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World Health Organization

Improving rural retention of health workers in Lao People's Democratic Republic: Technical workshop

Meeting report

23–24 June 2010
Vientiane, Lao People's Democratic Republic

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Abbreviations

ADB	Asian Development Bank
AFD	Agence Française de Développement
DOP	Department of Organization and Personnel
EDC/HP	Educational Development Centre for the Health Professions
HMR	Health Workforce Migration and Retention Unit, WHO
HRH	human resources for health
JICA	Japan International Cooperation Agency
Lux-Development	Luxembourg Agency for Development Cooperation
MOH	Ministry of Health
UHS	University of Health Sciences
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WPRO	World Health Organization Regional Office for the Western Pacific

1. Introduction and objectives of the workshop

This is the report of a technical workshop held in Vientiane, the Lao People's Democratic Republic, from 23 to 24 June 2010. The workshop was convened by the Department of Organization and Personnel (DOP) of the Ministry of Health (MOH) of the Lao People's Democratic Republic, in collaboration with the World Health Organization (WHO), in order to enable stakeholders to assess the potential avenues for the Lao People's Democratic Republic to take action on "Increasing access to health workers in remote and rural areas through improved retention". The main objectives that had been agreed were to:

- present the draft national human resources for health (HRH) policy and strategic plan for 2009–2020 and provide an update on related work, including medical education and training;
- share the final global and regional WHO recommendations on "Increasing access to health workers in remote and rural areas through improved retention";
- present the findings and recommendations of the recently commissioned report "Health worker incentives in the Lao People's Democratic Republic";
- develop a plan of action to implement health worker retention strategies throughout the country.

The technical workshop was attended by 64 delegates, who are listed in Annex 2. The participants represented a range of the stakeholders at district, province and national level in the Lao People's Democratic Republic, as well as international agencies and donors.

The two-day programme, detailed in Annex 1, provided delegates with the opportunity to examine the HRH context in the Lao People's Democratic Republic and to assess the scope for incentives and other policy interventions to be used to improve health worker retention.

Delegates received information through presentations by national policy-makers and a range of HRH experts from WHO and other organizations. They were also provided with a range of background reports to support their moderated group work to identify relevant HRH policy priorities for the Lao People's Democratic Republic and to propose potential policy solutions.

This report summarizes the key points of these presentations and the group work, provides a record of the main HRH policy priorities and potential solutions that were identified and recommended by the delegates at the technical workshop, and sets out the "next steps" in establishing an action plan for the implementation of the HRH policy and strategy in the Lao People's Democratic Republic.

Section 2 of the report summarizes the Lao HRH policy context, based on the background information given to technical workshop participants and the presentations that were made. Section 3 outlines the WHO programme for "Increasing access to health workers in remote and rural areas through improved retention", and Section 4 summarizes the key outputs from group work, with the participants' recommendations and suggestions for the next steps to take forward the action plan.

2. The policy context for the workshop in the Lao People's Democratic Republic

The workshop officially started after opening remarks by Professor Dr Eksavang Vongvichit, Vice Minister of Health of the Lao People's Democratic Republic; Dong II Ahn, WHO Representative to the Lao People's Democratic Republic; and Jean-Marc Braichet, Coordinator, Health Workforce Migration and Retention Unit (HMR), WHO headquarters, Geneva. Participants were briefed on the workshop agenda by Asmus Hammerich, WHO Country Office, Lao People's Democratic Republic. They were then presented with a summary of Lao HRH policy and strategy (which was developed through the HRH Technical Working Group) by Dr Phouthone Vangkonevilay, Deputy Director of Personnel, Ministry of Health.

In addition, participants were provided with a series of background papers to enable them to focus on HRH issues relevant to health worker retention and to contribute to a better understanding of how the Lao People's Democratic Republic may take forward a plan of action on "Increasing access to health workers in remote and rural areas through improved retention". The key aspects of the presentations and background papers are summarized in the next sections of this report.

Key issues in human resources for health

According to data collated by WHO in June 2007, there were 18 017 health workers in the Lao People's Democratic Republic in 2005, including civil servants in the Ministry of Health, contractual staff, and health workers under the two other ministries that manage non-public health facilities: the Ministry of Defence and the Ministry of Public Security. Less than 50% of the total (8942) are in public health facilities managed by the Ministry of Health, including hospital health centres and district health offices/hospitals, with the majority in the latter.

Eighty-eight percent of staff at district level are mid- and low-level staff, with physicians representing only 6% of district-level staff. Unfortunately, comprehensive and up-to-date data on numbers and distribution of health workers in the country are difficult to collate, which limits the ability to develop a comprehensive current overview.

Maldistribution of staff, both geographically and by facility level, is reported to be a significant issue. There are 2992 high- and mid-level medical staff at health-facility level, equating to 0.53 workers per 1000 inhabitants, significantly below the WHO target of 2.5. These workers tend to be concentrated in regions with higher socioeconomic status, and rural areas are unattractive to newly trained competent health workers.

Relatively low wages by international standards – on average, equivalent to approximately US$ 405 per annum – may contribute to recruitment difficulties and to low health worker motivation and productivity. In 2007, the Asian Development Bank (ADB) commented that, because of poor wages, Lao health workers "can ill afford to work full time in a health facility, or be posted to remote health centres where they cannot earn an additional income" .

National policy on human resources for health

Workshop delegates were informed that the Lao national policy on HRH, developed in late 2009 and in draft at the time of the workshop, was likely to receive final approval in the near future. This national framework will be an important component in the development and implementation of any sustained national approach to incentives or broader retention strategies. It reinforces the provision of incentives for health workers as an element in the strategic development of the health workforce.

The document endorses a number of measures for improving access to health workers in rural areas, including the use of specific incentives in targeted areas as well as addressing broader elements such as employment terms and conditions, wage rates, working conditions and equipment, training, classification and staff mix.

Educational Development Centre for the Health Professions

Workshop participants were informed about a new training initiative, in response to a request from the Lao MOH University of Health Sciences (UHS) . The rationale for a proposed WHO-supported Educational Development Centre for the Health Professions (EDC/HP) is based on a shortage and imbalance in skill mix and distribution of qualified health workers; the urgent need to scale up and improve the quality of health professions education; insufficient educational capacity and a need for major further investment and coordinated effort in strengthening educational institutions.

The purpose of the UHS's new EDC/HP will be to serve as a dedicated national centre to support all aspects of the training of health professionals at the UHS and other health professions education institutions. It will also mobilize resource persons and cultivate their capacity to support educational development. Starting in 2010, the centre will be based at the UHS as the national institution for health profession education in the context of the Complex Hospital, Institute, Project and University (CHIPU) framework, and will support all aspects of educational development, giving priority to teacher training and curriculum development.

Decree on stipulation of incentive for Government staff who work in remote areas

Workshop delegates were informed that the draft *Decree on stipulation of incentive for Government staff who work in remote areas*, which includes health workers, is under consideration by the Lao Government and is likely to be approved in the near future.

