</table>

### 3. Issues and challenges that impact HRH deployment, utilization and retention

<table>
<thead>
<tr>
<th>No.</th>
<th>Issues/challenges</th>
<th>Causes/hindering factors</th>
<th>What worked well/facilitating factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lack of policy and plan on deployment</td>
<td>• HR issues do not receive high-level recognition at policy level</td>
<td>• World Health Assembly/Regional Committee resolutions, guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lack of HRH database</td>
<td>• National service standards including HRH skills needed for provision of health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Costed HRH plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Insufficient budget/public health posts</td>
<td>• Mechanism to attract workers to rural and remote areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Political will/commitment</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>No sanction of post/creation of post</td>
<td>• Insufficient budget/public health posts</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Political will/commitment</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Demand-supply gap:</td>
<td>• No HRH plan or ineffective HRH plan implementation</td>
<td>• Training and use of community health workers and other non-medical practitioners for providing health service at the primary care level</td>
</tr>
<tr>
<td></td>
<td>• geographical maldistribution</td>
<td>• No HRH database to assess real demand</td>
<td>• Increase number of educational institutions within quality framework</td>
</tr>
<tr>
<td></td>
<td>• imbalance in the mix of skills of health workforce</td>
<td>• Insufficient educational institutions</td>
<td>• HRH production plan and effective implementation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Maldistribution of health workforce</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lack or oversupply of workforce</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Issues/challenges</td>
<td>Causes/hindering factors</td>
<td>What worked well/facilitating factors</td>
</tr>
<tr>
<td>-----</td>
<td>-------------------</td>
<td>--------------------------</td>
<td>--------------------------------------</td>
</tr>
</tbody>
</table>
| 4.  | Lack of qualified staff | • Ineffective recruitment  
• Lack of in-service education/ continuing education  
• Ageing | • Effective HRH recruitment  
• Continuing education programme |
| 5.  | Work beyond the scope of practice  
Work beyond what they were trained for | • Inadequate workforce  
• Non-availability of staff to deliver certain services  
• Ineffective HR management  
• Non-clarity of role  
• Non-availability of a written document on job description/role performance | • HRH plan including job description at various levels  
• Vigorous recruitment of required staff; contractual staff at interim level |
| 6.  | Heavy workload | • Inadequate workforce  
• Too many vertical programmes  
• Lack of team work  
• Ineffective HR management | • Use of volunteers as change agents to carry out simple tasks under supervision of health providers  
• Integrated service and team work approach |
| 7.  | Poor working environment (poor infrastructure and communication)  
Inadequate incentives (career path, promotion, recognition)  
Inadequate social environment and amenities  
Low job satisfaction | • Insufficient funds  
• Inadequate financial/non-financial incentives (compensation, workplace security, career path, welfare and safety, etc.) | • Incentives (monetary/non-monetary) * for service in rural areas. (weightage for post-graduate admissions, compulsory posting in rural areas during undergraduate, internship and post-graduate education, compulsory rural posting of medical doctors after graduation),  
*Nepal study revealed that non-financial incentives are more relevant.* |
<table>
<thead>
<tr>
<th>No.</th>
<th>Issues/challenges</th>
<th>Causes/hindering factors</th>
<th>What worked well/facilitating factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>Migration (intra-outside of the country)</td>
<td>• Poor working environment</td>
<td>• Improved working environment especially in the rural areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lack of retention policy (HRH policy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Political interference</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Individual motivation/attitude</td>
<td></td>
</tr>
</tbody>
</table>
### Annex 6

#### Outcome of Group Work Session II

A. Strategic actions to address the identified priority issues/challenges in HRH governance, production and deployment, utilization and retention

