The Decade for Health Workforce Strengthening in the SEA Region 2015–2024: mid-term review of progress, 2020

In 2014, Member States of the WHO South-East Asia Region agreed to the ‘Decade for Strengthening Human Resources for Health in the SEA Region 2015–2024’. The WHO Regional Committee for South-East Asia endorsed resolution SEA/RC67/R6 on ‘Strengthening Health Workforce Education and Training in the Region’ the same year. This resolution requested the Regional Director to report on progress in health workforce development to the Regional Committee every two years, starting in 2016, for a decade.

The mid-term review of progress in 2020 (3rd review report) is based on reporting by Member States on 14 indicators for doctors, nurses, midwives, dentists, pharmacists and other primary health care workers. The Human Resources for Health Regional Meeting to review progress, challenges and opportunities, originally scheduled to be held in Bangkok on 20–22 April 2020, was cancelled due to the COVID-19 pandemic. An online regional consultation was conducted on 23 June 2020.

A mid-term review report for the Decade for Health Workforce Strengthening in the SEA Region and case studies on improving retention of health workers in rural and remote areas are submitted to the Seventy-third Session of the Regional Committee. They include further analysis on the health workforce situation in the SEA Region; progress, challenges and the way forward on human resources for health; as well as country profiles on this sector for all Member States of the SEA Region.

This Working Paper was presented to the High-Level Preparatory Meeting for its review and recommendations. The HLP Meeting reviewed the paper and made the following recommendations for consideration by the Seventy-third Session of the Regional Committee.

Actions by Member States

(1) Use the window of opportunity afforded by the COVID-19 pandemic to increase investment in the health workforce.

(2) Strengthen HRH governance by strengthening the capacity of HRH units.

(3) Increase production of, quality of education, job creation for and distribution of nurses and midwives as per country contexts.
Actions by WHO

(1) Monitor and report progress on the Decade of Strengthening of HRH through the fourth progress report scheduled for 2022.

(2) Provide technical support to Member States as appropriate to strengthen HRH to achieve UHC and health security.

(3) Organize a one-week executive online course on HRH leadership and management.

This Working Paper and the HLP Meeting recommendations are submitted to the Seventy-third Session of the WHO Regional Committee for South-East Asia for its consideration and decision.
Introduction

1. The WHO South-East Asia Region has some common health workforce challenges. These include and involve shortages, unequal distribution of health workers, difficulty in retention, adapting health workers’ education to fit rapidly changing needs, poor quality education in some cases, and improving health worker performance. It is critical that these challenges are met effectively by Member States, because health services cannot be delivered without health workers, and this limits progress on universal health coverage and the achievement of the Sustainable Development Goals.

2. Recognizing these challenges, in 2014 all Member States committed to a “Decade for Strengthening Human Resources for Health in the South-East Asia Region 2015–2024”. The same year, Regional Committee resolution SEA/RC67/R6 on “Strengthening Health Workforce Education and Training in the Region” requested the Regional Director to report on progress in health workforce development every two years for the next decade. There was particular focus on transformative education and rural retention.

3. The first review in 2016 noted that it was hard to report on progress using quantitative metrics because of a lack of standardized indicators and patchy data. The review did show, encouragingly, that a wide range of actions were being implemented by countries, and provided some important policy messages:

- HRH strategies must link to plans to improve service delivery, and more policy attention is needed on primary health care workers.
- A “bundle” of interventions are needed to improve workforce education and rural retention: there is no one magic bullet.
- More attention to HRH governance is required, because actions within and beyond the health sector are needed for significant and sustained HRH strengthening.
- There is an urgent need for better HRH data to judge whether health workforce strengthening is in fact happening, as well as to inform policy decisions.

Accordingly, since 2016, the focus areas were expanded from transformative education and rural retention to also include improving health workforce governance and workforce data.

4. For the second review in 2018, SEA Region Member States adopted some of the new standardized HRH indicators developed by WHO. Fourteen indicators were agreed upon, and data quality improved. The most important finding was that the availability of health workers had increased since 2014. Suggested actions emerging from that review were to:

- improve regional evidence on implementation and impact of interventions for rural retention and transformative education;
- further explore the role of accreditation in creating a culture of quality in health professional education;
• strengthen HRH governance, by reinforcing the capacity of HRH units and by increasing HRH planning expertise through suitable training; and
• continue with efforts to improve HRH data, and include primary health care workers in regular reporting.

5. This 2020 mid-term report of the Decade for Health Workforce Strengthening comes at a special time. There is ample regional and global commitment. In the last two years health workforce strengthening has been kept in the global political spotlight through the 2018 Astana Declaration on Primary Health Care, the 2019 United Nations Political Declaration on Universal Health Coverage, and the “2020: Year of the Nurse and the Midwife” initiative.

6. The COVID-19 pandemic has greatly raised the profile of health workers who are struggling to cope with the emergency as well maintain other essential services. The pandemic has brought the spotlight on issues facing the HRH and is stimulating a reappraisal of needs and approaches to HRH strengthening.