The draft Decree establishes that rural and remote areas (defined according to criteria specified in the document) are a clear priority for targeting of financial incentives. It outlines criteria for eligibility and provides details of additional payment rates, determined as a percentage increase on base pay, as well as non-financial incentives such as the provision of housing.

It will be important to review the final version of the Decree to assess its implications (including budgetary ones) for the work planned to encourage the retention of health workers in rural areas, as it is likely to be a major policy element in this area of action.

Review of health worker incentives in 2009–2010

The report of a consultancy agreed between the MOH and the WHO Regional Office for the Western Pacific (WPRO) in 2009 was circulated to workshop participants: it made recommendations for next steps in the possible introduction of incentives for health workers and was a precursor to this technical workshop.

The review stressed that a greater degree of precision was required in the policy debate about what types of incentives should be considered. The outcomes to be delivered by a health worker incentive package need to be viewed in this context, and the issues of sustainability and value for money carefully considered. It recommended that a workshop (the present one reported here) should be held in the Lao People's Democratic Republic in mid-2010 to engage stakeholders in identifying potential incentives.

On the second day of the workshop Professor James Buchan, one of the consultant authors, presented a summary of the review's report, emphasized the need to be clear about the purposes of any incentives, highlighted that retention in rural and remote areas had been the most often reported use for incentives during the consultancy visits to the Lao People's Democratic Republic in December 2009–January 2010, and stressed the need to align the use of incentives with broader HRH policies.

Key recommendations of the WPRO consultancy report, 2010, were as follows:

- Support full implementation of the current draft Decree on stipulation of incentive for Government's staff, soldiers, police who work in the remote areas as it applies to health workers.
- Establish mechanisms to monitor implementation of the Decree and report on its impact and outcomes, in terms of the extent of coverage of the Decree-based incentives, etc.
- Document, review and assess the lessons learned from previous projects and programmes conducted in the Lao People's Democratic Republic that have incorporated the use of incentives.
- Convene a workshop on retention of rural workers, building on work already under way (the draft Decree) and on the current WHO-led programme on evidence-based recommendations for policies to improve retention of staff in remote and rural areas.
- Build on results of the WHO-supported workshop to conduct a broader-based review of options for use of incentives, within the context of implementation of the current draft HRH strategy for the health sector in the Lao People's Democratic Republic, a key objective being to identify costs, benefits and risks. The focus should include options described as:
  - geographical: prioritize rural and remote retention;
  - programmatic: prioritize achievement of key Millennium Development Goals;
  - cadre-oriented: target particular health cadres;
  - systematic: develop an incentive package related to an integrated approach of performance assessment, review and development.

Full identification of the advantages, disadvantages and implementation costs of each option will be required.

3. WHO support for human resources for health: WHO programme on remote and rural retention

In Session II of the workshop, participants were first provided with a regional overview of HRH and retention by Rodel Nodora, WPRO, Manila, with input from Laure Garancher from the WHO Country Office, Viet Nam. This regional presentation set out the key components of the *Regional strategy on human resources for health, 2006–2015*, including the four priority areas of HRH strategy and planning, production and development of HRH, HRH management and retention, and HRH governance and partnerships. Country examples of retention strategies were provided to participants, who were also reminded of threats, risks and opportunities when developing HRH strategies.

The regional presentation was complemented by one from Viet Nam, which highlighted challenges in attracting and retaining health workers at community health clinic level, and stressed that the main issues in rural and remote areas were difficulty of access, transport, and the fact that communication could be difficult between health workers and an ethnically diverse population. A range of policy interventions was highlighted, including a five-year HRH workplan, a decree on health worker rotation, and a project to recruit and train locally based midwives.

Participants then received a presentation of the WHO global recommendations on "Increasing access to health workers in remote and rural areas through improved retention" by Jean-Marc Braichet and Laura Stormont, from WHO/HRH/HMR, Geneva. Workshop participants were given a detailed briefing on this new programme, which was established by WHO in February 2009 with other stakeholders in response to various international calls for action from global leaders, civil society and Member States. Its ultimate goal is to improve access to health care by improving the distribution of health workers in relatively underserved areas in rural and remote regions.

The programme's main focus is to support countries to address the critical issues of retention and equitable distribution of health workers. An international expert group had been convened in order to examine existing knowledge and evidence and provide up-to-date, practical guidance to policy-makers on how to design, implement and evaluate strategies to attract and retain health workers in remote and rural areas. The workshop served as an opportunity to assess the potential and implications of the Lao People's Democratic Republic becoming a case-study for the new programme.

The programme consists of three strategic pillars:

- building and sharing the evidence base;
- producing and disseminating policy recommendations and guidelines;
- supporting countries in the analysis, evaluation and implementation of effective strategies.

Following an examination of relevant evidence gained through literature reviews, case-studies and reports, as well as consideration of shared country experiences, it was concluded that the best results would be achieved by choosing and implementing a "bundle" of contextually relevant retention interventions. The 16 interventions that were identified as having a significant influence on recruitment and retention possibilities for the staffing of remote and rural areas are listed below in four main categories: education, regulation, financial incentives, and personal and professional support.

Recommended interventions: education

1. Use targeted admission policies to enrol students with a rural background in education programmes for various health disciplines, in order to increase the likelihood of graduates choosing to practise in similar areas.
2. Locate health professional schools, campuses and family medicine residency programmes that are situated elsewhere than in the capital and other major cities, because graduates of such schools and programmes are more likely to choose to work in rural areas.
3. Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations.
4. Revise undergraduate and postgraduate curricula to include rural health topics, so as to enhance the competencies of health professionals working in rural areas and thereby increase their job satisfaction.
5. Design continuing education and professional development programmes that meet the needs of rural health workers and are accessible from where they live and work.

Recommended interventions: regulation

1. Introduce and regulate enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction.
2. Introduce different categories of health workers, with appropriate training and regulation for rural practice.

3. Ensure that compulsory service requirements in rural and remote areas are accompanied by appropriate support and incentives.
4. Provide scholarships, bursaries or other education subsidies with enforceable agreements of return to service in rural or remote areas, so as to increase recruitment of health workers in such places.

Recommended intervention: finance

1. Use a combination of fiscally sustainable financial incentives – hardship allowances, grants for housing, free transport, paid vacations, etc. – sufficient to outweigh the opportunity costs that health workers perceive to be associated with working in rural areas.

Recommended interventions: personal and professional support

1. Improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools, etc.), as these factors have a significant influence on a health worker's decision to locate to and remain in a rural area.
2. Provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make posts in remote and rural areas professionally attractive.
3. Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, use telehealth facilities to provide additional support.
4. Develop and support career development programmes and provide senior posts in rural areas, so that health workers can move up the career path as a result of experience, education and training without having to relocate.
5. Support the development of professional networks, rural health professional associations, rural health journals, etc. in order to improve the morale and status of rural providers and reduce feelings of professional isolation.
6. Adopt public recognition measures such as rural health days, awards and titles at local, national and international levels to lift the profile of working in rural areas and create the conditions to improve intrinsic motivation.