1. Strategic actions to address the identified priority issues/challenges in HRH governance

<table>
<thead>
<tr>
<th>SI No.</th>
<th>Issues/challenges</th>
<th>Strategic Objective</th>
<th>Strategic Action</th>
<th>Benchmark/indicator to assess its progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Policies often not evidence based</td>
<td>Formulate/strengthen evidence-based HRH policies</td>
<td>• Advocate for an HRH policy based on evidence/conduct stakeholders’ consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Formulate national/subnational policy working group</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Conduct needs analysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Promote HRH research</td>
<td>Evidence-based HRH policy developed</td>
</tr>
<tr>
<td>Sl No.</td>
<td>Issues/challenges</td>
<td>Strategic Objective</td>
<td>Strategic Action</td>
<td>Benchmark/indicator to assess its progress</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 2.    | Lack of costed HRH strategic plan/plan has not been implemented. | Develop/strengthen need-based/equity-driven, costed HRH strategic plan              | • Establish multisectoral taskforce (stakeholder)  
• Establish baseline/norms and standards  
• Develop guidelines for implementation  
• Conduct HRH projection  
• Develop monitoring and evaluation framework  
• Perform costing analysis and allocate resources accordingly | Costed HRH strategic plan developed/available                                   |
| 3.    | Weak HRH database and information systems                   | Establish/strengthen HRH information system as part of national Health Management Information System (HMIS) | • Analyse existing situation and need for HRH information  
• Develop standardized tools for identification and reporting of data  
• Build IT system  
• Make HMIS easy to access and transparent and update it regularly | HRH information system established                                      |
<table>
<thead>
<tr>
<th>Sl No</th>
<th>Issues/challenges</th>
<th>Strategic Objective</th>
<th>Strategic Action</th>
<th>Benchmark/indicator to assess its progress</th>
</tr>
</thead>
</table>
| 4.    | Ineffective HRH management and lack of/inadequate HRH structure and staffing in place | Strengthen HRH management structures and functions in relevant ministries | • Establish structured/well-equipped HRH Management Unit within the Ministry of Health  
• Build capacity of HRH officers  
• Develop regulatory framework, including monitoring and evaluation | HRH management unit established/strengthened. |
| 5.    | Absent/ineffective regulatory mechanisms for health professionals | Build transparent, sustainable participatory and responsive accountability mechanisms/systems | • Establish/strengthen regulatory body  
• Institute performance-based system  
• Involve civil society and community watchgroup  
• Involve professional bodies  
• Availability of information in a transparent manner | Regulatory system for health professionals established/strengthened |
2. Strategic actions to address the identified priority issues/challenges in HRH production

<table>
<thead>
<tr>
<th>SI No.</th>
<th>Issues/challenges</th>
<th>Strategic objective</th>
<th>Strategic action</th>
<th>Benchmark/indicator to assess its progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lack of HRH production policy and plan</td>
<td>Comprehensive, evidence-based, long-term and costed HRH production policy for adequate and competent teaching staff emphasizing on community-based health workforce</td>
<td>Develop, review and update existing HRH policies strategies, plans and projections including other relevant ministries in the process</td>
<td>Short- and long-term national plans in place with adequate budget allocation with regular review and reporting</td>
</tr>
<tr>
<td>2.</td>
<td>Inadequate financial allocation that affects quantity and quality of teachers and infrastructure Maldistribution of educational institutions</td>
<td>Increase investment in HRH production</td>
<td>Encourage public-private partnership to strengthen equitable HRH production</td>
<td>Increased number of institutions established in underserved areas</td>
</tr>
<tr>
<td>3.</td>
<td>Education does not provide adequate knowledge, skills required to meet the health challenges and health service requirement</td>
<td>Quality assurance in HRH education</td>
<td>• Set up a mechanism for accreditation of health professional educational institutions • Set up a licensing system for health professionals</td>
<td>• Regional guidelines on accreditation of educational institutions used/adapted at the country level • Licensing system for health professionals established.</td>
</tr>
</tbody>
</table>
3. Strategic actions to address the identified priority issues/challenges in HRH deployment, utilization and retention