Current situation, response and challenges

7. The 2020 mid-term review of progress on the Decade for Strengthening Human Resources for Health in the South-East Asia Region has again been informed by a self-reported survey by Member States using the National Health Workforce Accounts online platform. The survey has 14 standard indicators, drawn from the National Health Workforce Accounts indicators,¹ and from the Global HRH Strategy: “Health Workforce 2030”.

8. These 14 indicators (Fig. 1) were agreed upon by the Member States during a regional workshop on “Improving the generation and use of HRH data in the SEA Region” held in Delhi in 2017. Five categories of health professionals – doctors, dentists, nurses, midwives and pharmacists – are covered by the indicators. In addition, data on availability of other primary health care workers have been reported by Member States for the first time in the SEA Region in the 2020 report. Also, some extra nursing indicators were collected for the first State of the World’s Nursing Report that was released in April 2020.

9. In addition to the survey, a more detailed review of progress in each Member State was planned to be carried out during the Regional Meeting for the mid-term review of progress on the Decade for Strengthening Human Resources for Health, scheduled to be held in Bangkok on 20–22 April 2020. This meeting had to be cancelled due to the COVID-19 pandemic. However, a series of online consultations have been held with Member States, including a Regional Consultation on 23 June 2020, with the participation of 10 Member States from the SEA Region and about 100 participants, on the key findings in this report.

10. Major findings of the mid-term review are as follows:

   (i) The first and most important finding of the mid-term review is that the availability of doctors, nurses and midwives in the SEA Region has increased by 21% since 2014. Almost all Member States have improved the overall availability of doctors, nurses and midwives during this time. Nine countries are now above the first WHO HRH threshold of 22.8 doctors, nurses and midwives per 10 000 population set in 2006, compared with six countries in 2014. However, there remains more to do, as only two countries have reached the current WHO threshold of 44.5 doctors, nurses and midwives per 10 000 population, derived as the basic density needed to achieve the health-related SDG targets (Fig. 2). Based on projections, it is estimated that an additional 1.6 million doctors and nurses will be required in the countries of the SEA Region by 2030.


(ii) Second, for the first time, 10 countries have reported on the availability of primary health care workers. This is a considerable achievement, given the different types of primary health care workers across countries of the Region. Data do seem to be incomplete in some cases, but experience suggests that it will progressively improve over time. Primary health care workers have contributed significantly to overall health workforce density in five Member countries of the SEA Region.
(iii) Third, interventions to improve rural retention have shown encouraging results in the SEA Region. Several countries have been implementing bundles of rural retention interventions, in some cases for many years. The positive impact has now been documented through six country case studies in the Region (Bhutan, Indonesia, Myanmar, Sri Lanka, Thailand and Chhattisgarh State in India). The case studies brought out that the interventions have to be coherent, coordinated, measured and sustained over time if the benefits are to be achieved and maintained. More policy attention was needed on new cadres, such as mid-level health workers.

(iv) Fourth, there is a maturing body of regional experience with transformative education. There are some unique innovations in different Member States, which hold real promise of progress, and which require evaluation. These are highlighted in the following paragraphs.

(v) Fifth, there is definite improvement in the completeness of HRH data reported by Member States. The investment in better HRH data is paying dividends for policy-makers. In addition to better data on the more traditional descriptors of worker density, production and distribution, there is also growing interest in analysing health labour markets, and facility workloads, to improve health workforce governance and management.

Source: Country data reported to WHO through NHWA online platform as of 15 December 2019. Note: Brackets next to each primary health care worker category show the ISCO-08 classification.
Health workforce governance: strategic direction, coordination and partnership

11. Ten countries have HRH strategies, which are currently up-to-date or in the process of being revised (Table 1). These strategies include actions on education of health professionals, retention and performance of health workers, and HRH data. There also appears to be growing attention to linking HRH strategies more explicitly with service delivery changes, which is needed for optimum progress.

<table>
<thead>
<tr>
<th>Country</th>
<th>Name of the document</th>
<th>Period</th>
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<tbody>
<tr>
<td>Bangladesh</td>
<td>Bangladesh Health Workforce Strategy 2015</td>
<td>2016–2021</td>
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<tr>
<td>Bhutan</td>
<td>Health human resource masterplan</td>
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<tr>
<td>DPR Korea</td>
<td>National Strategic Plan of human resources for health development</td>
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<td>India</td>
<td>No HRH strategy. Contained in National Health Policy 2017</td>
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<td>Indonesia</td>
<td>Action plan for the development of HRH</td>
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<td>Maldives</td>
<td>National Health Workforce Strategic Plan</td>
<td>2014–2018 (revision initiated)</td>
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<td>Myanmar</td>
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<td>Thailand</td>
<td>Health workforce plan</td>
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<td>Timor-Leste</td>
<td>Timor-Leste human resources for health masterplan</td>
<td>2020–2024</td>
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12. HRH plans need to be linked to service delivery strategies. Several countries of the SEA Region have been developing or updating their essential service packages (ESP); for example, Bangladesh, India, Nepal, Sri Lanka and Timor-Leste. Importantly, there has been explicit consideration of health workforce availability and skills in discussions on essential packages of what services are to be provided at which level and by whom.

