To accelerate the HRH situation in Member countries, especially education and training, there is a need to review the progress made and identify what actions need to be taken to ensure the commitment of strengthening HRH in supporting universal health coverage.

As per RC Resolution SEA/RC67/R6 on strengthening health workforce education and training in the Region, the regional meeting on strengthening human resources for health in South-East Asia: time for action and commitment was conducted, which discussed gaps in policy and implementation or rural retention interventions and health education: and developing country action plans (2015–2016) by prioritizing WHO’s 16 recommendations on rural retention policies and 11 recommendations on transforming professional education.

WHO has developed a global policy recommendation on increasing access to health workers in remote and rural areas through improved retention, which addresses not only financial incentives for retention but also recommendations on education, regulatory, professional and personal support. WHO has also developed the guidelines for transforming and scaling up health professionals’ education and training. WHO recommendations on retention and transforming education need to be translated into action and HRH information systems need to be functional and robust for timely monitoring of progress made.

The report provides a review of the situation and priority areas in countries under three themes: (i) rural retention of health workforce; (ii) transforming and scaling up health professionals’ education and training; and (iii) human resources for health in the UHC context.
Strengthening human resource for health in South-East Asia: Time for action and commitment

Report of a regional meeting,
Thimphu, Bhutan, 19–21 November 2014
Content

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronyms</td>
<td>v</td>
</tr>
<tr>
<td>Executive summary</td>
<td>vii</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. Objectives</td>
<td>5</td>
</tr>
<tr>
<td>2.1 General objective</td>
<td>5</td>
</tr>
<tr>
<td>2.2 Specific objectives</td>
<td>5</td>
</tr>
<tr>
<td>3. Inaugural session</td>
<td>6</td>
</tr>
<tr>
<td>3.1 Address by HE Minister of Labour and Human Resource, Government of Bhutan</td>
<td>6</td>
</tr>
<tr>
<td>3.2 Address by the Regional Director, WHO South-East Asia</td>
<td>7</td>
</tr>
<tr>
<td>3.3 Keynote Address by Dr Jim Campbell, Director, Health Workforce, WHO/HQ</td>
<td>8</td>
</tr>
<tr>
<td>4. Current situation of HWF in SEAR</td>
<td>10</td>
</tr>
<tr>
<td>5. Country situation on rural retention and transforming education of health workforce, achievement, challenges and priorities</td>
<td>12</td>
</tr>
<tr>
<td>6. Rural retention of health workforce - Policy gaps and action plan</td>
<td>22</td>
</tr>
</tbody>
</table>
7. Strategic directions for collaboration and mobilization support in strengthening HWF ................................................................. 29
8. HRH in UHC context – 10-year vision on HRH strengthening .......... 31
9. Global health workforce evaluation tool ........................................ 39
10. Transforming and scaling up education and training of health professionals - Policy gaps and action plan .............................. 41
11. Accountability framework for countries and WHO .......................... 48
12. Conclusion .................................................................................. 50
13. Recommendations ........................................................................ 52
14. Closing session ............................................................................. 54

Annexes
1. Agenda .......................................................................................... 56
2. List of participants .......................................................................... 57
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAAH</td>
<td>Asia–Pacific Action Alliance on Human Resource for Health</td>
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<td>BHS</td>
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<td>BMHC</td>
<td>Bhutan Medical and Health Council</td>
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<tr>
<td>CD</td>
<td>communicable disease</td>
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<tr>
<td>CME</td>
<td>continuing medical education</td>
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<tr>
<td>CPD</td>
<td>continuous professional development</td>
</tr>
<tr>
<td>GDP</td>
<td>gross domestic product</td>
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<td>GHWA</td>
<td>Global Health Workforce Alliance</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>HPE</td>
<td>health Professional education</td>
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<td>HRH</td>
<td>human resources for health</td>
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<tr>
<td>HW</td>
<td>health worker(s)</td>
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<td>HWF</td>
<td>health workforce</td>
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<td>ILO</td>
<td>Indian Labour Organization</td>
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<tr>
<td>IPE</td>
<td>interprofessional education</td>
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<tr>
<td>JICA</td>
<td>Japan International Cooperation Agency</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<tr>
<td>NCD</td>
<td>noncommunicable disease(s)</td>
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<tr>
<td>NTD</td>
<td>neglected tropical disease</td>
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<tr>
<td>RTA</td>
<td>road traffic accident</td>
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<tr>
<td>SEA</td>
<td>South-East Asia</td>
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<td>SEAR</td>
<td>South-East Asia Region</td>
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<td>SMPP</td>
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<td>SRH</td>
<td>sexual and reproductive health care</td>
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<tr>
<td>TPE</td>
<td>transforming professional education</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Executive summary

With reference to the WHO South-East Asia Regional Committee Resolution SEA/RC67/R6 on Strengthening health workforce education and training in the Region, a regional meeting on strengthening human resource for health in South-East Asia: Time for action and commitment was held on 19–21 November 2014 at Thimphu, Bhutan. The general objective of the meeting was to create a common vision and build inspiration among Member States, WHO and other partners on time for action and commitment to strengthen health workforce in South-East Asia. The specific objectives included assessing gaps in policy and implementation of rural retention interventions and health education; and developing country action plans (2015–2016) by prioritizing WHO’s 16 recommendations on rural retention policies and 11 recommendations on transforming professional education.

There were 80 participants, including senior government officials and academicians from the eleven member countries; representatives from network and partners; temporary advisers and WHO staff. In the opening session, the Minister of Labour and Human Resource, Government of Bhutan welcomed the participants and the Regional Director, WHO South-East Asia delivered the inaugural address.

The meeting was organized under three themes: (i) rural retention of health workforce; (ii) transforming and scaling up health professionals’ education and training; and (iii) human resources for health in the context of universal health coverage (UHC). The key conclusions and recommendations of the meeting were as follows:
Conclusions

(1) It is time for action and commitment to strengthen health workforce in the SEA Region, and the Decade for Health Workforce (HWF) strengthening in the South-East Asia Region (SEAR) (2015–2024) is the essential platform for continued and sustained effort for actions.

(2) Investment in rural retention and transforming health professional education can synergistically support the achievement of national human resources for health (HRH) goals in response to UHC global commitment.

(3) The importance of the role and contributions of all cadres of HWF to the health of the population is recognized and efforts should strengthen all these groups.

(4) Accountability between government and citizens in Member States, and between Member States and WHO is essential to ensure the achievement of the national HRH goals.

(5) Adequate and functioning information systems are essential for evidence-based policy decisions.

Recommendations to Member States

(1) Member States, through MOH, should convene consultations with wider stakeholders and all relevant partners to develop a two-year integrated HRH action plan focusing on (a) rural retention and (b) health professional education transformation, in the context of the decade of health workforce strengthening in the Region (2015–2024) and in line with the national HRH strategies.

(2) Team work/units should be established and adequate funding support ensured to implement these action plans, with regular reviews and change in courses of action, if needed. In the context of the requirement by the Regional Committee resolution, the action plans should be revised every subsequent two years for the next decade.

(3) Member States should report progress of the implementation of their action plans, to country stakeholders and partners, and the WHO Regional Office by May 2016, to be discussed at the Sixty-ninth Regional Committee in September 2016.
Recommendations to WHO

(1) WHO at all levels should prioritize support for the implementation of the country action plans 2015–2016 and throughout the Decade in keeping with the Resolutions’ commitment on health workforce and UHC, including technical and financial supports, and reprogramming of the programme budgets.

(2) WHO should support normative work, HWF information systems development, convene platforms and fora for joint learning and sharing experiences among countries in the Region.

(3) A biannual progress report (including implementation, process and outcome) of the Decade should be produced for wider audience in and outside the South-East Asia Region (SEAR).
The analysis in the World Health Report 2006 concludes that adequate number of committed health workforce (HWF) with proper skill mix, especially at primary health care level, is essential in achieving population health outcomes. Policy-makers in all countries, regardless of their level of economic development, struggle to achieve health equity and to meet the health needs of their populations, especially vulnerable and disadvantaged groups. One of their most complex challenges is ensuring that people living in rural and remote locations have access to trained health workers.

