Regional Strategy on Strengthening Health Workforce Education and Training in the WHO South-East Asia Region

Report of the expert group meeting
Bangkok, Thailand, 29–30 May 2014

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Contents

Acronyms

AAAH	Asia–Pacific Action Alliance on Human Resources for Health
ANMTC	auxiliary nurse and midwife training centres
GNMTC	general nurse and midwife training centres
CHW	community health workers
CPD	continuing professional development
DCI	Dental Council of India
DNB	Diplomate National Board
HR	human resources
HRH	human resources for health
HSC	health sub-centre
HWF	health workforce
HFWTC	health and family welfare training centre
IAAHHE	Indonesian Accreditation Agency for Health Higher Education
ICT	Information and Communication Technology
INC	Indian Nursing Council
IHPP	International Health Policy Programme
M&E	monitoring and evaluation
MCN	Medical Council Network
MCI	Medical Council of India

NCHPE	National Centre for Health Professions Education, Nepal
NHSRC	National Health Systems Resource Centre, India
NHTC	National Health Training Centre, Nepal
SEAPHEIN	South-East Asian Public Health Education Institutes Network
SEARAME	South-East Asia Regional Association for Medical Education
SIHFW	State Institute of Health and Family Welfare
TNA	training needs assessment
UHC	universal health coverage
WHO	World Health Organization

1. Introduction

Strengthening health workforce (HWF) education and training is necessary to produce and develop health-care providers in adequate numbers with required competencies and appropriate mix of skills who can effectively deal with health challenges and deliver effective and responsive health services. This may require the organizational, institutional and instructional structure of HWF education and training systems to be reformed in Member States.

It is also imperative for countries to devote more attention to training and education of community-based health workers to further bolster the primary health-care approach to health services. An effective community-based HWF is one of the ways to ensure that essential health interventions reach the "unreached" population to achieve universal health coverage (UHC).

However, efforts at the country level to strengthen HWF education and training in the WHO South-East Region are largely fragmented due to limited resources and lack of clear policy directions. There is a need to have clear national health policies, strategies and plans on the focus of the health systems, HWF requirements and their education. These will provide clear directions on the kind of health-care providers needed, and the competencies and levels of skills needed at various levels of the health services. Thus, these will determine how education and training of health-care providers should be provided.

The WHO Regional Committee for South-East Asia in its Sixty-fifth session in September 2012 adopted resolution SEA/RC65/R7 on Strengthening health workforce education and training in the Region. The resolution sought to draw the attention of Member States to the urgent need to improve HWF education and training. This is imperative to produce competent health workers who will meet the needs of the health systems and population, and to achieve universal health coverage. The resolution urged Member States, among others, to conduct comprehensive assessments of HWF education and training, based on an agreed common

regional protocol. This assessment would serve as the basis for formulation of evidence-based policy and its implementation.

Acting on the Regional Committee resolution, the WHO Regional Office for South-East Asia has developed a draft protocol to guide Member States on how to carry out comprehensive assessments of HWF education and training. The draft protocol, as a tool for the comprehensive assessment, was finalized at the regional informal consultation held in New Delhi in July 2013. Member States have since conducted the comprehensive assessment with standard protocol and submitted country assessment reports.

The Regional Office organized the regional expert group meeting to review and finalize the draft Regional Strategy on Strengthening Health Workforce Education and Training in Bangkok on 29–30 May 2014. This strategy was developed in collaboration with the International Health Policy Programme (IHPP), Bangkok, Thailand.

The meeting was attended by 15 experts, including representatives of networks such as the South-East Asia Regional Association for Medical Education (SEARAME), South-East Asian Public Health Education Institutes Network (SEAPHEIN), Medical Council Network (MCN)-WHO SEA Region and the Asia–Pacific Action Alliance on Human Resources for Health (AAAH).

2. Objectives

The objective of the meeting was to finalize the draft of the regional strategy on strengthening HWF education and training in Member States of the WHO South-East Asia Region.