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>Issues/challenges</th>
<th>Strategic objective</th>
<th>Strategic action</th>
<th>Benchmark/indicator to assess its progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Lack of policy on deployment</td>
<td>To have a policy on deployment</td>
<td>Develop a policy and plan on deployment</td>
<td>Availability of a policy and plan on deployment</td>
</tr>
<tr>
<td></td>
<td>Lack of policy on deployment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Demand-supply gap (No sanction of post/creation of post)</td>
<td>Increase availability of health workforce</td>
<td>• Refine and update country HRH profile</td>
<td>• HRH profile updated annually</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improve coordination between demand and supply</td>
<td>• Develop/review and implement national HRH plan</td>
<td>• HRH plan developed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Promote preventive aspects of primary health care</td>
<td>• Promote public-private partnerships</td>
<td>• Public health workforce plan integrated into HRH plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Advocate for a balance in health promotion, disease prevention and curative aspects in educational programme of HRH</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Poor working environment</td>
<td>To have a proper working environment</td>
<td>• Strengthen HRH management</td>
<td>• Low attrition rate</td>
</tr>
<tr>
<td></td>
<td>Poor working environment</td>
<td></td>
<td>• Develop a plan to improve the working environment (improve salary, career path, welfare, continuing education and safety, etc.)</td>
<td>• High job satisfaction</td>
</tr>
<tr>
<td>Sl No.</td>
<td>Issues/challenges</td>
<td>Strategic objective</td>
<td>Strategic action</td>
<td>Benchmark/indicator to assess its progress</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
</tbody>
</table>
| 4.    | Utilization (no clarity of role, heavy workload, inadequate qualified health workforce) | To have adequate competent workforce to deliver effective health-care services       | • Effectively recruit and utilize workforce as per their qualifications  
• Strengthen service management (develop job description of health workforce, develop a mix of skills, multi-disciplinary team approach, promote the use of service standards) | Availability of job description and service standards for each category and level of workforce |
| 5.    | Retention and migration (intra-outside of the country)                             | To have a proper migration and retention policy                                      | • Ensure proper working environment (improve salary, career path, welfare, continuing education, safety, school for children and transportation, etc.)  
• Develop a policy and database on migration  
• Develop policy and measures to retain workforce in the rural community (transformation of education regarding social accountability to the nation, Provide incentives, mandatory rural area service, promotion and career development for those working in rural areas, recruitment of students from the rural community, decentralization of recruitment of the health workforce) | Availability of policy on migration and retention |
B: Actions at the country level to strengthen the public health workforce’s governance, production and deployment, utilization and retention

1. Combined actions to strengthen the public health workforce’s governance, production and deployment, utilization and retention

<table>
<thead>
<tr>
<th>SI No.</th>
<th>Country Action</th>
<th>Responsible organization</th>
<th>Benchmark/indicator to assess its progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sensitize the policy-makers to commit and invest in public health workforce development</td>
<td>Ministry of Health (MoH)</td>
<td>Public health, public health workforce is in the government agenda, Percentage of funds for public health increased</td>
</tr>
<tr>
<td>2</td>
<td>Include public health workforce policy and plan in the national HRH policy and plan</td>
<td>MoH</td>
<td>Availability of policy and plan on public health workforce in the national HRH policy and plan</td>
</tr>
<tr>
<td>3</td>
<td>Develop public health workforce database as an integral part of HRH information system</td>
<td>MoH</td>
<td>Public health database available and updated</td>
</tr>
<tr>
<td>5</td>
<td>Create monitoring and supervision systems to ensure effective service from public health workforce</td>
<td>MoH</td>
<td>Monitoring system established, Supervision system established</td>
</tr>
<tr>
<td>6</td>
<td>Develop mechanism and take effective measures for deployment, development and retention of public health workforce</td>
<td>MoH</td>
<td>Measures developed to deploy, develop and retain public health workforce</td>
</tr>
<tr>
<td>SI No.</td>
<td>Country Action</td>
<td>Responsible organization</td>
<td>Benchmark/indicator to assess its progress</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Involve local government, community, NGOs and other stakeholders in the deployment and development of public health workforce</td>
<td>MoH, Local government, community, stakeholders</td>
<td>Availability of public health database</td>
</tr>
<tr>
<td>8</td>
<td>Promote research and disseminate best practices</td>
<td>MoH, education institutions, research institutions, civil society</td>
<td>Number of best practices/research reports/documents/publications</td>
</tr>
</tbody>
</table>

2. Actions at the country level to strengthen the public health workforce’s governance

<table>
<thead>
<tr>
<th>SI No.</th>
<th>Country Action</th>
<th>Responsible organization</th>
<th>Benchmark/indicator to assess its progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Clear policy/specifying definition of public health workforce/expressing government commitment towards strengthening the public health workforce</td>
<td>Ministry of Health</td>
<td>Availability of policy on strengthening public health workforce</td>
</tr>
<tr>
<td>2.</td>
<td>Establish multisectoral coordination mechanism</td>
<td>Ministry of Health</td>
<td>Coordination mechanism established</td>
</tr>
<tr>
<td>3</td>
<td>Mapping out existing public health workforce and projection of future needs and integrated them into the HRH strategic plan</td>
<td>HR Directorate, MoH, Civil Service Commission</td>
<td>Public health workforce plan integrated into the HRH plan</td>
</tr>
<tr>
<td>4</td>
<td>Appropriate resource allocation and adequate compensation system</td>
<td>Ministry of Health, Ministry of Finance</td>
<td>Increased resources allocated to public health workforce development</td>
</tr>
<tr>
<td>5</td>
<td>Monitoring and supportive supervision</td>
<td>Ministry of Health and relevant stakeholders</td>
<td>Supportive supervision system of public health workforce established</td>
</tr>
</tbody>
</table>
### 3. Actions at the country level to strengthen the public health workforce’s production