As noted above, workshop participants were informed that a bundle of contextually relevant recommendations was deemed to be more likely to have the desired impact than single interventions. They were also reminded that a rural retention policy should be grounded in the national health plan and should be informed by an in-depth understanding of the health workforce. This understanding can be gained from conducting a comprehensive situation analysis, a labour market analysis and an analysis of the factors that influence the decision of health workers to relocate to, stay in or leave remote or rural areas.

Workshop participants were informed that there would be a global publication of the recommendations in July 2010, with a planned formal launch in September 2010, followed by other regional and national launches. Widespread dissemination is planned at international, regional and local level. The full recommendations of the WHO group were available in July 2010 at http://www.who.int/hrh/retention/home/en/index.html.

The session concluded with a presentation on "Taking the Lao People's Democratic Republic forward as a focus country" by Jean-Marc Braichet. Workshop participants were informed that, considering that the Lao Government had already identified HRH as a health priority and was making efforts to improve retention of health workers through the draft Decree and plans for significant improvements in medical education, there was scope for the Lao People's

Democratic Republic to be one of the pilot countries for the WHO recommendations. Through working in collaboration with a broad variety of key stakeholders, including professional associations, relevant ministries, partners and nongovernmental organizations, as well as rural and remote communities themselves, WHO could provide key technical support for the implementation and subsequent monitoring and evaluation of retentions strategies led by the Government in the future.

Criteria for focus countries are as follows:

- they should be one of the 57 countries with a shortage of HRH, as identified in *The World Health Report 2006*;
- they should show clear political will for action;
- they should have a national HRH plan;
- they should be geographically and linguistically diverse;
- they should have had previous working relationships or good contacts with WHO;
- they should have the presence of important global players (e.g. Global Health Initiatives)

Mali, Senegal and Zambia, among other countries, were in discussion about being focus countries for the programme; the Lao People's Democratic Republic would be the first country in Asia if it wished to take up the opportunity. In follow-up discussions, it was stressed that the Lao MOH and WHO aimed to make a long-term commitment to the programme, including dedicated staff in the WHO Country Office and on-going links with other development partners.

4. Key outputs from discussion sessions

Session III in the afternoon of the first day was based on a moderated round table discussion, where different stakeholders and development partners had the opportunity to share their experiences and views on HRH and health workers' retention. This was followed by group work to undertake situation analyses of different aspects of recruiting and retaining health workers in remote areas.

Participants at the workshop were allocated to eight working groups, and representatives from development partner agencies were distributed across these groups. Agencies represented at the workshop included:

- Agence Française de Développement/French Embassy (AFD)
- Asian Development Bank (ADB)
- Capacity Plus
- Japan International Cooperation Agency (JICA)
- Luxembourg Agency for Development Cooperation (Lux-Development)
- The World Bank
- United Nations Children's Fund (UNICEF)
- United Nations Population Fund (UNFPA)

For the purposes of effective group work, in terms of time management and reporting back, the eight initial groups were subsequently merged into four larger working groups, each of which was asked to concentrate on one major aspect of HRH in relation to recruitment and retention of health workers in remote areas:

- Group A. Availability and recruitment – "Finding them"
- Group B. Medical education and training – "Educating them"
- Group C. Allocation, distribution and deployment – "Placing and keeping them in the areas where they are needed"
- Group D. Performance and incentive mechanisms – "Motivating them"

The groups were briefed that over the two days of their work they should cover five components of the HRH issues they were considering: 1) situation analysis; 2) possible interventions; 3) prioritization of interventions; 4) road map for implementation; and 5) measuring results: monitoring and evaluation.

On the first day of the workshop (Session III) the groups focused on the first two components; each working group reported its initial situation analysis and possible interventions at the end of Session III in order to receive feedback from plenary. On the second day (Session IV) the groups developed their work further by prioritizing interventions, setting out an implementation road map, and identifying possible methods of monitoring. Initial discussion among the participants covered a broad range of issues related to retention of health workers. It was noted that many incentives had been tried in the Lao People's Democratic Republic, including the use of non-financial incentives such as promises of preferential treatment for promotion, and types of bonding of staff. However, there was limited evidence and evaluation of these measures – often because the incentives had been used at local level or in vertical programmes that lacked a monitoring and evaluation component. Another major constraint that was identified was the centrally determined staff quota, which limited flexibility in staffing allocation. There was also a risk that staff working in remote areas felt that they were overlooked when decisions were made about promotions, access to training, etc.

Group A. Availability and recruitment – "Finding them" highlighted the current shortage of workers in rural areas, particularly those in higher occupations. The group also pointed to issues of gender, with a lack of recruitment of women in rural areas, in part because insufficient numbers were recruited and trained locally. Participants restated the constraints imposed by the quota system and highlighted that many local workers were working as volunteers, often for years, while they waited for the possibility of a permanent job. These workers should be given priority when job opportunities arose. The group also reported that this year's quota allocation of 25 Government posts per district may have led to few posts being created in health care. They also noted that nursing and midwifery schools were now being established in areas outside the capital and it was anticipated that this would improve recruitment and retention in provinces.

Group B. Medical education and training – "Educating them" noted that localized recruitment from remote areas into some professions was difficult because of selection criteria requiring minimum secondary-school education. There were also broader difficulties in knowing how many students should be recruited each year, as many newly graduated students in primary health care could not find a position because of the quota. Participants emphasized the need for curriculum development to look at scope of practice and the extent of appropriately supervised rural-based experience during training; and also the need for management training. They identified a lack of well-qualified teachers and insufficient training materials as being constraints of education delivery.

Group C. Allocation, distribution and deployment –"Placing and keeping them in the areas where they are needed" highlighted issues related to both quality and quantity of available staff. The current policy of allocation was based on priority needs, but proposals compiled at province level were often altered at national level, and different provinces had different quota levels. They also noted that the population being served by the health workforce composed 49 ethnic groups with different languages, which had implications for the need for interpreters among other issues and could create language barriers. Schools now have quotas to recruit students from ethnic minority groups; it was reported that the "return rate" from these students was higher for low-level cadres, but that for higher cadres the attrition is 50% because some stay in urban areas. Even when there were quotas, often it was not possible to attract new graduates to rural areas; the incentives that might be available, such as housing, were not well promoted or understood, and there was insufficient recruitment from remote areas. The absence of proper equipment in some health centres also meant that graduates could not function effectively.

Group D. Performance and incentive mechanisms –"Motivating them" noted that new graduates often lacked the skills and confidence to work in isolation in remote areas, there was a lack of consistent guidelines as to how long staff should serve in such areas and about the rewards to which they should be entitled, e.g. accelerated promotion or further training. Good supervision was an important motivating factor, but without a budget for supervision staff sometimes felt abandoned. It was difficult to set targets and monitor activity and achievements in health centres and rural areas, because the limited available information systems were focused on hospital-based staff; the group also reported that there was feeling that information went upwards in the system but that no feedback filtered back down. Lack of regular payment of salaries in remote areas (an average delay of three months was cited), lack of opportunities for additional earnings, and quotas were also cited as constraints on the effective motivation of health workers.