3. Opening session

Dr Tong Chol Pak, Regional Adviser, Human Resources for Health and Fellowships, WHO Regional Office welcomed the senior experts from the Region and thanked all Member States for their contribution in completing the country assessment for HWF education and training. This would make it possible to develop a regional strategy for discussion at the expert group meeting, he said.

Dr Pak stated that globally more than a billion people continue to lack access to quality health services. This is because of a combination of factors such as shortage, imbalanced skill mix and uneven geographical distribution of health workers. WHO estimates that an additional 4.3 million health workers are needed worldwide. The crisis in the HWF has serious implications on the health and well-being of millions of people, yet not enough trained health workers are being produced to bridge this shortfall.

Scaling up of educational programmes to produce a multidisciplinary service delivery team that includes a carefully balanced mix of clinicians, community health workers (CHWs) and health managers is both urgent and essential. However, the solution does not lie in simply increasing the number of health workers. The shortage of health workers is compounded by the fact that their skills, competencies, clinical experience and expectations are often poorly suited to the health needs of the population they serve.

WHO is working with a wide range of stakeholders to scale up the health workforce quantitatively and qualitatively. This also includes improving the quality and relevance of health workers to meet the needs of the twenty-first century and contributing to better population health outcomes.

A competent and motivated HWF forms the core of a high-quality and efficient health system. To achieve universal health coverage, countries need to have adequate numbers and types of competent HWF to deliver essential health interventions. However, six out of the 11 Member States countries of the WHO South-East Asia Region face human resources for health (HRH) crisis with fewer than 23 health workers per 10 000 population. This is the "threshold" density of doctors, nurses and midwives below which coverage of essential interventions – including those necessary to meet the health-related Millennium Development Goals – may not be adequately possible. The commitment of Member States to an effective and motivated HWF is reflected in the 2006 Dhaka Declaration on Strengthening Health Workforce in the countries of the South-East Asia Region and the Regional Committee resolutions on the issue adopted at its Fifty-ninth Session in 2006.

Although considerable efforts have been made to strengthen education and training of health workers in countries, more remains to be done to produce desirable results in most. Good practices exist for the

education of the HWF in countries of the Region. However, most countries encounter serious challenges in educating their HWF, such as limited institutional capacity in terms of numbers, competencies of teaching staff and inadequate infrastructure.

Dr Pak stressed the need for developing a comprehensive regional strategy on strengthening of HWF education and training in Member States of the SEA Region. The draft strategy will be finalized and improved, based on the discussions at the meeting, he stated.

Dr Viroj Tangcharoensathien, Senior Adviser, IHPP, was elected as chairperson of the meeting. Dr Weerasak Putthasri was rapporteur.

4. Country presentations: experiences with national assessments

4.1 Bangladesh

Dr Muzaherul Huq, Chairman, Public Health Foundation of Bangladesh, presented the experience of Bangladesh with the comprehensive assessment of HWF issues and challenges.

There are two methods of data collection related to the HWF situation applied in Bangladesh:

(1) data collected directly from respondents; and

(2) data collected indirectly from secondary sources in both public and private sectors.

Too many or incomplete records, and their poor quality and confusing terminology can, however, pose problems. In 2008, the Government of Bangladesh had tried to put in place a good system to collect and analyse data. But there remained many issues of concern, such as:

- populations in small areas;
- existing problems in the institutional set-up;
- lack and misuse of resources; infrastructure and logistics; and
- shortage of trained ICT (information and communication technology) staff.

There were also various barriers in terms of IT infrastructure, such as lack of Internet connectivity and alternate power supplies. Not all data are trusted by civil society and the government, and bureaucratic delays in coordination within and between organizations are also a challenge.

The Government of Bangladesh has announced "Digital Bangladesh" and “Vision 2021 and 2014” to improve the overall communication and coordination of all sectors of Bangladesh, health is considered as a priority. Bangladesh has a well-structured and uniform distribution of health facilities and community health services in order to reach out to every family particularly in rural setting. The challenge is to equitably distribute the HWF in all the establishments. To improve the distribution and availability of the HWF, availability of proper data is a must.

eHealth services has recently been introduced and being provided on cellphones and the Internet throughout Bangladesh with the following three objectives:

- improving health systems efficiency
- bridging the urban-rural digital divide
- reaching out to citizens.