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>Country action</th>
<th>Responsible organization</th>
<th>Benchmark/indicator to assess its progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Sensitize the importance of public health workforce among policy-makers</td>
<td>Ministry of Health, Ministry of Education and Ministry of Finance</td>
<td>Meetings/seminars organized</td>
</tr>
<tr>
<td>2.</td>
<td>Engage with national planning process to prioritize the production of public health workforce issues in the annual budget</td>
<td>Professional organizations, Ministry of Labour</td>
<td>Public health workforce issues are on the parliamentary or cabinet agenda</td>
</tr>
<tr>
<td>3.</td>
<td>Establish public health workforce observatories to strengthen public health workforce</td>
<td>HR units</td>
<td>Observatories exist</td>
</tr>
<tr>
<td>4.</td>
<td>Review the existing national accreditation and licensing process to identify gaps</td>
<td>Professional and regulatory bodies</td>
<td>Task-force formed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>Country Action</th>
<th>Responsible organization</th>
<th>Benchmark/indicator to assess its progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.</td>
<td>Career-ladder development plan</td>
<td>Ministry of Health</td>
<td>Career ladder for public health workforce available</td>
</tr>
</tbody>
</table>
### 4. Actions at the country level to strengthen the public health workforce’s utilization

<table>
<thead>
<tr>
<th>SI No.</th>
<th>Country action</th>
<th>Responsible organization</th>
<th>Bench mark/indicator to assess its progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inclusion of public health workforce policy and plan in the national HRH policy and plan</td>
<td>MoH</td>
<td>Availability of policy and plan on public health workforce in the national HRH plan</td>
</tr>
<tr>
<td>2</td>
<td>Capacity building of all categories of public health workforce</td>
<td>MoH, educational institutions, training centres; other stakeholders</td>
<td>Number of training programmes provided percentage of HWF trained</td>
</tr>
<tr>
<td>3</td>
<td>Strengthening and regulation of service provision of public health workforce</td>
<td>MoH, academic institutions and regulatory bodies</td>
<td>Availability of a quality assurance system for service provision</td>
</tr>
<tr>
<td>4</td>
<td>Development of a public health workforce database as part of the national HRH database</td>
<td>MoH</td>
<td>Availability of public health database</td>
</tr>
<tr>
<td>5</td>
<td>Research and dissemination of best practices</td>
<td>MoH, educational institutions; academic/research institutions, civil society</td>
<td>Number of best practices/research reports/documents/publications</td>
</tr>
<tr>
<td>6</td>
<td>Develop mechanisms for retention of public health workforce</td>
<td>MoH</td>
<td>Policy on retention of public health workforce available</td>
</tr>
</tbody>
</table>
Annex 7

**Outcome of Group Work Session III**

*Actions at the country level for implementing the Voluntary WHO Global Code of Practice on the International Recruitment of Health Personnel*