Sessions IV and V. Development and presentation of proposed plan of action

Each of the four groups completed its work by prioritizing interventions, developing a road map for implementation (what, when, where, who, how?) and identifying potential for monitoring progress and impact. The groups' conclusions and recommendations were reported back to the plenary, followed by a moderated discussion during which consensus was reached on the ideas to be taken forward for the plan of action. The discussion was helpful in reaching broad agreement on priority areas, as well as clarifying or contesting points made by each of the four groups.

The following tables present a summary of the moderated output from each of the four groups, presented in a standard structure that sets out the key points of the initial situational analysis; the identification of both existing and possible future interventions; agreed prioritization of interventions; a road map for implementation; and measurement, monitoring and evaluation issues.

These matrices are used in order to highlight the linkage between different aspects of the potential implementation of interventions, and also the possibility of alignment or overlap between different interventions. It is important to note that the working groups were considering the possibilities for bundles of interventions rather than single interventions: there is a need for prioritization, but also a need to identify possible linkages.

Summary of working group discussions

Group A. Availability and recruitment – "Finding them"				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
1. Shortage of health workers in remote and rural areas 2 Qualified people are not attracted to or want to work in remote and rural areas – lack of recruitment of high-level health workers 3. Gender issue – lack of recruitment of women in rural areas, particularly in areas with significant ethnic minorities 4. Insufficient trained women health workers, and they do not apply for the posts 5. Many ethnic minorities do not allow male health workers to see and touch female family members (e.g. for antenatal care or delivery care) 6. Under quota recruitment system, local health authorities are not able to recruit type of cadre they need due to small number of applicants who want to work in remote and rural areas (e.g. district hospital has post for a surgeon but no applicants)	1. Shifting UHS from MOE to MOH, allowing MOH to recruit students: increasing opportunities to recruit students from remote and rural areas 2. Government is creating new nursing schools in areas outside Vientiane capital: will be able to get more students from remote and rural areas 3. Include field training in rural areas for 6th year students: 1 month clinical rural rotation to increase experience 4. Graduated medical students freely find their own position under quota system, increasing opportunity to apply for positions in rural areas 5. At the same time, MOH is also running recruitment through the quota system allocation, based on the needs of the provinces	1. Recruit HWs based on the positions as already defined in the structure of MOH, according to needs of the areas 2. Establish a process to recruit new students for training from rural and remote areas, according to quota of required health cadres 3. Provide training opportunities for medical students and graduated medical students from rural and remote areas	1. Making contract with students who go to rural HCs (contract between students, MOH and district authorities) 2. Database of health staff to be fixed and maintained (need to organize some way for provinces to be able to work with this database as well); in addition, the database's technical problems need to be solved 3. Set up legislation and regulation that a volunteer who has worked in a rural area for some 2 years should be given priority when a post becomes available 4. Map and identify all rural HCs and staff currently working there, clearly identifying the gaps (link different data sources and try to update them regularly) 5. Establish a committee to be specifically responsible to identify staffing needs of the provinces	1. Utilizing the existing database in order to better understand health workforce and monitor where they are, numbers, etc.; make reports based on updates 2. Number and percentage of students who have completed contracts 3. Number and percentage of students, especially from rural and remote areas, who have been accepted 4. Number and percentage of students who received field training in rural areas

Group A. Availability and recruitment – "Finding them" (continued)				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
7. Huge numbers of trained, qualified staff who did not get a post in central or big cities work as volunteers for a few years, then are lost to other jobs; it is necessary to ensure they are posted before training more 8. Recruitment processes: • Recruitment plan stipulates how many people will be recruited to MOH • Quota system for each area (based on population need and type of health workers that area requires) • This year, each district received 25 Government positions for all sectors (education, health, agriculture, etc.); in many districts, positions were not allocated for health sector	6. Legislation and regulation: stipulate how many health workers should be allocated to each different health facility and at what educational level: *Estimate: HC type A may need 5 HWs, HC type B may need 3 HWs; district hospitals should have 1–1.5 HWs/bed; provincial hospitals should have 2–2.5 HWs/bed; central level should have 2.5–5 HWs/bed* 7. Training opportunities for HWs in rural and remote areas 8. Future interventions: • Continue present recruitment strategies that have already been implemented • Continue the quota system, but ensure it meets the needs of health • More selection and targeted admission of students from rural and remote areas and ethnic minorities		6. Recruitment for the provinces should be appropriate according to the position and category of cadres they actually need 7. Explain to students and local authorities so they can understand the way in which HWs should be allocated 8. District health office makes recruitment plan according to needs, based on existing information and statistics 9. Inform local authorities and schools how many students they can accept of each health cadre 10. Set up selection criteria and processes for students for each cadre, according to level of education 11. Include field training in rural areas for 5th and 6th year students 12. Implement all the work plan of Step 3, activity 1.	

Note: HC = health centre; HW = health worker; MOE = Ministry of Education.

Group B. Medical education and training – "Educating them"				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
1. Recruitment of students representing the population in local areas (e.g. Hmong): problem with selection criteria that require minimum secondary education 2. Renovation of educational facilities is needed 3. Difficult to know number and type of cadres to be recruited annually, as many PHC graduates could not find a position after training due to low quotas 4. Difficult to have appropriate number of staff and proper skill-mix: employment rate of new graduates from nursing school is 10% in public sector 5. PHC HWs training is not strong enough: PHC orientation does not cover medicine (e.g. diagnosis, treatment) 6. Develop continuing training 7. Less possibility of practice for students 8. Need for curriculum improvement 9. Insufficient qualified teachers 10. Insufficient training in management	1. There is a course to upgrade students from ethnic minorities to secondary educational level before entering PHC schools 2. Training for PHC has been developed for different areas such as SBA and communicable diseases 3. Lower level HWs can be upgraded to middle level and receive training on providing treatment 4. Programme to upgrade medical assistant to medical associate has been started this year in 3 public health schools 5. JICA project in Champasak province to link medical schools and hospital 6. MOH revises scope of practice for certain categories of staff (e.g. nurse, midwife) that can lead to better curriculum 7. WHO's programme to improve teaching skills of UHS's staff (NTTC) 8. The National Institute of Public Health has a programme to upgrade management capacity for leaders from district areas	1. Initial training 2. Targeting poor, poorest and rural areas 3. Continuous education	1. Qualification of teachers: • accreditation of teachers (NY) • MTU and EDC (OG) • improve teaching methodology (OG) 2. Improve training materials (OG) 3. Improve training facilities and housing, especially if schools are decentralized (dormitory, canteen, etc.) (OG) 4. Develop management of training (OG) 5. Revise curriculum to reflect rural needs (including epidemiology, disaster response) (OG) 6. Need guidelines for quality assurance (NY) 7. Improve student evaluation (NY) 8. Develop licensing for HWs (example of existing community midwives) (OG) 9. Develop relations between schools and teaching hospitals (OG) 10. Adapt medical school entrance examination for ethnic minority students (OG) 11. Focus on HWs in 47 poorest districts and then extend projects to 72 poor districts nationwide (OG)	