The World Health Organization (WHO) responded to calls to action from global leaders, civil society and Member States and a comprehensive set of specific strategies was drawn up in 2010 to assist countries in encouraging health workers to live and work in remote and rural areas. These 16 evidence-based recommendations relate to the movements of health workers within the boundaries of a country and focus solely on strategies to increase their availability in remote and rural areas through improved policies for attraction, recruitment and retention.

The recommendations apply to all types of health workers in the formal, regulated health sector (public and non-state), as well as to students aspiring to or currently attending education programmes in health-related disciplines. This includes health-care providers (doctors, nurses, midwives, mid-level health workers, pharmacists, dentists, laboratory technicians, community health workers etc.) as well as managers and support workers (human resource managers, health managers, public health workers, epidemiologists, clinical engineers, teachers and trainers).
These practical guidelines can be used by all countries. As such, they complement the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the Sixty-third World Health Assembly in May 2010.

**Table 1: WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention, WHO 2010**

<table>
<thead>
<tr>
<th>A. Education</th>
<th>A-1: Students from rural backgrounds</th>
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<tbody>
<tr>
<td></td>
<td>A-2: Health professional schools outside of major cities</td>
</tr>
<tr>
<td></td>
<td>A-3: Clinical rotations in rural areas during studies</td>
</tr>
<tr>
<td></td>
<td>A-4: Curricula that reflect rural health issues</td>
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<tr>
<td></td>
<td>A-5: Continuous professional development for rural health workers</td>
</tr>
<tr>
<td>B. Regulatory</td>
<td>B-1: Enhanced scope of practice</td>
</tr>
<tr>
<td></td>
<td>B-2: Different types of health workers</td>
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<tr>
<td></td>
<td>B-3: Compulsory service</td>
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<td></td>
<td>B-4: Subsidized education for return of service</td>
</tr>
<tr>
<td>C. Financial incentives</td>
<td>C-1: Appropriate financial incentives</td>
</tr>
<tr>
<td>D. Professional and Personal support</td>
<td>D-1: Better living conditions</td>
</tr>
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<td></td>
<td>D-2: Safe and supportive working environment</td>
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<td></td>
<td>D-3: Outreach support</td>
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<td></td>
<td>D-4: Career development programme</td>
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<td></td>
<td>D-5: Professional networks</td>
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<td></td>
<td>D-6: Public recognition measures</td>
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In 2013, WHO published eleven recommendations for transforming and scaling up education and training of health professionals. The recommended considerations and interventions, thereby, apply to all levels of education and training of health professionals across the continuum of undergraduate, postgraduate, faculty development and continuous professional development (CPD) in both the public and private sectors in all countries. These 11 recommendations call for new approaches in the education of health professionals that are needed to transform systems
Table 2: Eleven recommendations on transforming and scaling up education and training of health professionals, WHO 2013

<table>
<thead>
<tr>
<th>I. Faculty development</th>
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<tbody>
<tr>
<td>1. Design and implement continuous development programmes for faculty, teaching staff relevant to the evolving health-care needs of their communities</td>
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<tr>
<td>2. Mandatory faculty development programmes that are relevant to the evolving health-care needs of their communities</td>
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<tr>
<td>3. Innovative expansion of faculty, through the recruitment of community-based clinicians and health workers as educators.</td>
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<th>II. Curriculum development</th>
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<td>4. Adapt curricula to the evolving health-care needs of their communities.</td>
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<th>III. Simulation methods</th>
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<td>5. Apply simulation methods of contextually appropriate fidelity levels in the education of health professionals.</td>
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<tr>
<th>IV. Direct entry of graduates</th>
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<td>6. Direct entry of graduates from relevant undergraduate, postgraduate or other educational programmes into different or other levels of professional studies.</td>
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<tr>
<th>V. Admission procedures</th>
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<tr>
<td>7. Use targeted admissions policies to increase the socioeconomic, ethnic and geographical diversity of students.</td>
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<tr>
<th>VI. Streamlined educational pathways and ladder programmes</th>
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<tbody>
<tr>
<td>8. Streamline educational pathways, or ladder programmes, for the advancement of practicing health professionals</td>
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<tr>
<th>VII. Inter-professional education</th>
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<tr>
<td>9. Implement interprofessional education (IPE) in both undergraduate and postgraduate programmes</td>
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<table>
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<tr>
<th>VIII. Accreditation</th>
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<tr>
<td>10. Accreditation of health professionals’ education where it does not exist and strengthening it where it does exist</td>
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</table>

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<tr>
<th>IX. Continuous professional development (CPD) for health professionals</th>
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</thead>
<tbody>
<tr>
<td>11. CPD and in-service training of health professionals relevant to the evolving health-care needs of their communities</td>
</tr>
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</table>
and encourage the move away from the traditional focus on tertiary care hospitals to initiatives that foster community engagement.

The primary beneficiaries of these guidelines are policy and decision-makers in the health and education sectors, educators, and future and current health professionals. However, the guidelines are conceived for the ultimate benefit of users of health services, whose needs should determine the quantity, quality and relevance of the education of health professionals.

The two sets of WHO global recommendations are synergistic: one recommends Member States to produce more HWF relevant to country health and health systems needs; the other ensures that they serve the rural, disadvantaged and hard-to-reach areas. These recommendations have yet to be prioritized according to the country context, translated into practical country level actions, implemented at scale, progress monitored, evaluation conducted on what works and what does not, and modify interventions to suit the health systems context.

In response to global calls by various World Health Assembly resolutions and the 2012 UN General Assembly Resolution for moving closer to universal health coverage (UHC), the Regional Director gives her highest commitment to strengthen HWF which is the backbone for health systems functioning; and reliable health system is a key path in “moving closer to UHC”.

It is time for actions at the country level, with concrete political commitments beyond rhetoric. A Decade for Health Workforce Strengthening in South-East Asia (2014–2023) should be jointly declared by the Regional Director and the Member States. Reaping short outcomes through the implementation of a two-year action plan with regular updates will gain political support at country level. Throughout the Decade, there would be five action plans with visible concrete outcomes, benefiting the people, which will gain further political support. Action plan and implementation must be backed by political and financial support; supervision and monitoring progress.
2.1 General objective

To create a common vision and build inspiration among Member States, WHO and other partners on “it is time for action and commitment to strengthen HWF in South-East Asia.”

2.2 Specific objectives

For country level technical partners:

1. to assess the gaps, in their countries, in policy and implementation of rural retention interventions;

2. to assess the gaps, in their countries, in policy and implementation of the transformation of health professional education;

3. to prioritize 16 retention policies and 11 transformation of health professional education, and develop country action plan for 2015–2016; and

4. to agree on a decade for HWF strengthening in SEAR with tangible action plan and roadmap for implementation of the action plan.
3

Inaugural session

3.1 Address by HE Minister of Labour and Human Resource, Government of Bhutan

HE Lyonpo Nyeema Sangay Tshempo, Minister of Labour and Human Resource, Royal Government of Bhutan welcomed all participants and said that HWF is one of the six main building blocks of the health system and an integral component of health-care delivery; and the meeting, appropriately entitled “time for action and commitment” could not have come at a better time. In spite of all the advances made in the health sector, few rudimentary challenges still persist; the most important of which is ensuring availability of an appropriately trained care provider till the lowest level of health facility.
“Guided by the philosophy of Gross National Happiness, the health sector of Bhutan envisions building a healthy and happy nation through a dynamic health professional system, attainment of the highest standard of health by people within the broader framework of overall national development in the spirit of social justice and equity. Towards realizing this vision, the health sector strives to build adequate and competent health workforce to achieve universal health coverage”, His Excellency added. Recognizing the perennial shortage of health workers in the country, the health sector in Bhutan has undertaken a multitude of initiatives including the launch of BSc Nursing Programme, Accelerated Nursing Programme, and recruitment of expatriate doctors and specialists, among others. Above all, the University of Medical Sciences of Bhutan was established by an Act of Parliament in 2012.

H.E. Lynpo Neema concluded by stressing on the need for skills and knowledge in the field of health and medicine in view of the rapidly changing health scenario. He hoped that the participants would shed light on this aspect which would contribute towards addressing the health workforce needs of the Region.