1. Combined outcome of Group A, B and C’s deliberations

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>Activity</th>
<th>How to carry out the activity</th>
<th>Timeframe</th>
<th>Responsible organization</th>
<th>Required support from WHO or any other agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Designation of a dedicated person to be the focal point</td>
<td>MoH to appoint a person</td>
<td>April 2012</td>
<td>MoH</td>
<td>–</td>
</tr>
<tr>
<td>2.</td>
<td>Advocacy and sensitizing relevant national organizations/ ministries/ professional organizations, health professionals</td>
<td>Disseminate the document Organize meetings to orient concerned stakeholders on the Code</td>
<td>2012-2013</td>
<td>MoH</td>
<td>WHO support (consultant)</td>
</tr>
<tr>
<td>3.</td>
<td>Conduct situation analysis on the migration of workforce in and out of the country</td>
<td>Form a team to do a study Review of related documents, laws, regulations Conduct a study to review the situation of workforce migration Submit a report to the MoH for policy decision</td>
<td></td>
<td>MoH</td>
<td>–</td>
</tr>
<tr>
<td>Sl No.</td>
<td>Activity</td>
<td>How to carry out the activity</td>
<td>Timeframe</td>
<td>Responsible organization</td>
<td>Required support from WHO or any other agency</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>--------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>4.</td>
<td>Seek government’s decision</td>
<td>Submit the report on situation analysis, World Health Assembly resolution</td>
<td></td>
<td>MoH</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>If yes, continue items 5-9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Create a mechanism and structure</td>
<td>Form a taskforce, committee or unit responsible for the implementation of the Code</td>
<td></td>
<td>MoH</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Create a mechanism for implementation and reporting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Develop plan of action to implement the code</td>
<td>Develop a plan of action with outputs, timeframe, budget and responsible person</td>
<td></td>
<td>Appointed taskforce, committee or unit</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Submit a plan for MoH approval</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Roll out and implement the plan</td>
<td>Carry out approved activities</td>
<td></td>
<td>Appointed taskforce, committee or unit</td>
<td>WHO technical support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Regular monitoring of the progress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Report the outputs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Support research</td>
<td>Identify areas for research</td>
<td></td>
<td>MoH</td>
<td>WHO technical support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Call for proposals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provide grants to approved proposals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Disseminate the findings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of findings for policy decision</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Reporting the progress in the implementation of the Code</td>
<td>Submit a report of the implementation of the code every 6 months to MoH and the World Health Assembly as requested</td>
<td></td>
<td>Appointed taskforce, committee or unit and MoH</td>
<td>–</td>
</tr>
</tbody>
</table>
## 2. Outcome of Group A's deliberations

<table>
<thead>
<tr>
<th>No.</th>
<th>Activities</th>
<th>How to carry out the activity</th>
<th>Timeframe</th>
<th>Responsible organization</th>
<th>Required support from WHO or any other agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Designation of national focal point/related authority</td>
<td>Through endorsement by the relevant authority</td>
<td>April 2012</td>
<td>Ministry of Health</td>
<td>National focal point</td>
</tr>
<tr>
<td>2.</td>
<td>Advocacy or publicizing the implementation of WHO Global Code</td>
<td>Stakeholders, meeting and publication</td>
<td>May 2013</td>
<td>WHO</td>
<td>HMS and academic institutions and professional bodies</td>
</tr>
<tr>
<td>3.</td>
<td>Data collection of in and out migration</td>
<td>Establishment of a working committee for database linked to HMS Use WHO guidelines for gathering data</td>
<td>May 2013</td>
<td>National focal point</td>
<td>Technical support for research</td>
</tr>
<tr>
<td>4.</td>
<td>Research on factors related to health personnel migration</td>
<td>Multisectoral research through academic institutions</td>
<td>2015</td>
<td>Ministries of Health</td>
<td>Multi-country research on common issues</td>
</tr>
<tr>
<td>5.</td>
<td>Review the domestic laws/policies related to recruitment and in/out migration</td>
<td>Expert Advisory Group Preparation and distribution of guidelines</td>
<td>2013</td>
<td>Ministries of Health</td>
<td>Facilitating role</td>
</tr>
<tr>
<td>6.</td>
<td>Bilateral agreement for technical cooperation and recruitment</td>
<td>Development of a mechanism</td>
<td>2013</td>
<td>Ministries of Health</td>
<td>Reporting system</td>
</tr>
<tr>
<td>7.</td>
<td>Monitoring and reporting</td>
<td></td>
<td>2013</td>
<td>Ministries of Health</td>
<td></td>
</tr>
</tbody>
</table>
### 3. Outcome of Group B’s deliberations