Group B. Medical education and training – "Educating them" (continued)				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
11. Need to develop training materials	9. ADB is supporting a 3-month training programme on public health management at the UHS, bachelor degree for management and support to send students abroad		12. Having supportive supervision (NY) 13. Continuous training to upgrade PHC workers from lower to middle level (OG). 14. Upgrade job description specific to HCs types A and B (NY) 15. Develop incentive recruitment package (OG) 16. HCs type A need laboratory technicians and pharmacists (OG) 17. Career path should be develop for HWs in CHCs, with clear training possibilities (OG) 18. Need comprehensive plan for continuous education (OG) 19. Decree from MOH to have appropriate training (OG) 20. Need short course training on first aid (OG) 21. Special training for doctors at district hospital on emergency (OG) 22. Organization of continuous training between province and capital (OG) 23. Strengthening village health volunteers CBD (OG) 24. Enforcement of legislation and regulation on compulsory services.	

Note: CBD = Community based distribution; HC = Health centre; HW = Health worker; MTU = Medical teaching unit; NTTC = National Teacher Training Centre; NY = Not yet; OG = On-going; PHC = primary health care; SBA = Skilled birth attendant

Group C. Allocation, distribution and deployment – "Placing and keeping them in the areas where they are needed"				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
1. Provinces make proposals to DOP on number of vacancies 2. More staff but with low quality: surplus and shortage 3. Allocation is based on priority areas: MCH, emergency care, needs of different types of hospital and field of medical treatment, and future plan to establish HCs according to MOH policy 4. All proposals compiled at provincial level are reported to MOH: proposals do not always come back in exactly the same number 5. Quota/allocation criteria are based on vacancy or job description, geography, proportion of HWFs to population and the need of each province or locality, and also depend on the national situation and changes experienced ***Issues and challenges*** 6. Although quotas are available, there are no applicants because new graduates do not want to go to rural areas 7. Language barrier, especially among ethnic minorities 8. Incentives are not present to meet the needs of HWFs	1. Development of HRH plan and policy 2. Job descriptions are being developed by provinces, which will provide information for determining allocations/quota 3. District health office, district hospital and HC mandates are available and are being disseminated 4. Proposed increase in budget of social sector from 20% to 35% of the overall budget 5. National assembly putting pressure on Government and health sector to meet the MDGs: example will be no quota for health sector 6. Government tasked the health sector to propose one policy to provide free services, such as antenatal care, deliveries and children under 1 year old 7. Consolidate all social security schemes under one national health care insurance to have pool of funds for service delivery 8. Allocation and deployment should be based on policy on recruitment	1. **Education** • Priority to students from provinces who would go back to their hometowns after they graduate; ensure they are in the quota list after they graduate▪ Currently there are specific courses for those with certificate courses, but they are limited to district-level work district levels; there should be bachelor courses for those who want to improve or bridge their qualifications. 2. **Regulation** • Working in rural areas to be made compulsory before graduates receive 100% of their salary, at least for 12 months as part of the probation period, followed by a performance appraisal before they can be given a permanent term • Private practice after official working hours to be permitted • Guidelines for placement to be based on the real needs or demand of each locality (putting the right people in the right place) • Develop documents, decrees or guidelines on how to retain HWFs and a strategy of deployment based on locality needs • PACSA should urgently approve the incentives policy for HWFs in rural areas	1. Education, training and deployment will be MOH responsibilities 2. Legal framework, decrees, regulation drafted by MOH together with PACSA 3. Quota will be fixed by PACSA 4. Incentives will be implemented by the provincial and district health offices together with local governments and communities: • specific resources such as equipment will be arranged by the MOH • accommodation will be under the local authority	1. Quality control units in MOH already exist that carry out monitoring and evaluation 2. DOP establishes the performance appraisal 3. Provincial and district levels have similar structures to the central level of appraisal 4. Other international organizations, nongovernmental organizations and private enterprise in the districts can also do the monitoring and evaluation, perhaps working in the MOH or at different levels doing supportive supervision rather than inspection

Group C. Allocation, distribution and deployment – "Placing and keeping them in the areas where they are needed" (continued)				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
9. Incentives are not clear or are not available from the Government, e.g. accommodation, allowances, compensation for poor working conditions 10. Not enough people from rural areas apply to be trained 11. Recruitment is based on job description and MOH prescription, e.g. 3–5 HWs per HC 12. Only 20–25% of quota requested by province are allocated, plus the problem of retirees results in shortage of HRH 13. At district level, staff have low qualification, e.g. 2 years certificate 14. In some areas there is over-staffing; in the past, HC could be manned by graduates with 2 years of training, then qualification was raised to 4 years: • what to do with staff who do not meet the new qualification? • funds have been secured from ADB to enhance the qualifications of staff now rendered under-qualified	9. Health sector, PACSA and MOH work together to develop common guideline for staff recruitment 10. MOH should speed up development of strategy for human resource development through cabinet so it can be the basis for the allocation, distribution and deployment of HWFs	• Government should develop policy to look after personal and professional needs to encourage retention: - for those interested in working in rural areas, based on quota, contracts will specify: clear timelines of stay; clear incentives upon completion of contract (e.g. membership of unions, eligibility for bridging programmes, rewards system such as performance medals); provision of basic needs, communication - equipment, vehicles, and income-generating activities if private practice is not feasible - contracts should be transparent and incentives should be clearly stated; HWs should have access to information before they sign and, when posted, they should have continuous access to information including the technical information they need • Before the deployment, Government should finish job description writing at Ministry of Labour level; before making the job announcement, should define the work and the terms and conditions of the contract • Because of quota and limited budget, we should prioritize the most difficult and remote areas or districts		

Group C. Allocation, distribution and deployment – "Placing and keeping them in the areas where they are needed" (continued)				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
15. Ethnic HWs are prioritized in enhancement training in all cadres/ professionals because they go back to their areas to serve; schools have separate quotas for ethnic staff from remote areas and district hospitals who need to enhance their qualifications 16. Return rate is higher for low level cadre; for higher level 4 years training, attrition is 50% because some trained ethnic minorities stay with their girlfriends in the urban areas, or women follow their husbands who relocate. 17. Limited HC activities for bachelor graduates due to lack of equipment and other resources		3. **Financial incentives** • Policy for additional income or salary (classify rural areas based on difficulty of living and accord supplements, e.g. 50% for the most difficult, 40% for the 2nd and 30% for the 3rd); provide accommodation in rural areas; offer further education, eligibility for membership in associations/ union, supervision and giving of incentives based on performance • Rewards for outstanding performance: currently salaries increase every 2 years, but with outstanding performance the increases could be more frequent or larger. 4. **Personal and professional support** • Provide enabling environment for HWs • Take care of graduates by providing work for them, e.g. arrange future work placement for those in 5th or 6th years of study • Incentives: find out real differences between HWFs now working at hospitals and facilities and the future HWFs		