It seeks to achieve these through four approaches:

- infrastructure development
- capacity-building
- monitoring and supervision
- advocacy through visible results.

Five kinds of solutions – simple, low-cost, innovative, locally appropriate and scalable – were provided.

Selected eHealth/mHealth programmes are remote time attendance, complaint-suggestion box, SMS-based advice on pregnancy (mHealth), SMS-Stat GIS, priority disease surveillance, client education, eLearning and telemedicine.

The targets in improving the current systems include a national assessment to identify the human resource (HR) gap in each category, HR projection, HR planning, its training, strengthening HR management, a policy of incentive packages, and a central HR information system with proper data of HWF in all its aspects.

The Bangladesh government also needs to build trust between civil society and the government by promoting public–private partnerships in its HRIS, The government also needs to minimize bureaucratic bottlenecks to promote and strengthen the coordination mechanism. Involving private organizations and institutions will strengthen the capacity of HR information system and it can ultimately help in establishing the country's Health HR observatory in future.

4.2 India

Professor Shiv Mathur outlined India's experience with HWF education and training.

In the field of HRH in India, the numbers of physicians, nurses and allied health professionals are still inadequate. It is estimated that by 2022, India will need 400 000 more doctors, 1.7 million more nurses and 6.41 million more allied health professionals. While the doctor–people ratio is 1:1507, 60% of health workers are located in urban areas where only 28% of the population lives. In terms of HRH institutions, there are 387 medical colleges (181 in the government sector and 206 private sector), 301 dental colleges, 7401 nursing colleges/auxiliary nurse medical training centres (ANMTC)/general nurse-midwife training centres (GNMTC), and 938 institutions for allied health professionals. The number of medical colleges has dramatically increased in recent years. Taking 1995 as the base year, the number of medical colleges has increased 250% by 2014 with yearly intake of students rising by 408%. However, by 2022, India will need an additional 240 medical colleges.

The comprehensive assessment by National Health Systems Resource Centre (NHSRC) (2013–2014) reveals that the state of Chhattisgarh was the first to introduce a three-year course for rural medical assistants in 2002. The preliminary report on assessment of professional skills of rural medical assistants on comparison with other alternatives was positive. The Assam Rural Health Regulatory Act came into force in Assam in 2004. The HWF is

employed under the National Health Rural Mission as rural health professionals at health sub-centres (HSC). As of March 2013, 362 HSCs across 27 districts of Assam state in India are managed by rural health professionals.

India has adopted a few strategic measures to promote HRH. The Bachelor in Rural Health Care course should provide training on a well-defined package of essential skills. The selection process and teaching approach should be biased in favour of a preference for rural areas while focusing on primary health care. Conditional licensing to practise exclusively in the public sector is necessary. Integration with other systems of medicine, hiring the services of the doctors and nurses in the under-served area, expanding the public–private partnership, and starting a bachelor's course in community health are strategic priorities in the context of promoting HRH.

The National Health Workforce Development Plan aims to increase the level of HR through medical education in government institutions, support the reform process in the Medical Council of India (MCI), Dental Council of India (DCI) and Indian Nursing Council (INC), and bridge the skill gap between medical doctors and CHWs.

Educational and training measures could be most effective in the long run to attract and retain the services of skilled service providers in rural and remote areas of India.

The key actions identified in the comprehensive assessment by NHSRC (2013–2014) are:

(1) upgrade district hospitals to medical colleges;

(2) increase intake in the existing medical colleges;

(3) scale up the DNB programme;

(4) expedite the setting up of the National Board for Allied Health Sciences; and

(5) create a mid-level cadre for health-care providers.