3.2 Address by the Regional Director, WHO South-East Asia

Dr Poonam Khetrapal Singh, WHO Regional Director for South-East Asia, said that a recent review of human resources for health or HRH country profiles conducted in February 2012 revealed that countries with HRH crisis continued to be in crisis; funding support for HRH development was still not sufficient to bring about the desired improvement in most countries; HRH education, deployment and management as well as migration of HWF within and outside the countries remained challenges; and maldistribution of HWF existed in most countries.
These challenges need to be carefully addressed, if HWF is to function effectively; otherwise, it will not be possible to achieve UHC, which is now a priority for all countries. Focus needs to be sustained on certain key areas, namely (i) production and medical education; (ii) recruitment and deployment; (iii) training and capacity-building; (iv) retention and support practices; (v) workforce management; and (vi) human resource management information system.

Dr Khetrapal Singh said that an area of major concern was the fact that although large number of HWF were being produced from numerous medical schools and training institutions across countries every year in South-East Asia, it had not translated into any significant increase in their availability in the public health system, especially in the under-served areas.

Participants from Member States should assess the gaps in their policy and implementation; specifically (i) rural retention interventions, and (ii) transformation of health professional education, based on which, each country was expected to prepare action plans based on (i) WHO’s 16 rural retention policies and (ii) WHO’s 11 recommendations for transforming and scaling up education and training of health professionals.

The Regional Director requested participants to focus on the “how-to-do” as much as on the “what-to-do”, during their deliberations. She concluded by saying that WHO was committed to supporting roll-out of action plans to strengthen HWF in Member States.

3.3 Keynote Address by Dr Jim Campbell, 
Director, Health Workforce, WHO/HQ

In his keynote address on strengthening HWF for UHC, Dr Jim Campbell said that the HWF implications of UHC post-2015 and Sustainable Development Goals were described.

Four critical dimensions to reinforce the central role of HRH were: availability, accessibility, acceptability and quality; and these collectively reinforced the UHC agenda. A fit-for-purpose HWF should have the competencies and quality standards required to meet the current and anticipated future population needs. Most importantly, it should be correlated with the dimensions of geography, demography, population
coverage, health benefits package and financial affordability; and be able to achieve the intended policy outcomes.

The ILO - World Social Protection Report (2014) estimated that at least 41.1 health workers (HW) per 10 000 population were necessary to provide services to all in need. This figure was based on calculations of median values of the density of HW in countries where socioeconomic conditions and health financing characteristics were conducive to UHC. The world would be short of more than 10 million HW; and if not addressed, this would have serious implications for the health of billions.

Post-2015, the HWF implications for ensuring healthy lives and promote well being for all at all ages would include the following:

- reducing maternal mortality and end preventable deaths of newborns and U5 children and ensure universal access to sexual and reproductive health (SRH) care services;
- ending the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases (NTD) and combat hepatitis, water-borne diseases, and other communicable diseases (CD);
- reducing by one third of premature mortality from noncommunicable disease (NCD) through prevention and treatment, and promote mental health and well-being;
- strengthen prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol;
- halving global deaths and injuries from RTA;
- achieving UHC, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all; and
- reducing the number of deaths and illnesses from hazardous chemicals and air, water, and soil pollution and contamination.

WHO guidelines on “Transforming and scaling up health professional education and training” and “Global policy recommendations for increasing access to HW in remote and rural areas through improved retention” provide tools for action. However, there was a need for strong commitment towards increasing recruitment, development and training and retention of workforce; as well as measuring the impact of interventions. This would require a proportionate increase in the percentage of GDP spent on HRH.
Almost a decade has passed since the World Health Report 2006 on working together for health, identified the crisis in global HWF. According to the report, six Member States out of 11 in South-East Asia Region have a critical shortage of HRH. The analysis in 2012 and World Health Statistics 2014 show that despite encouraging progress in HWF development, challenges still exist in the Region. For instance, weak HWF policy and planning, low investment in HRH, and discrepancies between demand and supply. As a consequence, shortage, inadequate competency, maldistribution and poor working environments are common issues in the Region.

Despite rapid urbanization, more than 50% of the world’s population lives in rural and remote areas, whereas globally only 24% of medical doctors and 38% of nurses are working in rural area. A similar situation can be seen in the South-East Asia Region, where more than 62% of the population lives in rural areas and the availability of HWF in those areas is below necessary numbers to meet the health-care needs.

The future demands for HWF are affected by the evolving disease burden, characterized by a greater need for prevention, treatment and care of noncommunicable diseases such as diabetes, stroke, cancer, mental and neurological disorders. These chronic diseases are rapidly increasing and they are no longer limited to urban areas. Demographic changes towards increased ageing population require different cadres of HWF catering to specific needs, health-care and psychosocial support to the elderly. We need health education to equip care providers with the right mix of skills and competencies necessary to respond to the ever-changing and evolving needs.
of populations; these trained care providers should be positioned at every level of health facility as well as in the community, especially in the rural, disadvantaged and hard-to-reach areas.

The challenges include inadequate leadership and political commitments, which are closely linked to the slow progress in HWF development in many low- and middle-income countries. The inadequate intersectoral collaboration between the ministry of education which trains HWF and the ministry of health and private sector which employ them, increases the complexities of HWF planning and management. Moreover, the available evidence, recommendations and global good practices on strengthening HWF in education and deployment/retention have not been widely recognized by countries for application.

The priority should be to ensure that existing HRH policies/strategies/plans result in tangible outcomes. In order to address the critical shortage of HWF in rural and disadvantaged areas, in 2010, WHO issued a global policy recommendation on increasing access to HW in remote and rural areas through improved retention, which addresses not only financial incentives for retention, but also recommendations on education, regulatory, professional and personal support. On the other hand, in order to provide guiding principles for transforming and scaling up education and training of health professionals, WHO has developed guidelines. WHO recommendations on retention and transforming education need to be translated into action and HRH information systems need to be functional and robust for timely monitoring of progress made.
Country situation on rural retention and transforming education of health workforce, achievement, challenges and priorities

The two sets of WHO global recommendations are synergistic: one recommends producing more HWF relevant to the needs of health systems; the other ensures that they serve the rural, disadvantaged and hard-to-reach areas.

The countries of the South-East Asia Region (SEAR) have carried out self-assessment of the current situation and deduced major achievements; they have reviewed main challenges and key priority areas for rural retention and transforming professional education.

A. Rural retention

1. Bangladesh

*Doctors*

Major achievements include admission quota for underprivileged sections of the community; setting up teaching institutes outside major cities; rural postings during studies; regular revision of curricula; CPD for doctors serving in rural areas; flexibility for practice; introduction of “community health-care
provider’s”; two-year compulsory rural service; introduction of telemedicine and m-health services; and opportunities for in-country and outside country training.

Lack of strong political commitment and resource constraint are limiting factors. Key priority areas include: developing strong HR policies such as career development for those serving in rural and remote areas and performance management systems; improving living conditions in rural areas; and review of financial and non-financial incentives.

**Nurses**

Some of the key achievements for rural retention of nurses are regular revision of curricula; CPD; opportunities for higher education; financial incentives for hard-to-reach areas; telemedicine and m-health services; and recognition for outstanding performance in the public health system. Strengthening governance of nursing education; rural post creation and improving living conditions at rural-and-remote areas are key priority areas for improvement.

2. **Bhutan**

**Doctors and nurses**

According to health policies, doctors and nurses are required to serve in rural areas and follow a rotation system and they get difficult-area allowance as incentive. Telemedicine services aim to bridge the gap between rural and urban health-care settings. There is a need to revise the incentive packages and improve living conditions and set up performance management systems.

3. **Democratic People’s Republic of Korea**

**Doctors and nurses**

Twelve of the 14 medical colleges are located outside the capital and curricula are aimed at enhancing job satisfaction of health workers in rural areas. Rural postings are part of the teaching schedule and their reorientation as part of CPD is organized in the field. Health workers are conferred national orders, awards and other titles irrespective of whether they are working in urban or rural areas. The Government is trying to improve medical care services through telemedicine throughout the country.
4. Indonesia

Doctors

Some medical schools established outside major cities have quotas for students from rural areas. Internship in rural areas is compulsory for registration and the government provides financial incentives for HW assigned to remote and very remote areas apart from encouraging local governments to provide additional benefits. Since 2008, MoH provides scholarship for specialist courses, linked with a bond for compulsory service. Three years of rural service is one of the qualifying criteria for the National Outstanding Award for Health Workers.