Group C. Allocation, distribution and deployment – "Placing and keeping them in the areas where they are needed" (continued)				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
		• Advocacy campaigns to promote the Decree by using different media for campaigns to encourage future HWFs to settle in rural areas; organize study tours for students in their final year so they can see for themselves the opportunities and challenges • Disseminate the Decree urgently, especially to final-year students, to encourage them to work in rural areas based on the quota assigned • Lay the groundwork, prepare the organization or build its capacity to manage the HWF • Prepare the community and engage its participation to work with the HWF • Prepare logistics and resources or provide an enabling environment for the HWF to live in the area • There should be regular monitoring, supervision and evaluation to encourage HWFs to work in rural areas • Incentives should be in line with what is really needed and based on the capability to provide them		

Group D. Performance and incentive mechanisms – "Motivating them"				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
Main reasons for staff not being willing to be posted in rural areas: 1. Lack of experience and skills of young graduates: as they lack practice during medical training, some are afraid to be posted to rural areas where they will feel isolated 2. Lack of guidelines as to how long staff should be posted in rural areas and types of rewards to which they may be entitled, e.g. promotions or further training opportunities 3. Varying levels of support from districts/provinces 4. Lack of budget for supervision: good supervision is an important motivating factor, without it staff feel abandoned 5. No target setting and monitoring as to what HWs are meant to achieve; this is linked to the need for a good information system: • currently the health management and information system is mainly focused on hospitals and not on HCs/rural areas; there	1. **Non-financial incentives**: promotion or further education • After 3–4 years' rural/remote work experience, HWs expect to be promoted • There should be a clear rule of the rewards/ recognition accorded to staff posted in rural areas, e.g. further education • Decree No.82 of 2003 states that after 2–3 years of posting in rural areas, staff would be entitled to promotion; this has not been enforced by DOP • In 2006 in a survey of 400 graduates, 80% responded that they were interested in being posted to rural areas, but lack of clarity on regulations and concerns about lack of promotion opportunities created barriers • Housing and availability of equipment/ infrastructure: - Example of 2 Belgium-funded provinces highlighted that many HCs experienced quotas and low salaries: their short-term contract motivation seems to come from housing, availability of equipment/infrastructure (e.g. motorcycles) to cover vaccination tasks, in-service training and related per diem payments and development opportunities	1. Need a situational analysis in order to prioritize the problems: • e.g. include assessment of existing bottlenecks for salary payments, a study on HWs' preference 2. Need to reform existing system: modernize it; make it younger and more professional 3. There should be clear rules set by the Government, and a decree specifying details as to how long staff should be posted in rural areas, etc. • need to follow up the Government plan of 2011–2015 • update existing Decree 4. Need for mapping of activities at provincial/district level of which actors are involved in what activities (e.g. which donors are providing what types of incentives) • central level responsibility; provincial Government does not have the autonomy to negotiate directly with donors such as ADB or UNFPA • but such negotiation is feasible with nongovernmental organizations operating at provincial level	1. What? • establish clear rule on incentives • need to include both financial and non-financial incentives • need a situational analysis in order to prioritize the problems, including e.g. assessment of existing bottlenecks for salary payments, study on HWs' preference • need to improve sector-wide coordination 2. When? • within the existing Government plan for 2011–2015 3. Who? • MOH to establish how the Decree will be implemented; to be responsible for fund-raising among donors, and to work with provincial authorities • central role for the DOP: to develop a database to follow up staff (movements, entry, exit, development needs, etc.)	DOP is working on a tool for monitoring and evaluation, but it needs to be developed further in collaboration with partners and under the leadership of the UHS

Group D. Performance and incentive mechanisms – "Motivating them" (continued)				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
is a feeling that information goes from HWs upwards but they do not receive feedback 6. Irregular salary payments: in urban areas salaries are paid monthly, in rural areas average delays of 3 months 7. As students now have to pay fees for special courses, they have to take other jobs (urban areas offer better earning opportunities) 8. Quotas (since 1995) limit numbers of staff that could be absorbed into the Government/civil services (though there is willingness to work on short-term contracts or as volunteers in rural/remote areas)	• Incentive policies should focus on the local level, not the central level: - in the past, villages would provide food (e.g. rice) as an incentive. now new types of incentives are needed: villages face economic difficulties and are no longer able to continue to provide food incentives - also in the past, non-financial factors motivated HWs to work in rural and remote areas, e.g. political commitment, social mobilization - now staff expect financial support from the central Government 2. **Financial incentives** • Contracting in, example of Luxemburg project in Vientiane and Savannakhet provinces: - health units were paid incentives according to performance; they received additional pay per outputs (e.g. number of vaccinations) and quality measures (e.g. cleanliness, 24-hour opening, clear accounts, reporting of activities to the central level); bonuses were distributed among staff, who decreased their level of private practice to focus on Government, but there were some concerns regarding sustainability	5. DOP needs to develop a database to follow up staff: • need to establish intersectoral links; e.g. MOE has clear rules on age of retirement; link with PACSA database (Government priorities for database updates: MOH, MOE and MOA) • to include profile of staff in the database (e.g. background, type of training each individual has received in the past, need to improve system for aggregation of data submitted by province) **Non-financial incentives** 6. Housing; equipment; per diem allowances 7. Promotion system: easier at central level; need to develop the system for HWs based in remote/rural areas 8. Development opportunities (e.g. scholarships) 9. Recognition mechanisms (e.g. certificate); and system for the selection of the best performing staff (e.g. 10% rewards, not only at central level but in rural areas):	• donors to focus on improving the health infrastructure in rural areas, e.g. housing, equipment, per diem allowances • provincial authorities to work closely with donors • institute of public health to follow up the quality of the implementation UHS should be in charge of monitoring and evaluation	

Group D. Performance and incentive mechanisms – "Motivating them" (continued)				
Step 1. Situation analysis	**Step 2. Existing and possible future interventions**	**Step 3. Prioritization of interventions**	**Step 4. Road map for implementation**	**Step 5. Measuring results: monitoring and evaluation**
	• Authorize staff to operate private practice at Government facilities after hours, with a system of how revenues should be shared (e.g. x% for doctor, x% for nurse, x% for hospital) • National assembly is currently meeting to discuss financial incentives to Government workers: - until now only the MOE provided incentives; but now the Government plans to provide incentives to all civil servants - Decree resulting from national assembly discussions to be signed by the prime minister	• there is a new Government initiative for the recognition of staff performance: national physician, national midwife, national nurse, all HWs; there will be committee to establish the criteria, using each hospital's council to select staff • titles: honorary professorships **Financial incentives** 10. Salary payment		

Note: HC = Health centre; HW = Health worker; MOA = Ministry of Agriculture; MOE = Ministry of Education; PACSA = Public Administration and Civil Service Authority

The matrices above provide a detailed account of the work of each group. Priority interventions identified by the groups are summarized briefly below.