A high-level expert group was set up in 2011 to ensure the availability of adequate numbers of trained health-care providers at different levels, introduce competency-based continuous education, strengthen existing

State Institute of Health and Family Welfare (SIHFW)/health and family welfare training centre (HFWTC), and invest in setting up additional educational institutions. This also included the establishment of the District Health Knowledge Institute and a dedicated training system for CHWs. It has also proposed state health universities in all states and the National Council for HRH at the central level.

Management and institutional reforms for HRH in India should incorporate certain measures that are key.

(1) The reform process should introduce an all-India and state-level public health service cadres to strengthen the management of the UHC system.

(2) HRH institutions should ensure career growth opportunities for competency-based professional advancement.

(3) A national health IT network should be set up in the country on the basis of uniform standards.

(4) More investment should be made in health sciences research and innovations to improve policy and provide feasible solutions to strengthen the health systems and delivery of UHC.

The health training policies of the National Institute of Health and Family Welfare, must aim at redefining the 10-year vision for training and five-year action plan. Among other changes, health training institutions in all states should also be given more functional autonomy. Training and HR plans should be linked in each state to career plans of health-care professionals. Training needs assessment (TNA) and impact assessment needs to be mainstreamed, and lastly, induction training for doctors in public health systems must be made mandatory.

4.3 Indonesia

Dr Andreasta Meliala and Dr Titi Savitri Prihatiningsih of Indonesia made a presentation on that country's experience with the comprehensive assessment of HWF education and training in countries of the South-East Asia Region.

There are 753 nursing schools, 728 midwifery schools, 176 public health schools, 44 nutrition schools, 36 environmental health schools, and

74 medical schools in Indonesia (2013). At the national level, there is a link between the national education system and the national health system. Indonesia is still in the process of implementing the National Education System Act. Types of governance are: owner, executive and accreditor. There is a clear cut-off with regards to function and responsibility of each agency. Accreditation and competency testing are the usual methods of quality assurance.

Governing mechanisms and financial management of health institutions vary in the public and private sectors. In terms of governing mechanism, a public sector institution applies a government regulation to develop its financing management. Private sector applies other rules. Financial management varies in terms of source of funding (government subsidy and entrepreneurship), and unit cost (lowest for public health school and highest for medical school).

The medical curriculum is generally reviewed every four to five years, and the most recent was for the period 2008–2013. This review led to the addition of some topics such as health system, UHC and information and communication technology. Faculty members were mostly recruited from public hospitals and Continuing professional development (CPD) was a mandatory programme in every school. The main teaching methods were competency-based, problem-based and the lecture. However, the community-based subject was not indicated as the first rank in the curriculums.

The perception of students toward "working in rural and deprived area" was positive. They were willing to be deployed to these kind of settings. Most students expressed preference for jobs in the public sector. However, postings in remote areas were ensured through government and mandatory programmes. Environmental health schools need more attention in terms of accreditation, the means to attract external funding, periodic curriculum review and development, CPD programmes for faculty members and teaching methods. The review also found that schools in remote areas lagged behind in all respects.

Lessons learned from Indonesia include technical issues and more related to method and administration. In terms of research method, variable measurement should be sharpened, since there were huge variations of institutions status and capacity in Indonesia.

Data sources were also a challenge, particularly in the financial aspect. Most of the resource persons had given a general description only. Translation and complexity of the instrument were not easily applied to Indonesia. Team-work, accessibility and reporting are the key technical issues and manpower and finance the important administrative ones.

For the way forward, Indonesia plans to develop the links between current challenges that the study findings reveal and the changing demand scenario. The study recommended advocacy to policy-makers in both the education and health sectors. Also, they should communicate with school managers in order to present the findings and make proper and reasonable recommendations.

The Indonesian Accreditation Agency for Health Higher Education (IAAHHE) accredits health study programmes for medical, nursing, dental, pharmaceutical and nutrition professionals. This agency was established under the National Education System Act (2003). The scoring comprises "accredited", "accredited subject to conditions" and "not accredited". Results are valid for 5–7 years. Accreditation processes include desk evaluation, field visit, feedback, monitoring and evaluation, and facilitation.