Bigger resource allocation is required for proper implementation of incentive schemes, and local government needs to show more commitment. Priority areas include needs assessment of health facilities and provision of necessary support; and continued efforts to develop career progression for health professionals working in rural areas.

Nurses

Polytechnic high schools established in all provinces admit students with a rural background. As part of CPD, MoH has developed distance learning programmes both on in-service training and pre-service training for rural remote HW. Rural area incentives; scholarships linked with compulsory service and public recognition for rural service also exists for nurses.

5. Maldives

Doctors

Legally government-sponsored medical students are required to join the service, and there is differential remuneration for working in remote areas.

However, breach of undertaking is inadequately addressed; salaries are not competitive. Living conditions in small islands is not very good. These are key areas that the government needs to address.
Nurses

More than 50% of student intake is from rural areas, and all courses have a component of postings in rural hospitals and the community.

CPD opportunities are limited, and there is no added financial incentive for working in remote islands. Providing a safe and supportive living and working environment is one of the high priorities of the government.

6. Myanmar

Doctors

Myanmar has a routine practice of exposing UG students to rural community experiences and clinical rotations to attract and adapt health workers to rural areas. Curriculum is updated every two years to include changing needs of the community. All medical students have to serve for at least three years and for five more years if they get a PG seat. All government servants working in remote and socially difficult areas receive twice the regular salary.

There are plans to strengthen provisions of better housing for health staff and a special education grant for the population from hard-to-reach areas to attend medical and allied universities.

Nurses

All students are from a rural background in nursing training schools outside major cities - out of 27 nursing schools only two are located in major cities. Rural postings are mandatory and curricula reflect rural health issues. They have a bond to serve for three years in the public sector after training. Outstanding health workers are chosen biannually and special consideration for further training and promotion given to nurses and midwives serving in border areas.

7. Nepal

Doctors and nurses

After graduation, doctors have to serve in remote areas for two years, after which they get opportunities for higher education facilities. This has made rural service attractive.
Key challenges include poor living conditions, limited financial incentives for rural service and CPD. Career progression is also not linked to performance. Providing adequate faculty for nursing courses is another priority area.

8. Sri Lanka

Doctors

Five percent of the total number of seats are allocated to 16 educationally disadvantaged districts. Medical education has expanded beyond cities and curricula have been revised to include rural exposures. Private practice for MOs after working hours (dual practice) has been instrumental in retention of doctors in rural areas. Best public health teams are selected and awarded annually.

Provision of adequate CPD opportunities and better living conditions in rural areas are priority areas.

Nurses

Most nursing institutes are situated outside major cities and they use non-urban settings for training. Provincial councils deploy nurses on a need-basis in rural/underserved areas.

A list of rural/difficult stations is to be finalized, so that targeted interventions can be planned for better living conditions. Appropriate financial incentives for rural service also need to be planned.

9. Thailand

Doctors

Students from rural areas have been admitted in medical schools since 1974, and 80% of medical schools are located in major provinces outside Bangkok. Curricula are revised every seven years and medical schools provide community and rural clinical attachments. Medical studies are subsidized, but doctors can avail specialist training with a government scholarship only after three years of compulsory service. There is a combination of financial and non-financial incentives for rural service.
CPD is passively organized, not mandatorily required and not guided by country health needs; but rather supply driven. The incentive schemes require evaluation.

Nurses

Nursing students from rural areas have been getting admission since 1960, but new norms have seen a decrease in their proportion. The majority of schools are in rural areas, and rural postings are part of the curricula, which get updated every four years.

CPD credits are mandatory for re-licensing, but there is limited access to training programmes in certain situations. The compulsory service policy may be evaluated for further strengthening. Accommodation is not available for every nurse.

10. Timor-Leste

Doctors and nurses

Since 2007, students with rural backgrounds are enrolled in medical and nursing programmes. There is a rotation policy under which all new medical and nursing graduates are first posted in community health centres for at least two years. Doctors and nurses are sent abroad for further studies.

Doctors and nurses are unwilling to serve in rural areas due to lack of infrastructure and poor living conditions. Moreover, the MoH is yet to implement extra remuneration for serving in remote areas.

B. Transforming professional education

1. Bangladesh

Doctors

Postgraduate training policy necessitates mandatory two years’ professional service at rural or hard-to-reach areas. MBBS curriculum updated during 2012–2013 incorporated evolving community health needs. Quotas for tribals, freedom fighters and poor students are some of the measures to increase socioeconomic, ethnic and geographical diversity of students.
Focus areas include development of national training guidelines for health professionals and more appropriate CME programmes. Formation of national HPE accreditation council is also under process.

**Nurses**

Nursing education and services under the HNP sector plans to enhance national capacity including a continuing education programme for faculty members and other supporting workforce. Faculty development programmes are mandatory and 26% of the allocated budget was spent for overall training of the staff of DNS for the period July 2011–June 2014.

Key challenges comprise huge shortages of teaching workforce, and lack of adequate infrastructures in nursing schools. Strengthening the monitoring and evaluation system and career development structures are also concerns.

2. **Bhutan**

**Doctors and nurses**

Short-term training courses are conducted for doctors. Curriculum is designed according to evolving needs and revised periodically to update and address current needs. The Bhutan Medical and Health Council (BMHC) mandates certain credit CPD to maintain active registration.

There is no targeted admission policy at the national level. Simulation is expensive and not readily available and further compounded by lack of funds.

3. **Democratic People’s Republic of Korea**

**Doctors and nurses**

Students receive pedagogical education; in-service teachers receive obligatory reorientation every two years and health professionals every three years through CME. Curriculum is revised every four years.
4. Indonesia

**Doctors**

CPD for faculty is mandated by the Ministry of Education and are obliged to implement three core functions of higher education including community services. Curriculum has to be updated every five years and 20% has to include local health-care needs. Targeted admissions are achieved through special quota for rural and under-served areas.

Private medical schools are unable to implement mandatory faculty development and procure adequate simulation tools. Due to budget constraints and limited opportunities, many professionals are unable to pursue CPD.

**Nurses**

Community-based HW have been involved as educators on a temporary basis. Targeted admission policies are implemented in many nursing schools and the government provides scholarship to students from underdeveloped areas.

Nursing education also faces implementation issues due to budget constraints.

5. Maldives

**Nurses**

CPD for faculty is mandatory and curricula are developed according to the country’s needs. Advanced models and mannequins are used for teaching, but they are very expensive to procure and maintain. Lack of clinical sites for student placements and in-service CPD is an area of major concern.

6. Myanmar

**Doctors**

Community-based HW are invited for guest lectures. Curriculum is revised through education seminars, but it is difficult to cover all disciplines due to time constraints. There is a reserve quota for students from remote and hard-to-reach areas. Myanmar finds it difficult to recruit faculty for basic disciplines.
Nurses:
CDP for faculty is planned to accommodate diverse needs and community-based HW are utilized as guest lecturers. Retaining teaching staff is a major challenge.

7. Nepal

Doctors and nurses

Few seats are reserved for students from remote areas and the curriculum is updated regularly; but basic science teachers are in short supply, and there is no mandatory faculty development. Accreditation of health professionals’ education is also not done and CPD opportunities are limited.

8. Sri Lanka

Doctors

Medical schools have taken steps to revise their curricula to adopt emerging needs and community-based clinicians, general practitioners and health workers are also used as faculty for training. Sri Lanka has implemented targeted admission policies for backward districts. The Postgraduate Institute of Medicine and other medical schools use inter-professional education.

Faculty development programmes are not uniform and there is lack of an adequate number of qualified trainers. There are certain disagreements among clinicians regarding health priorities for inclusion in the curriculum. Infrastructure development in training facilities is one of the key priority areas.