Group A. Availability and recruitment –"Finding them"

- Provide training opportunities for medical students and graduates from rural and remote areas.
- Establish a process to recruit new students for training from rural and remote areas, according to quota of required health cadres. Bridging courses on basic education could be provided for those who have not yet reached the standard required for medical school entry.
- Recruit health workers based on the available positions, as already defined in the structure of the MOH, according to the needs of the areas.

Group B. Medical education and training – "Educating them"

- Initial training.
- Targeting poor, poorest/rural areas.
- Continuous education.

Group C. Allocation, distribution and deployment –"Placing and keeping them in the areas where they are needed"

- Education.
- Regulation.
- Financial incentives.
- Personal and professional support.

Group D. Performance and incentive mechanisms –"Motivating them"

- Non-financial mechanisms – housing, career support, development opportunities, recognition.
- Financial incentives – remote allowance; night-duty fee; performance- based incentives.
- In reporting back the identified priority interventions for full consideration in plenary, the working groups emphasized the need for a full situation analysis and mapping of experiences with current interventions. The need for improved HRH data and information systems was also highlighted, both to assist in prioritizing and implementing interventions, but also to enable the monitoring of impact and effect.

5. Session VI. Next steps: Government and development partners working together to improve retention of health workers

Asmus Hammerich, WHO, Lao People's Democratic Republic, reviewed the initial objectives of the workshop and noted that progress had been made, with all objectives having been met. He noted also that there would be scope in the short term for WHO to provide technical support in some critical areas, such as improvement of the information systems, medical education and training, and situation analysis.

Rodel Nodora, WHO WPRO, also expressed support for the continuation of work in the Lao People's Democratic Republic, identifying the possibility of support for developing an HRH database, curriculum development, and short-term training needs through WHO fellowships.

Several of the donor agencies involved in the workshop also took the opportunity to make some final contributions as to how they could contribute to the Government's efforts in HRH. UNFPA noted that the issue of retention of health workers was very important in order to reduce maternal mortality by locating skilled health workers where women lived, and indicated that they would continue to support this work to the fullest extent of its mandate and resources. UNICEF stated that it would continue to support the MOH and other partners. JICA reported its new project to strengthen human resource development (HRD), including provision for training rural students. Lux-Development expressed the aim of being actively involved in the programme, with a focus on encouraging a positive working environment and improved management systems. Capacity Plus stated its wish to become involved in issues of management development, retention and productivity of health workers.

Jean-Marc Braichet briefly highlighted progress so far in establishing the Lao People's Democratic Republic as a focus country, and then set out the proposed next steps. He reminded workshop participants that considerable progress had already been made: there had been substantial consultations with national authorities and the WHO country office; the consultants' report on health workforce incentives in the Lao People's Democratic Republic had been published and disseminated widely throughout the country; the technical workshop had been arranged and conducted as planned in June 2010, and the publication of the global recommendations was imminent, in July 2010. This would be followed by planned publication of the meeting report from the technical workshop in September 2010.

Noting the long-term commitment of WHO (at the country office, the regional office and headquarters) and its strong collaboration with interested partners, working with the Technical Working Group on HRH issues in the Lao People's Democratic Republic, Dr Braichet laid out the proposed next steps. A key step would be the monitoring and evaluation of the implementation of the Ministerial Decree on retention in remote areas, within the context of the new HRH policy and strategic plan. He also stressed WHO commitment to working with others to contribute to the evidence base and document experiences to enrich further implementation and to participating in further partnerships to strengthen rural health workforce retention.

Dr Braichet reiterated WHO's commitment to developing the Lao People's Democratic Republic as a focus country for the broad-based programme of increasing access to health workers in remote and rural areas, in collaboration with national counterparts. He noted three forthcoming events that would highlight the global recommendations and provide possibilities for the participation of country representatives: the full launch of recommendations, planned for South Africa in September 2010; the Asia–Pacific Action Alliance on Human Resources for Health (AAAH) meeting, in Bali, Indonesia, in October 2010, at which there would be a session on the global recommendations; and the Second Global Forum on HRH, to be held in Bangkok, Thailand, in January 2011.

The workshop was formally closed with final thoughts from Professor Dr Eksavang Vongvichit, Vice Minister of Health of the Lao People's Democratic Republic, who reaffirmed his Government's support to become a focus group country.

Annex 1: Agenda

Wednesday, 23 June 2010 – Day 1

Chair: Professor Dr Eksavang Vongvichith, Vice Minister of Health

0830	Registration
0900–1015	**Session I. Current situation in the Lao People's Democratic Republic**
0900	**Welcome and opening remarks** Ponmek Dalaloy, Minister of Health, Lao People's Democratic Republic Dong Il Ahn, WHO Representative, Lao People's Democratic Republic Jean-Marc Braichet, WHO/HRH/HMR, Geneva, Switzerland
0930	**Presentation of the Lao People's Democratic Republic HRH policy and strategy development through HRH Technical Working Group coordination and current retention interventions including medical education** Phouthone Vangkonevilay, Deputy Director of Department of Personnel, Ministry of Health, supported by WHO Country Office
1015–1030	*Coffee break*
1030–12-00	**Session II. WHO programme on rural retention**
1030	**Regional overview of HRH and retention** Rodel Nodora, WHO Regional Office for the Western Pacific, with inputs from WHO Country Offices Cambodia and Viet Nam
1100	**Presentation of the WHO global recommendations on "Increasing access to health workers in remote and rural areas through improved retention"** Jean-Marc Braichet and Laura Stormont, WHO/HRH/HMR
1120	**Taking the Lao People's Democratic Republic forward as a focus country** Jean-Marc Braichet, WHO/HRH/HMR
1140	Presentations to be followed by moderated discussion
1200–1330	*Lunch*
1330–1545	**Session III. Round table with partners working in the Lao People's Democratic Republic**
1330–1545	**Round table with partners to share their current work on HRH and retention in the Lao People's Democratic Republic** Participants: • Agence Française de Développement/French Embassy (AFD) • Asian Development Bank (ADB) • Japan International Cooperation Agency (JICA) • Luxembourg Agency for Development Cooperation (Lux-Development) • The World Bank • United Nations Children's Fund (UNICEF) • United Nations Population Fund (UNFPA) together with international nongovernmental organizations and other partners
1545–1600	*ER-AnnexTableBreak*

1600–1700	**Session III. Round table with partners working in the Lao People's Democratic Republic (continued)**
1600	**Round table with partners to share their current work on HRH and retention in the Lao People's Democratic Republic (continued)**
1730	*Reception cocktail at the hotel*