The Independent Agency of Competence Examination Development for Health Workforces conducts examinations to evaluate the competence levels of medical students, dentists and nurses in both public and private schools that includes feedback on the outcomes of education.

4.4 Nepal

Professor J.P. Agrawal of Nepal made a presentation on the experiences with and lessons learned from the assessment of HWF education and training in that country.

In accordance with resolution SEA/RC65/R7 on Strengthening Health Workforce Education and Training in the Region, of the Sixty-fifth session of the Regional Committee for South-East Asia, comprehensive national assessments of the education and training of the HWF was carried out in Member States. The national assessment in Nepal was done in conjunction with other countries of the Region using the same tools. A combined research methodology using both qualitative and quantitative methods was

used to complete the assessment. Also, a review of literature and reports available at the national level was conducted to collect information.

Activities conducted as part of the national assessment include the following:

(1) informal consultation on protocols for assessment of health workforce education and training in countries of the WHO SEA Region, Regional Office for South-East Asia, New Delhi, 17–19 July 2013.

(2) formation of joint investigation team on 27 August 2013 with the Human Resource and Financial Management Division of Ministry of Health and Population; and

(3) orientation programmes such as those for selected institutes and technical experts.

Activities conducted at the National Centre for Health Professions Education (NCHPE) level include:

(1) regular meetings between the principal investigator and selected technical experts;

(2) development of a plan of action; and

(3) data collection and analysis at the national level and institutional levels by technical experts.

These activities helped develop a good working rapport between technical experts and focal points from the institutions during the orientation programmes.

Results of the assessment show that there is a critical shortage of HR in the country, with only seven health workers (doctors, nurses and midwives) for every 10 000 population, which is far below the minimum standard of 23 set by WHO. Health sector policies are driven by the Nepal Health Sector Programme – Implementation Plan II (2010–2015). The HRH Strategic Plan 2011–2015 is the most important HRH planning tool in the country. Both these plans focus on utilizing a mix of professionals and skills in providing health services in the country.

Faculty development is limited to medical, nursing and public health institutions. This is also restricted to few health-care priorities, such as HIV/AIDS, malnutrition, safe motherhood and communicable diseases. There is no recruitment of educators from among community-based clinicians and health workers. In other words, the recruitment of faculty is based mainly on undergraduate grades and not necessarily on community experience of the health professional. The evolving health-care needs of the communities were included in the curricula. This is widely applied by medical, nursing and public health schools, and guided by evidence such as burden of disease, epidemiological and demographic transitions. Simulation methods with contextually appropriate fidelity levels are applied in the education of health professionals. This, however, is limited to public medical and nursing schools skills laboratories. Though the regulatory bodies require skills laboratory-based learning in all institutions, few have complied.

Admission procedures gear admissions policies to increase the socioeconomic, ethnic and geographical diversity of students. This applied only to government scholarships on the basis of ethnic, gender and geographical representation. The Medical Council of Nepal has requested universities to develop criteria for the same. However, most universities have not yet admitted the targeted number of students from rural and marginalized communities. There are no streamlined educational pathways or career advancement programmes. Educational institutions work independently with different educational requirements across programmes and limited scope to streamline educational pathways or advancement programmes.

The regulatory bodies are the accreditation agencies for the education of health professions, and implementation is satisfactory. However, there is no separate accreditation body in Nepal yet. Continuous professional development for health professionals is ensured mainly by professional medical, nursing and public health societies. The Medical Council is working on mandatory continuous professional development and enforcing periodic relicensing. This is in the final stage of approval but has not yet come into force. Ministry of Health and Population provides in-service training to its community health workforce through the National Health Training Centre (NHTC).

Lessons learned during the assessment in Nepal include the importance of:

(1) proper planning for assessments of HWF education and training;

(2) clarifying the objective for the orientation of stakeholders;

(3) motivation and field experience of technical experts;

(4) enforcement in implementation of developed strategies; and

(5) regular follow-up of programmes.