<table>
<thead>
<tr>
<th>Sl No.</th>
<th>Activity</th>
<th>How to carry out the activity</th>
<th>Responsible organization</th>
<th>Timeframe</th>
<th>Required support from WHO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Sensitize relevant national organizations/ministries/units/professional organizations (e.g. SAARC section, ASEAN section, etc.) with the World Health Assembly resolution and the WHO Code of Conduct</td>
<td>Put the Code of Conduct on national and international agendas through inter-parliamentarian meetings</td>
<td>Ministry of Health, ILO, SAARC, ASEAN</td>
<td>2012-2013</td>
<td>Yes</td>
</tr>
<tr>
<td>2.</td>
<td>Disseminate the Code of Conduct to health authorities and other relevant ministries, and private sectors both health and non-health, as well as civil societies dealing with migration and employment</td>
<td>Designate a person to disseminate the Code of Conduct</td>
<td>MoH</td>
<td>End of 2012</td>
<td>No</td>
</tr>
<tr>
<td>3.</td>
<td>Create awareness about the Code among stakeholders, especially the affected health workforce</td>
<td>Develop communication strategies for target groups, Develop supporting system (hotlines, etc.)</td>
<td>MoH, ILO, SAARC, ASEAN, Civil Societies</td>
<td>2012-2013</td>
<td>No</td>
</tr>
<tr>
<td>4.</td>
<td>Monitor and evaluate the national implementation of the Code</td>
<td>Designate/establish a unit to institutionalize the Code of Practice, Commission research to document evidences on issues related to Code of Conduct, Create and update database for monitoring</td>
<td>MoH, all stakeholders</td>
<td>End of 2012</td>
<td>Yes</td>
</tr>
</tbody>
</table>

---

End of 2012: MoH, ILO, SAARC, ASEAN, Civil Societies
End of 2012: MoH, all stakeholders
End of 2012: The designated unit
End of 2012: The designated unit
End of 2012: The designated unit
## 4. Outcome of Group C’s deliberations

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Activity</th>
<th>How to carry out the activity</th>
<th>Timeframe</th>
<th>Responsible Organization</th>
<th>Required support from WHO or any other agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Advocacy</td>
<td>Meetings and workshop with key ministries and partners</td>
<td>6 months</td>
<td>MoH</td>
<td>WHO</td>
</tr>
<tr>
<td>2</td>
<td>Situational analysis</td>
<td>Review of database, records, existing law and practices</td>
<td>6 months</td>
<td>MoH, Ministry of Labour (MoL), HR Ministry</td>
<td>WHO</td>
</tr>
<tr>
<td>3</td>
<td>Government approval</td>
<td>Submission of report of situational analysis</td>
<td>6 months</td>
<td>MoH</td>
<td>NA</td>
</tr>
</tbody>
</table>
| 4     | Create a mechanism and structure for implementation of the Code | • Establishment of a unit  
• Formation of multistakeholder Board/Committee  
• Development of an implementation plan | 12 – 18 months | MoH in consultation with stakeholders (MoL), HR Ministry, Ministry of Justice, Ministry of External Affairs, Regulatory Body, Professional Associations, Private Sector, Academia) | WHO, ILO |
| 5     | Roll-out of implementation plan | • Establishment of database  
• Regular monitoring and reporting  
• Formulation of laws and regulations; bi-lateral agreements  
• Operational research | Ongoing | The designated unit | WHO, ILO |
A competent and well motivated health workforce (HWF) forms the core of a high-quality and efficient health system. However, the HWFs in most countries of the WHO South-East Asia Region are in crisis. The World Health Report 2006, “Working together for health”, revealed that 6 of the 11 countries of the SEA Region had fewer than 23 health workers (doctors, nurses and midwives) per 10,000 population—the “threshold” density of doctors, nurses and midwives below which the coverage of essential interventions, including those necessary to meet the health-related Millennium Development Goals, is likely to be jeopardized.

Member countries are committed to achieving an effective and well motivated HWF as witnessed in the 2006 Health Ministers’ Dhaka Declaration on Strengthening Health Workforce in the Countries of South-East Asia Region and the Regional Committee resolution on Strengthening the Health Workforce in South-East Asia that it adopted at its Fifty-ninth session in 2006. Consequently, the Regional Strategic Plan for Health Workforce Development in the SEA Region was finalized and disseminated in 2007.

As five years had passed since the Dhaka Declaration, and since the subsequent resolution was adopted and the strategic plan finalized, it was decided to assess the progress made in the implementation of the recommendations that had been made, as well as the lessons learnt. Therefore, the WHO Regional Office for South-East Asia organized a Regional Consultation on Strengthening Management of Human Resources for Health in the South-East Asia Region from 13 to 16 February 2012 in Bali, Indonesia. Seventy participants from all 11 countries of the South-East Asia Region, including regional and global health partners attended the consultation. This publication contains an account of the deliberations and the recommendations made during the consultation.