Thursday, 24 June 2010 – Day 2

0830–0930	**Session IV. Retention plan of action for the Lao People's Democratic Republic**
	Chair: Professor Dr Eksavang Vongvichith
0830	**Health worker incentives in the Lao People's Democratic Republic: presentation of report and recommendations** Jim Buchan, WHO consultant
0930–0945	*Coffee break*
0945–1200	**Session IV. Retention plan of action for the Lao People's Democratic Republic (continued)**
0945	**Development of a plan of action** Participants in four working groups to discuss key questions and provide recommendations for next steps: **A.** Availability and recruitment – "Finding them" **B.** Medical education and training – "Educating them" **C.** Allocation, distribution and deployment – "Placing and keeping them in the areas where they are needed" **D.** Performance and incentive mechanisms – "Motivating them"
1200–1330	*Lunch*
1330–1500	**Session V. Presentation of the proposed plan of action**
1330	**The working groups present their recommendations** Presentations to be followed by moderated discussion and consensus building on the ideas to be taken forward for the plan of action
1500–1600	**Session VI. Next steps**
1500	**WHO working with the Lao People's Democratic Republic to improve retention of health workers** Asmus Hammerich, WHO/Lao People's Democratic Republic Rodel Nodora, WHO/WPRO Jean-Marc Braichet, WHO/HRH/HMR **Final thoughts and conclusions** Eksavang Vongvichit, Vice Minister of Health
1600	*Closure of workshop*

Annex 2: List of participants

National participants, Ministry of Health

1	Dr Ponmek Dalaloy	Minister of Health
2	Professor Eksavang Vongvichit	Vice Minister of Health
3	Dr Phisith Phoutsavath	Department of Health Care
4	Mr Khamphone Phouthavong	Department of Personnel
5	Dr Soulaxay Phoummala	National Institute of Public Health
6	Professor Sithat Insisiengmay	Department of Hygiene and Prevention
7	Associate Professor Bounkong Sihavong	Mahosot Hospital
8	Associate Professor Vanliem Boualivong	Mittaphab Hospital
9	Associate Professor Khampe Phongsavath	Setthathirath Hospital
10	Dr Set Chittanavanh	Mother and Child Hospital
11	Dr Bunsa Oupathana	Deputy Director of Cabinet, University of Health Sciences
12	Dr Somchit Boupha	Vice Rector, University of Health Sciences
13	Dr Sengchoy Panyavong	Centre of Information, Education and Health
14	Dr Khamphet Manivong	Department of Planning and Finance
15	Dr Chansaly	Deputy Director of Health Service Improvement Project
16	Dr Phouthone Vangkonevilay	Department of Personnel
17	Mr Khampheuy Simmalavong	Department of Personnel
18	Dr Kobkeo Souphanthong	Mother and Child Health Centre
19	Dr Somephone Phangmixay	Deputy Director of Health System Development Project
20	Dr Kotxaythoun Phimmasone	World Bank Project
21	Dr Somchanh Xaysida	Department of Personnel
22	Dr Bounleuan Douangdeuan	Drug Revolving Fund, Food and Drug Department
23	Dr Inpong Thongphachanh	Department of Personnel
24	Dr Davanh Siboualipha	Department of Personnel
25	Dr Chanthakhat Paphassarang	Department of Personnel
26	Dr BounnYeme Ekkalath	Department of Personnel
27	Dr Somphone Chanthanasouk	Bolikhamxay Provincial Health Office
28	Mrs Bouavanh Phachoumphone	Vientiane Provincial Health Office
29	Dr Khoutdala Vongsalavanh	Saravanh Provincial Health Office
30	Dr Nanthi Souphanthong	Xiengkhouang Provincial Health Office
31	Ms Phouangkham Siphakham	Technical Officer

National participants, Lao Government

32	Mr Thongvanh	Public Administration Civil Service, Prime Minister's Office
33	Mr Phouvong Phimmasone	Deputy Director of Personnel, Ministry of Planning and Investment
34	Mr Phouvong Vongkhamsao	Deputy Director, Prime Minister's Office

International participants

35	Mr Philippe Devaud	Attaché de Coopération, Embassy of France
36	Ms Della Sherratt	International Skilled Birth Attendant Coordinator, UNFPA
37	Dr Jean-Marc Braichet	Coordinator, Health Workforce Migration and Retention Unit, HRH,WHO, Geneva, Switzerland
38	Professor Jim Buchan	WHO consultant, University of Technology, Sydney, NSW, Australia
39	Mrs Laura Stormont	Technical officer, Health Workforce Migration and Retention Unit, HRH, WHO, Geneva, Switzerland
40	Mr Peter Heimann	Chief Technical Adviser, Lux-Development-LAO/017
41	Dr Bart Jacobs	Health Financing, Social Health Protection Adviser, Lao–Luxembourg Health Sector Support Programme
42	Dr Frank Haegeman	International Health Planning and Management Adviser, Lao-Luxembourg Health Sector Support Programme
43	Dr Noda Shin-Ichiro	Chief Adviser, Capacity Development for Sector Wide Coordination in Health, JICA, Lao People's Democratic Republic
44	Dr Afaur Rahman	Chief of Health and Nutrition Section, UNICEF, Lao People's Democratic Republic
45	Ms Yuki Yoshimura	Program Officer, JICA
46	Mrs Wanda Jaskiewicz	Team Leader, Performance Support Systems, Capacity Plus
47	Mr Majnus Lindelow	Senior Economist, The World Bank, Lao People's Democratic Republic
48	Ms Win Hayman	Social Sector Specialist, ADB, Lao People's Democratic Republic

WHO Technical Advisers

49	Dr Nodora Rodel	Medical officer, Human Resources Development, WPRO, Manila, Philippines
50	Ms Laure Garancher	Country Representative, WHO, Viet Nam
51	Mrs Ann Robbins	Country Representative, WHO, Cambodia

WHO Technical Advisers in the Lao People's Democratic Republic

52	Dr Dong Il Ahn	Country Representative
53	Dr Asmus Hammerich	Programme Management Officer
54	Dr Supachai Douangchak	National Professional Officer
55	Dr Outavong Phathammavong	Project Assistant, HRH
56	Mrs Vanhpheng Sirimongkhoune	Secretary, Health System Development
57	Mr Geoffroy Poire	Program Administrative Officer

58	Mr Somphone Inthavong	Information Technology Officer
59	Ms Inthasone Xosanavongsa	Technical Assistant, Expanded Programme on Immunization
60	Mr Alesandro Famiee	Consultant, Expanded Programme on Immunization
61	Dr Liu Yunguo	Medical Officer, Maternal and Child Health
62	Dr Eunyoung Ko	Consultant, Maternal and Child Health
63	Dr Valeria de Oliveira Cruz	Technical Officer, Health Care Financing
64	Mrs Phetsamone Thavonesouk	Secretary, Tobacco Free Initiative