5. Draft Regional strategy on strengthening health workforce education and training in the WHO South-East Asia Region

The draft regional strategy on strengthening of health workforce education and training in Member States of the WHO SEA Region was reviewed and finalized by the technical experts at this meeting. After participants had thoroughly reviewed the document and made suggestions, the final guidelines were incorporated by consensus as highlighted below.

Vision: An HWF that contributes to the functioning of health systems to enable equitable access to health care and good health outcomes.

Goal: An adequate, competent and committed HWF with relevant skills-mix that contributes to health services in communities where they are most needed.

Mission: To build, empower and sustain institutional capacities of Member States to be able to formulate HWF policy and implement and monitor progress.

Strategic objectives:

The strategic objectives of the regional strategy are to:

(1) increase the capacity for quality training for the relevant HWF through institutional and instructional reforms;

(2) ensure educational strategies enable HWF to serve and sustain their contributions in rural communities or places where they are most needed; and

(3) strengthen the synergies between the HWF education systems and health-care systems.

A few key actions for each of the three strategic objectives and key monitoring indicators are listed overleaf.

Actions by strategic objective and monitoring indicators

Strategic objective	WHO actions	Country actions	Monitoring indicators
I. Increase capacity for quality training for adequate numbers of relevant HWF through institutional and instructional reforms.	1. Convene regional consultation on translating evidence on effective scaling and transforming health professional education into country actions. 2. Support and enable cross-country learning and sharing. 3. Address specific needs of Member States with limited in-country production capacities through intercountry collaboration for training. 4. Monitor progress annually through consultation workshops and reporting requirements.	1. Strengthen political and financial commitments for investment in HWF education. 2. Based on the outcomes of comprehensive assessment of HWF education systems, involve all relevant stakeholders (both instructional and institutional), and prioritize and implement actions. 3. Based on the outcomes of long-term projection of demand for different cadres of HWF, produce cadre mix including mid-level HWF, and other potential shifting of tasks.	1. WHO: • Regional consultations convened. • Intercountry collaboration agreed on. 2. Country: • Investment in HWF education system increased. • Based on country action plans: number of HWF training institutes accredited; application of IPE, CPD, curriculum reviews (including socially accountable graduates); use of simulation and ICT for learning; improved infrastructure; application of targeted admission and national licensing examination; training of additional numbers of health workforce. • Socially accountable graduates (with the intent to work in rural settings, etc.)

Strategic objective	WHO actions	Country actions	Monitoring indicators
II. Ensure educational strategies enable HWF to serve and sustain their contributions in rural communities or places where they are most needed.	1. Convene regional consultation, translate evidence on effective educational strategies for rural retention into country actions.	1. Strengthen political and financial support for implementing education strategies which support rural retention. 2. Based on the outcome of assessment of the scope of application of 5 out of the 16 WHO Global Policy recommendations on rural retention (2010), scale up effectiveness as appropriate.	1. Scope (national/sub-national) and number of cadres which apply education strategies in support of rural retention. 2. Policy/legislative/ regulatory framework in support of rural retention. 3. Before and after policy, the average number of years in rural health services and percentage of absenteeism.
III. Strengthen the synergies between HWF education systems and health-care systems.	1. Provide technical support to strengthen M&E systems. 2. Conduct mid-term reviews of five-year strategic plans.	1. Ensure effective collaboration and interlinking between HWF education and health service systems. 2. Devise policy towards and set up a regulatory framework to ensure that private HWF educational institutions are socially accountable. 3. Strengthen and use HWF information systems.	1. Functioning HRH focal point or unit in the ministry of health. 2. Improved collaboration between HWF education and health systems. 3. Improved social accountability by private HWF educational institutes. 4. Improved HWF information.

The participants agreed to incorporate the success factors for implementation of this strategy. Given the slow progress since the launch of the 2007 Regional Strategic Plan for Health Workforce Development in the South-East Asia Region, a few success factors that are key to the implementation of the Regional Strategy on Strengthening Health Workforce Education and Training in South-East Asia Region were identified. These were:

(1) political and financial commitment by Member States;

(2) continued efforts by the Regional Office and regular reporting by Member States;

(3) translating the regional strategies into national policy and actions by countries;

(4) cross-country learning, sharing and supporting;

(5) functional focal points/units in the ministries of health; and

(6) effective intersectoral coordination and actions between the health workforce education and health sectors.