Nurses

Curricula have been revised for nurses to match presents day challenges and nursing schools use field-level training at non-urban settings with the involvement of local clinicians.

Lack of adequate and qualified tutors for training programmes and their unwillingness to serve in non-popular stations is a major challenge. Gaps also exist in policies regarding recruitment and career development of trainers.
9. Thailand

**Doctors**

Data on disease burden, epidemiological and demographic transitions contribute towards identifying evolving health needs and setting priorities. Major curriculum reviews take place every seven years, but there is a mismatch between the curriculum and assessment tools and measurement. Thailand has a strong mechanism for quality assurance and standardization of education and accreditation.

The Thai Nursing and Midwifery Council enforces a mandatory CPE - 50 hours of continued nursing education in five years as nursing re-licensing requirement.

Little is known on effective faculty development and there is a need for more synthesis and tacit knowledge and experience to also understand the motivation of faculty members.

10. Timor-Leste

**Doctors and nurses**

The aim of the University of Timor-Leste Strategic Plan is that by 2015 all teaching staff should have relevant postgraduate degrees. In keeping with the principles of equity, districts are given proportionate representation in their courses.

Inadequate funding and lack of appropriate faculty, however, remain key challenges.
Rural retention of health workforce - Policy gaps and action plan

Given the evidence of the assessment on rural retention that each country had produced, with the application of conceptual framework of relationship between gaps of implementation and technical feasibility, all 16 recommendations were scored between one and five, for doctors and nurses. Based on the analyses, the countries drafted a two-year work plan for each of the three priorities - one for doctors and the other for nurses. The draft work plan (2015–2016) consists of major programme activities, implementing partners, targets and indicators.

The priority areas that countries identified for improving rural retention of doctors and nurses are given in Tables 3 and 4 respectively:

1. Bangladesh

For doctors

- A-5: Continuous professional development
- C-1: Appropriate financial incentives
- D-3: Outreach support
For nurses

- D-3: Outreach support
- B-1: Enhanced scope of practice
- D-6: Public recognition measures

2. Bhutan

For doctors

- A-3: Clinical rotations in rural areas during studies
- D-4: Career development
- D-5: Professional networks

For nurses

- A-3: Clinical rotations in rural areas during studies
- D-4: Career development
- D-6: Public recognition measures

3. Democratic People’s Republic of Korea

For doctors and nurses

- A-4: Curricula that reflect rural health issues
- D-3: Outreach support
- A-5: Continuous professional development

4. Indonesia

For doctors and nurses

- A-5: Continuous professional development
- A-1: Students from rural backgrounds
5. **Myanmar**

*For doctors*
- A-1: Students from rural backgrounds
- A-4: Curricula that reflect rural health issues
- B-3: Compulsory service

*For nurses*
- A-3: Clinical rotations in rural areas during studies
- A-5: Continuous professional development
- B-1: Enhanced scope of practice

6. **Nepal**

*For doctors and nurses*
- A-1: Students from rural backgrounds
- B-3: Compulsory service
- D-3: Outreach support
- D-5: Professional networks

7. **Sri Lanka**

*For doctors*
- D-1: Better living conditions
- D-3: Outreach support
- D-5: Professional networks

*For nurses*
- B-3: Compulsory service
- D-1: Better living conditions
- D-5: Professional networks
8. Thailand

For doctors
- A-4: Curricula that reflect rural health issues
- A-5: Continuous professional development
- B-3: Compulsory service

For nurses
- A-4: Curricula that reflect rural health issues
- B-1: Enhanced scope of practice
- C-1: Appropriate financial incentives

9.1 Timor-Leste

For doctors
- A-3: Clinical rotations in rural areas during studies
- A-4: Curricula that reflect rural health issues
- A-5: Continuous professional development

For nurses
- B-4: Subsidized education for return of service
- D-2: Safe and supportive working environment
- D-1: Better living conditions

Discussion points

General
- It is essential to know the quantum of workers in rural areas to be able to plan effectively for their retention.
- Priorities and rural retention strategies in the two-year action plan should be in sync with overall national priorities/targets and goals, and feasibility.
|                | A1 | A2 | A3 | A4 | A5 | B1  | B2  | B3  | B4 | C1 | D1 | D2 | D3 | D4 | D5 | D6 |
|----------------|----|----|----|----|----|-----|-----|-----|----|----|----|----|----|----|----|
| **Rural background** |    |    |    |    |    |     |     |     |    |    |    |    |    |    |
| Bangladesh      |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Bhutan          |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Democratic People’s Republic of Korea |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Indonesia       |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Maldives        |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Myanmar         |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Nepal           |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Sri Lanka       |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Thailand        |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
| Timor-Leste     |    |    |    |    |    |     |     |     |    |    |    |    |    |    |    |
Table 4: Summary of priority interventions among SEARO countries for rural retention for nurses

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<thead>
<tr>
<th>D6</th>
<th>Recognition</th>
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</thead>
<tbody>
<tr>
<td>D5</td>
<td>Network</td>
</tr>
<tr>
<td>D4</td>
<td>Career development</td>
</tr>
<tr>
<td>D3</td>
<td>Outreach services</td>
</tr>
<tr>
<td>D2</td>
<td>Safe workplace</td>
</tr>
<tr>
<td>D1</td>
<td>Living condition</td>
</tr>
<tr>
<td>C1</td>
<td>Financial incentive</td>
</tr>
<tr>
<td>B4</td>
<td>Subsidized education</td>
</tr>
<tr>
<td>B3</td>
<td>Compulsory service</td>
</tr>
<tr>
<td>B2</td>
<td>Different health workers</td>
</tr>
<tr>
<td>B1</td>
<td>Scope of practice</td>
</tr>
<tr>
<td>A5</td>
<td>CPD</td>
</tr>
<tr>
<td>A4</td>
<td>Curriculum</td>
</tr>
<tr>
<td>A3</td>
<td>Clinical rotation</td>
</tr>
<tr>
<td>A2</td>
<td>Main course outside school</td>
</tr>
<tr>
<td>A1</td>
<td>Rural background</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>Democratic People’s Republic of Korea</th>
<th>Indonesia</th>
<th>Maldives</th>
<th>Myanmar</th>
<th>Nepal</th>
<th>Sri Lanka</th>
<th>Thailand</th>
<th>Timor-Leste</th>
</tr>
</thead>
</table>

27
Further fine-tuning of priorities and activities through within-country consultations is required.

Key challenges include the need for intersectoral actions, commitment, fiscal space, and involving the MoE, public and private training institutes.

**Specific**

- **Bangladesh:** For enhanced scope of practice for nurses, the councils need to be consulted. Public recognition of nurses and community health workers should be tried.

- **Bhutan:** Does not have medical schools and plans should focus on non-doctors. Public recognition measures will go a long way in motivating them.

- **Indonesia:** e-learning (e-CPD) may not be good for clinical skills.

- **Myanmar:** Must evaluate outcomes of ongoing interventions. For enhanced scope of practice, there needs to be a review of current skill sets and what needs to be taught additionally.

- **Sri Lanka:** For better living conditions, physical infrastructure has to be developed, which will require major financing.
Strategic directions for collaboration and mobilization support in strengthening HWF

Ms Keiko Osaki, Senior Adviser on Health, JICA, in her presentation said that strengthening HRH is a key component of Japan’s Strategy on global health diplomacy, which was released in May 2013. In accordance with the government’s policy and in light of Japan’s health history and systems, which had achieved the longest life expectancy at birth at relatively low cost, JICA would strive to help developing countries tackle health challenges in partnership with the international community with a vision to achieve the Millennium Development Goals (MDG) and UHC.

Important perspectives in deploying JICA’s operations were as follows:

- strengthening strategic programmes based on international trends in global health, including discussion on HRH at GHWA and AAAH;
- aid coordination and promotion of medium- and long-term cooperation based on a country’s national plan;
- capacity development for developing countries;
- use and creation of empirical evidence; and
- contributions through the utilization of Japan’s health technology and industry.
To address the shortage of health workers, JICA will assist developing countries’ efforts to improve the quality of human resources, increase their number, and establish necessary systems and institutions. Specifically, JICA will provide support through the following focused interventions:

- upgrading the quality of the existing HWF through in-service training (e.g., nursing competency in Indonesia, NCD in Sri Lanka, BHS in Myanmar);

- constructing professional training facilities and/or developing curriculum and teaching materials to train more health professionals; and

- establishing policies for producing, recruiting, and retaining health workers and developing human resources management information systems.