6. Conclusions and recommendations

The expert group meeting reviewed, amended and agreed to the Draft Regional Strategy on Strengthening Health Workforce Education and Training in the WHO South-East Asia Region. It was agreed that the revised draft will be submitted and discussed at the High-Level Preparatory Meeting at the Regional Office in July 2014 for consideration by the Sixty-seventh Session of the WHO Regional Committee for South-East Asia in September 2014.

Annex 1

Agenda

(1) Opening session

(2) Objectives and background

(3) Country experiences in comprehensive assessment of HWF education and training: presentation and discussion

(4) Draft regional strategy for strengthening health workforce education and training in the WHO South-East Asia Region

(5) Conclusions and recommendations

(6) Closing session

Annex 2

List of participants

Bangladesh

Dr Muzaherul Huq
Chairman, Public Health Foundation of Bangladesh
Dhaka

Indonesia

Dr Titi Savitri Prihatiningsih
Associate Professor (Lektor Kepala)
Department of Medical Education
Faculty of Medicine UGM
Yogyakarta

Dr Kirana Pritasari,
Director of Center for Standardization, Certification and Continuing Education of HRH
Board for the Development and Empowerement of Human Resources for Health
Ministry of Health
Jakarta

Dr Andreasta Meliala
Director of Cooperation and Development Affairs
Hospital Management Post Graduate Program
School of Public Health
University of Gadjah Mada
Yogyakarta

Dr Dhany Kurniawan
Staff of Center for Standardization Certification and Continuing Education, HRH, Ministry of Health
Jakarta

India

Professor Shiv Mathur
Independent Public Health Specialist
Jaipur

Professor Rita Sood
President
South-East Asian Regional Association for Medical Education
New Delhi

Nepal

Professor Jagdish Prasad Agrawal
Executive Director
National Centre for Health Professional Education
Institute of Medicine, Tribhuvan University
Kathmandu

Sri Lanka

Professor Rajitha Wickremasinghe
President, South-East Asian Public Health Education Institutes Network
Colombo

Thailand

Dr Somsak Lolekha
Chairperson
Network of the Medical Councils of South-East Asia Region, and President, Medical Council of Thailand
Bangkok

Dr Viroj Tangcharoensathien
Senior Adviser
International Health Policy Programme,
Bangkok

Dr Wanicha Churnkrongkaew
Vice-President for Education
Mahidol University
Bangkok

Dr Weerasak Puthasri
Deputy Director
International Health Policy Programme
Bangkok

Dr Krisada Sawaengdee
Deputy Director and Vice President
Thailand Nursing and Midwifery Council
Bangkok

Dr Duangvadee Sungkhobol
Former Temporary International Professional,
HRH, WHO/SEARO
Nakornratchasrima

WHO Regional Office for South-East Asia

Dr Pak Tong Chol
Regional Adviser
Human Resources for Health and Fellowships (HRH)
World Health Organization
Regional Office for South-East Asia
New Delhi, India

Strengthening health workforce education and training is necessary to produce and develop health-care providers in adequate numbers with required competencies and appropriate mix of skills who can successfully deal with health challenges and deliver effective and responsive health services. This may call for reforming the organizational, institutional and instructional structure of health workforce education and training systems in Member States.

It is also imperative for countries to devote more attention to training and education of community-based health workers to further bolster the primary health-care approach to health services. An effective community-based health workforce can ensure that essential health interventions reach the "unreached" population to achieve universal health coverage.

An expert group meeting has been convened to draft the regional strategy on strengthening health workforce education and training in the WHO South-East Asia Region. The regional strategy, after adaptation, should help the countries in the South-East Asia Region to strengthen their health workforce education and training.

World Health Organization
Regional Office for South-East Asia
World Health House
Indraprastha Estate,
Mahatma Gandhi Marg,
New Delhi-110002, India
www.searo.who.int

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