In countries where the shortage of HWF is particularly severe, efforts are being made to expand health services at the community level through the recruitment of local volunteers and community HW with professional backgrounds (e.g., SMPP in Bangladesh, malaria control in Myanmar).

In order to support these activities, JICA will help formulate policies, train human resources, and create and scale up new models for intervention.
HRH in UHC context – 10-year vision on HRH strengthening

The countries deliberated on the UHC status and commitments with a focus on the national strategy on HRH. The participants described how the targets and indicators in the two-year action plan (2015–2016) on rural retention and transformative HPE synergistically contributes towards the decade of strengthening of HWF and the achievement of national HWF goals.
### Table 5: Summary of country presentations

<table>
<thead>
<tr>
<th>Country UHC Context</th>
<th>HRH Implications</th>
<th>National Strategy on HRH</th>
<th>HRH Goals and Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bangladesh</strong></td>
<td>Rapid urbanization has seen an increase in slum areas and vulnerable population, in addition to traditionally hard-to-reach and remote areas. NCDs, re-emergence of malaria and TB and natural disasters are major issues.</td>
<td>National Health Strategy to be finalized in March 2015 will reflect the agreed priorities for HRH, outlining immediate and longer-term steps in relation to SDGs and UHC. HRM unit has also developed an HRH Workforce Plan 2015–2025 (awaits endorsement).</td>
<td><strong>Goal:</strong> To ensure that properly motivated, appropriately skilled workforce is available, where and when it is needed to deliver the Government’s policy objectives successfully. <strong>Targets:</strong> Scaling up production of health workers equitably. Appropriate deployment, utilization and retention strategies.</td>
</tr>
</tbody>
</table>
| **Bhutan**          | Epidemiological transition includes:  
|                     | • geriatric problem, double burden of diseases;  
|                     | • rural urban migration;  
<p>|                     | • with the progress in the development of the country, demand and expectation of the quality of service increases. | HRH MP 2011–2023 aims at ensuring adequate and equitable distribution of appropriately motivated and skilled HW providing quality services. National HRH Strategies are to address issues of recruitment and deployment; quality of care; leadership and management; HWF development; competency and HR information system. | <strong>Staffing standards to ensure adequate skill mix of HW have been defined for each level of health facility.</strong> |</p>
<table>
<thead>
<tr>
<th>Country UHC Context</th>
<th>HRH Implications</th>
<th>National Strategy on HRH</th>
<th>HRH Goals and Targets</th>
</tr>
</thead>
</table>
| Democratic People’s Republic of Korea | • Effective and efficient universal free medical care system is in place.  
• Preventive, promotive and curative health care at PHC level with household doctor system.  
• Aim is at reducing the gaps between urban and rural areas, plain and mountainous areas. | • MDG related to maternal and child health is a priority in health sector.  
• Tuberculosis and malaria are re-emerging priority areas with NCD being an emerging priority area. | **Vision:** To ensure equitable access to effective public health services through harmonious distribution of sufficient, quality, motivated and relevant HWF.  
**Mission:** To strengthen capacity in planning, training, distribution, management of HRH so as to meet the increasing health needs.  
**Goal:** To strengthen health system through developing capacity of HWF for quality care, education, research and medical treatment. | • **Strategy 1:** Establish evidence-based HRH planning and develop national HRH Master Plan.  
• **Strategy 2:** Produce competent HRH to meet demand of HRH in health-care settings.  
• **Strategy 3:** Build capacity of existing HRH for quality health-care service delivery and strengthen HRH management system. |
| Indonesia | • Integration of all government insurance, Jamkesda and other commercial insurance into BPJS (National Insurance Management Agency).  
• Expansion of scheme to all citizens. | • High incidence of NCD, cancer, mental health.  
• High population of elderly.  
• Shifting health service strategy to prevention and promotion. | • Improve HRH availability, distribution in remote areas.  
• Improve types, quality and competence of HRH.  
• Improve planning and utilization.  
• Improve HRH regulation, financing and management. | • Percentage health facility that comply to HRH standard.  
• Percentage of PHO and DHO that has good planning HRH.  
• Number of HRH trained.  
• Number of HRH registered.  
• Number of HRH who received scholarship. |
<table>
<thead>
<tr>
<th>Country</th>
<th>UHC Context</th>
<th>HRH Implications</th>
<th>National Strategy on HRH</th>
<th>HRH Goals and Targets</th>
</tr>
</thead>
</table>
| Maldives | **Vision:** Access for all to competent and sustainable HWF within a robust and enabling health system towards achieving UHC, MDG and beyond.  
**Achievement:** Health-care facilities in all islands and health insurance for all citizens established from January 2012. | • Increasing life expectancy from 46.5 (1977) to 73/75 (2011).  
• Rapid increase in NCD.  
• Underutilization of local/rural health facilities.  
• Shortages of HRH in rural areas and high turnover workers in atolls.  
• Over-dependence on expatriate professionals.  
• Variability in the quality of training. | **HRH Strategic Plan 2014–2018 addresses**  
• External factors such as: geography, demography, epidemiology.  
• Internal factors such as health-care delivery system, distribution, recruitment retention etc.  
• HRH policy such as decentralization of health care.  
• Pre-service education, post graduate education and CPD. | National HRH goals and strategies include major components on  
• Policy leadership and management systems;  
• HRH education;  
• HRH financing and partnership. |
| Myanmar | • Formulation of essential health package (benefit package) for every citizen.  
• Reviewing current available MOH budget and negotiation with other key stakeholders to expand fiscal space for health. | • Myanmar Ministry of Health- HWF Strategic Plan 2012–2017  
• Aim to produce all categories of HRH in the country | • Strengthening leadership and management of HRH  
• Improving availability and distribution of HRH  
• Strengthening production and quality of HRH  
• Ensuring equity in HRH | To develop an effective HWF that can meet the challenges facing the Myanmar health system ensuring that competent and committed personnel, managerial and technical, appropriate in quantity and quality, are deployed where and when needed to adequately serve all the people of Myanmar. |
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<tr>
<th>Country UHC Context</th>
<th>HRH Implications</th>
<th>National Strategy on HRH</th>
<th>HRH Goals and Targets</th>
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<tr>
<td>Nepal</td>
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</table>
| • UHC principle is central point in National Health Policy 2014 and NHSP-III. | • Current HRH profile grossly inadequate to respond to evolving demographic and epidemiologic transition. | Strategic outputs:  
• Appropriate supply of HCW for labour market needs.  
• Equitable distribution of HWF.  
• Improved health workers performance.  
• Effective and coordinated HRH planning, development and management across health sector. | Goal: To ensure equitable distribution of appropriately skilled HRH to support the achievement of health outcome in Nepal. |
| • Plans to address urban rural disparities in terms of access to and quality of health services and emerging concerns like NCD, mental health, disability, injuries. | • Rising aspiration for better care, especially among increasing affluent population.  
• Mushrooming of expensive private facilities increases out-of-pocket expenditure. | | |
<table>
<thead>
<tr>
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<th>HRH Implications</th>
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<th>HRH Goals and Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td>Challenges:</td>
<td>Strategic objectives:</td>
<td>Improve care provider:</td>
</tr>
<tr>
<td></td>
<td>• Socio-demographic transition.</td>
<td>• Strengthen HRH planning process to respond to needs.</td>
<td>population ratio by 50% by 2024 (for medical officers, nurses and public health midwives).</td>
</tr>
<tr>
<td></td>
<td>• Epidemiological transition - NCD and some CD.</td>
<td>• Institutionalize HRH planning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Continuing challenges of nutrition.</td>
<td>• Improve the production and quality of training.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Environmental sanitation and climate change; Developmental and cultural changes.</td>
<td>• Develop and institutionalize HR management.</td>
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<tr>
<td></td>
<td>HRH vision</td>
<td>• Address health worker needs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A skilled and motivated HWF in right numbers to help achieve equitable access and good quality care, responsive to the needs of the population.</td>
<td>• Establish a performance management system for HRH.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HRH mission</td>
<td>• Ensure effective deployment procedures.</td>
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<tr>
<td></td>
<td>To strengthen the mechanisms and capacities in planning, production and management of HRH and develop them to equitably meet the population health needs and demands.</td>
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<tr>
<td>Country UHC Context</td>
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<tr>
<td>Thailand</td>
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<tr>
<td>Started in 2001.</td>
<td>Demographic transition.</td>
<td>Thai national strategy on HRH</td>
<td>Establish national HRH commission – cover all stakeholders.</td>
</tr>
<tr>
<td>Three schemes of health insurance.</td>
<td>Increased mobility.</td>
<td></td>
<td>HRH planning.</td>
</tr>
<tr>
<td>Covers curative (catastrophic and high-cost disease), health promotion and prevention.</td>
<td>Epidemiological transition.</td>
<td></td>
<td>HRH production – continuous development.</td>
</tr>
<tr>
<td>Increased access to care from 2.45 visits/year to 3.16 visits/year.</td>
<td>Increase demand of middle-income population.</td>
<td></td>
<td>Management (recruitment/retention/utilization).</td>
</tr>
<tr>
<td>Decreased household financial burden.</td>
<td>Increase expectation of quality care.</td>
<td></td>
<td>Community participation.</td>
</tr>
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<td></td>
<td>UHC.</td>
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<td>Country UHC Context</td>
<td>HRH Implications</td>
<td>National Strategy on HRH</td>
<td>HRH Goals and Targets</td>
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<tr>
<td>Timor-Leste</td>
<td>Inequitable distribution of HRH.</td>
<td>• WF Planning, focusing on initial and ongoing assessment of the need and demand for health workers and related deployment issues.</td>
<td>• Achieving staffing norms.</td>
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<td>• Pre-service education and CPD.</td>
<td>• Outreach services by a health professional at villages located more than one hour’s distance from the nearest health facility on foot.</td>
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<td>• Personnel management.</td>
<td>• Capacity-building.</td>
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<td>• Occupational health and safety.</td>
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- To improve access to health care.
- To ensure quality of care to the Timorese population.
- Strengthening management and support system.
- Strengthening community participation and donors’ collaboration.
- Achieving staffing norms.
Dr Erica Lynette Wheeler, Technical Officer, Health Workforce Department, WHO Headquarters, highlighted the responsibilities of the WHO Secretariat for resolution WHA 66.23 of May 2013 ‘Transforming and scaling up health professional education and training’ and described the building blocks for transformative education.

The task of WHO Technical Working Group on Health Workforce Education Assessment Tools was the implementation of resolution WHA 66.23, namely:

- to develop a standard protocol and tool for assessment that may be adapted to country context;
- to support Member States as appropriate in using the protocol to conduct comprehensive assessments of the current situation in HWF education;
- to provide technical support to Member States in formulating and implementing evidence-based policies and strategies in order to strengthen and transform HWF education; and
- to consult regionally in order to review the country assessment findings and submit a report, providing clear conclusions and recommendations, through the Executive Board, for consideration by the Seventieth World Health Assembly (2016).
The expansion and reform of education and training of health professionals to increase their quantity, quality and relevance to (i) meet population health needs and expectations; (ii) strengthen countries’ health systems; and (iii) improve population health outcomes.

Building blocks for transformative education and training include (i) HWF planning; (ii) governance, policy and funding; (iii) national standards-accreditation, regulation and vocational qualifications; (iv) curricula, faculty and education; (v) career and retention; and (vi) student selection.

Quality, quantity, relevance and sustainability are the major parameters necessary for TPE for UHC.

- **Quantity** refers to the number of HWF and the adequacy of that number to address the health needs of a specific population. **Policy level indicator:** A national and local policy environment that prioritizes and produces an adequate number of HWF cadres to deliver UHC (WHO threshold of 2.28 per 1000 pop.).

- **Quality** refers to the qualifications of HWF and the adequacy of these qualifications to address the health needs of a specific population. **Numerical indicator:** Proportion of health professional programmes that have achieved national accreditation or equivalent.

- **Relevance** refers to the relevance of HWF education to meet the current and future health needs of specific populations, including skill mix, availability and equitable distribution to the local context. **Policy level indicator:** A national and local policy environment that prioritizes and supports the equitable distribution of the HWF to underserved areas to deliver UHC.

- **Sustainability** refers to the ongoing commitment by government to support investment in institutions that educate HWF. **Policy level indicator:** Financial and material support to HWF educational institutions.
The countries critically reviewed the existing policies and practices for HWF education in the country, with the application of conceptual framework of relationship between gaps of implementation and technical feasibility, all the 11 WHO recommendations were scored between one and five, separately for doctors and nurses. Based on the score, 10 countries of SEAR drafted a two-year work plan for each of the three priorities - one for doctors and the other for nurses. The work plan (2015–2016) consists of major programme activities, implementing partners, targets and indicators.

The priority areas that the countries identified for transforming professional education include:

1. Bangladesh

For doctors:

- Continuous professional development
- Accreditation
- Admission procedures
For Nurses

- mandatory faculty development
- continuous professional development
- accreditation.

2. Bhutan

For doctors and nurses

- faculty development
- simulation methods
- curriculum development.

3. Democratic People’s Republic of Korea

For doctors and nurses

- faculty development
- curriculum development
- continuous professional development.

4. Indonesia

For doctors

- recruitment of community-based staff
- strengthening HR for accreditation process.

For nurses

- CPD for faculty
- adapt curricula to evolving health-care needs
- interprofessional education.
5. **Maldives**

*For doctors and nurses*
- CPD and in-service training of health professionals relevant to the evolving health-care needs;
- mandatory faculty development programmes that are relevant to the evolving health-care needs; and
- continuous development programmes for faculty, teaching staff.

6. **Myanmar**

*For doctors and nurses*
- educational accreditation
- simulation methods in health professional education
- mandatory faculty development programmes.

7. **Nepal**

*For doctors and nurses*
- simulation methods
- continuous professional development.

8. **Sri Lanka**

*For doctors*
- mandatory faculty development programmes
- CPD and in-service training for health professionals.

*For nurses*
- CPD for faculty
- faculty development to meet evolving health-care needs
- in-service training.
9. Thailand

For doctors and nurses

- Targeted admissions policies
- Adapt curricula
- IPE in both undergraduate and postgraduate programmes.

10. Timor-Leste

For doctors

- CPD for faculty, teaching staff
- Adapt curricula to the evolving health-care needs of the communities
- Targeted admissions policies.

For nurses

- Direct entry of graduates from relevant undergraduate, postgraduate or other educational programmes into different or other level professional study.

Discussion points:

General

- Good practices will require well thought-out plans, sequential actions and generating evidence. This will entail:
  - Assessment of current situation/past achievements, bottlenecks etc.
  - Policy formulation
  - Pilot assessment ➔ Reprogramming ➔ Scaling up
  - Clear baseline indicators for measurement of progress/success
Table 6: Summary of priority interventions among SEAR countries for TPE for doctors

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<tr>
<th></th>
<th>Bangladesh</th>
<th>Bhutan</th>
<th>Democratic People’s Republic of Korea</th>
<th>Indonesia</th>
<th>Maldives</th>
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Table 7: Summary of priority interventions among SEAR countries for TPE for nurses

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<th>Nurses</th>
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<td>Faculty dev, CPD</td>
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<td>Democratic People’s Republic of Korea</td>
<td>Indonesia</td>
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there is a need to ensure that two-year action plans synergistically contribute to national goals and targets

there must be synchronicity between interventions planned for rural retention and health professional education.

**Specific**

- **For all countries**: Mandatory faculty development is easier said than done. Simulation method is very expensive.
- **Bangladesh**: Priority for doctors need to be in sync with those for rural retention.
- **Bhutan**: Before pedagogy assessment, evolving health needs should be assessed, including those components beyond the health sector.
- **Democratic People’s Republic of Korea**: Clear activities need to be formulated.
- **Indonesia**: Plan is very well thought of - synchronized and logical.
- **Sri Lanka**: CPD can be planned for all in-service staff and not only for new recruits.
Accountability framework for countries and WHO

This was an exercise for the countries as well as WHO, whereby each country synchronized the action plans for rural retention and transforming professional education and outlined the support expected from WHO. WHO also expressed the time-bound expectations from countries to implement their action plans.

Most of the countries agreed on the following course of action as immediate follow-up steps to the regional meeting:

- briefing of draft recommendations of the regional meeting to the senior officials of the ministries of health;
- dissemination of the draft action plans and major discussion points during the Bhutan meeting;
- formulation of a road map to strengthen HRH with special focus to rural retention and transformative health professional education with the involvement of various stakeholders; and
- formulation of final action plans and sharing with policy-makers, implementers, relevant stakeholders and partners.

This was in sync with the WHO’s expectations from the Member States. Other short-term and longer-term actions expected from the countries and the timelines are as follows.

- All country teams to convene meetings with MoH/MoE/others as relevant to debrief and agree calendar of activities (Jan 2015 – June 2016): **December 2014**
• Countries confirm focal point for health workforce (HPE and Retention): December 2014

• Country coordination mechanism agrees national action plan on HPE and retention (aligned with national strategies/reporting): January 2015

• Intercountry networks (by theme) and regular teleconferences established: from February 2015

• Progress review at six months and 12 months: July 2015 and January 2016

• Country reports on Resolution SEA/RC67 “Regional strategy on strengthening health workforce education and training in SEAR”: May 2016

• WHO synthesis report on country actions prepared for Regional Committee; reviewed by country teams: June 2016

• Member States review of progress on Resolution SEA/RC67 at Sixty-ninth session of the Regional Committee: September 2016

Conclusion

Preamble

With reference to the WHO South-East Asia Regional Committee Resolution SEA/RC67/R6 on Strengthening health workforce education and training in the Region, a regional meeting on Strengthening HRH in South-East Asia: Time for Action and Commitment, 19–21 November 2014, was held in Thimphu, Bhutan; in this meeting, country-specific two-year action plans (2015–2016) were drafted in the context of the Decade for Health Workforce Strengthening in the Region (2015–2024). The Regional Committee Resolution mandates progress reports to be submitted to the Regional Committee for South-East Asia every two years starting 2016 for the next decade. Conclusions and recommendations made are as follows.

Conclusions

1. It is time for action and commitment to strengthen health workforce in SEAR, and the Decade for HWF Strengthening in SEAR (2015–2024) is the essential platform for continued and sustained effort for actions.

2. Investment in rural retention and transforming health professional education can synergistically support the achievement of national HRH goals in response to UHC global commitment.

3. The important role and contributions of all cadres of HWF to health of the population is recognized and efforts should strengthen all these groups.
(4) Accountability between government and citizens in Member States, and between Member States and WHO is essential to ensure the achievement of national HRH goals.

(5) Adequate and functioning information systems are essential for evidence-based policy decisions.
Recommendations

Recommendations to Member States

(1) Member States, through MoH convene wider stakeholders and all relevant partner consultations to develop two-year integrated HRH action plan focusing on (a) rural retention and (b) health professional education transformation, in the context of the Decade of Health Workforce Strengthening in the Region (2015–2024) and in line with the national HRH strategies.

(2) Work teams/units should be established and adequate funding support ensured for implementation of these action plans, with regular reviews and changed courses of action if needed, and in the context of the requirement by the Regional Committee resolution, to revise the action plans every subsequent two years for the next decade.

(3) Member States should report progress of the implementation of their action plans, to country stakeholders and partners, and the WHO Regional Office by May 2016, to be discussed in the high-level preparatory meeting for the Regional Committee in July 2016 and Sixty-ninth Session of the Regional Committee in September 2016.
Recommendations to WHO

(1) WHO at all levels prioritized support for the implementation of the country action plans 2015–2016 and throughout the Decade in keeping with the Resolution’s commitment on HWF and UHC, including technical and financial supports, and reprogramming of the programme budget.

(2) WHO should support normative works, HWF information systems development, convene platforms and forums for joint learning and sharing experiences among countries in the Region.

(3) WHO should produce biannual progress report (including implementation, process and outcome) of the decade for wider audience in and outside SEAR.
Dr Ornella Lincetto, WHO Representative to Bhutan, delivered the closing remarks. She hoped that participants would comprehend the HWF component in their national health policies and goals; and gaps if any. This would go a long way in framing strategies and prioritizing to get quick wins. She added that it was now time to translate the ideas into actual programme implementation with proper indicators and targets for monitoring and reporting systems. This would require synergy among various sectors particularly the ministries of health, education, finance, professional organizations, civil service committee and others.

She was thankful to H.E. Lympo Nyeema Sangay Tshempo and Dr Poonam Khetrapal Singh for highlighting the importance of HWF towards achieving UHC and better health outcomes. This ensured that the meeting started off on the right note. Strengthening of HWF in support of UHC and robust health systems is one of the WHO Regional Director’s strategic directions and flagship programmes and she expected that this meeting would accelerate implementation of interventions and HRH goals will be achieved.

Dr Lincetto said that over the last two and a half days, the participants had heard insightful presentations from WHO staff and technical partners, but the most significant feature of this meeting had been the highly participative country group work and the outputs. These deliberations had produced three products, namely,

(1) country long-term vision on HWF strengthening with a focus on retention and transforming education in the context of UHC;
(2) draft two-year country action plan on rural retention; and
(3) draft two-year country action plan on transforming health professional education with the focus on doctors and nurses.

She encouraged participants to perform similar exercises in their countries by engaging more stakeholders and partners to finalize the two-year action plans with a focus on rural retention and transformative education.

As stated by the Regional Director in her inaugural address, the WHO Regional Office for South-East Asia commits to support the countries as much as possible in strengthening HWF. As stated in the resolution on strengthening HWF education in South-East Asia, the Member States are accountable to report the progress made in the Sixty-ninth Regional Committee Meeting and thereafter every two years until the Seventy-seventh Regional Committee in 2024.

Dr Lincetto concluded by thanking their excellencies the Honourable Minister, and the Regional Director, WHO, South-East Asia; the active participants from Member States, networks and partners; the chair, co-chair, other speakers, the resource persons and colleagues from WHO.
Annex 1

Agenda

(1) Inaugural session
(2) Strengthening the health workforce in the South-East Asia Region for universal health coverage: time for actions
(3) Country situation on rural retention of health workforce, achievements, challenges and priorities
(4) Identification of gaps in policy and implementation of rural retention interventions in countries and formulation of country action plans based on WHO’s 16 rural retention policies
(5) Country 10-year vision on HRH strengthening with focus on retention and transforming education
(6) Identification of gaps in policy and implementation of transformation of health professionals’ education and training in countries
(7) Overview of the two-year action plans for strengthening health workforce in the area of retention and transformation of education
(8) Concluding session
Annex 2

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Strengthening human resource for health in South-East Asia: Time for action and commitment

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To accelerate the HRH situation in Member countries, especially education and training, there is a need to review the progress made and identify what actions need to be taken to ensure the commitment of strengthening HRH in supporting universal health coverage.

As per RC Resolution SEA/RC67/R6 on strengthening health workforce education and training in the Region, the regional meeting on strengthening human resources for health in South-East Asia: time for action and commitment was conducted, which discussed gaps in policy and implementation or rural retention interventions and health education: and developing country action plans (2015–2016) by prioritizing WHO’s 16 recommendations on rural retention policies and 11 recommendations on transforming professional education.

WHO has developed a global policy recommendation on increasing access to health workers in remote and rural areas through improved retention, which addresses not only financial incentives for retention but also recommendations on education, regulatory, professional and personal support. WHO has also developed the guidelines for transforming and scaling up health professionals’ education and training. WHO recommendations on retention and transforming education need to be translated into action and HRH information systems need to be functional and robust for timely monitoring of progress made.

The report provides a review of the situation and priority areas in countries under three themes: (i) rural retention of health workforce; (ii) transforming and scaling up health professionals’ education and training; and (iii) human resources for health in the UHC context.