13. Health labour market analyses (HLMA) can be used to strengthen health, social and economic policies by generating evidence on the market dynamics of the health workforce. Factors affecting the demand and supply of health workers to meet health needs are analysed, together with forecasts of future needs. In the last two years, Sri Lanka and the state of Chhattisgarh in India have undertaken health labour market analysis and Bangladesh is currently undertaking
The exercises have helped identify key bottlenecks and gaps in HRH supply and demand as well as identify strategies to improve the health workforce situation.

14. One issue that has become more prominent because of the rise in noncommunicable diseases and renewed efforts to improve access more generally has been the potential of mid-level health workers to improve access to care. Because of the importance of mid-level workers, the Regional Office has produced a technical brief on the topic. Evidence suggests that mid-level health workers can safely deliver most essential health interventions, provided they are properly trained and supported. Some countries in the Region are also exploring the introduction of family practitioners in primary health care services and, in some cases, as part of family practice teams.

15. In addition to policy direction, HRH governance involves effective coordination of intersectoral action, which is vital for progress on transformative education and rural retention. The WHO Global HRH Strategy recommends HRH coordination units as a means to strengthen HRH governance. Ten Member States now have an HRH coordination unit within the Ministry of Health, compared with eight in 2018. New units have been established in Myanmar and Thailand. In the last two years, HRH units in Bangladesh, India and Sri Lanka have expanded their technical staff and range of functions performed. These units cover a wide variety of functions and staffing levels, partly related to the mix of strategic versus administrative functions. While there is no "one size fits all" for what HRH units should do, there does appear to be scope for improving the capacity of these units to support strategy development, coordination and monitoring of HRH strategy implementation.

16. The 2018 Regional HRH Meeting acknowledged the importance of building management and leadership capacity of senior policy-makers of Member States. The Regional Office has been working jointly with WHO headquarters to develop a curriculum for a one-week course on HRH management and leadership for senior policy-makers. The first executive course was planned to take place in September 2020. However, due to COVID-19, curriculum development and preparation of training materials have been delayed. WHO is considering changing the training to the online mode and rolling it out during the first half of 2021.

Rural retention

17. Member States have tried many strategies to improve rural retention, and for many years. Global guidance using best available evidence was published by WHO in 2010. To date, there has been little documentation of implementation and results in the SEA Region. The Regional HRH Meeting in 2018 recommended that the Regional Office should document this progress in the Region. Six country case studies in Bhutan, India (Chhattisgarh state), Indonesia, Myanmar, Sri Lanka and Thailand were undertaken in 2019, using a template developed by the Regional Office. The case studies captured the rationale behind rural retention policies, the process of implementation and, where possible, impact.

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18. What emerges clearly from the case studies is that there are good working examples of policies being developed and implemented with coherence and sustained focus. Countries have implemented bundles of interventions, and not just single interventions. These bundles include many types of educational interventions; regulatory interventions (notably compulsory service and scholarships/return of service); financial incentives; and, to a lesser extent, professional support linked to working conditions, outreach and use of telehealth, and public recognition measures.

19. Thailand, Bhutan and the three districts studied in India’s Chhattisgarh state – Dantewada, Sukma and Bijapur – showed a positive impact on increasing health workforce availability and uptake of services by implementing bundles of rural retention policies.

20. Key lessons that emerged from the country case studies are:

- For a successful outcome, a combination of rural retention interventions should be coordinated and sequenced, and it should address the country-specific challenges.
- Education interventions and financial incentives have been most reported and are important, but more policy attention must be given to new cadres such as mid-level health workers.
- Focus on financial sustainability and on a long-term view, including policy alignment between the Ministry of Health and Ministry of Education and other stakeholders, is important.

21. Another important finding was the limited information available to support implementation and evaluation. In most of the six countries, it was difficult to document outcomes that could be attributed to the rural retention interventions. In future, countries should consider how to improve the HRH information systems in ways that help analyse the impact of interventions. Some data on HRH distribution and vacancy rates are now being collected, and this can be used as a baseline for future tracking.

22. International outmigration of health workers continues to affect the availability of the domestic health workforce in some countries. The 3rd round of reporting on implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel was carried out in 2018. Nine of the 11 SEA Region countries reported on the Code (highest reporting rate by any WHO Region). India is the highest world contributor on medical doctors and the second highest on nurses.

23. In 2019, the relevance and effectiveness of the WHO Global Code of Practice on the International Recruitment of Health Personnel was reviewed. India, Indonesia and Thailand were part of the Global Working Group. The main conclusion was that the Code’s relevance was actually growing, and there was evidence of its effectiveness. However, it has not yet realized its full potential. The report will be discussed at the next World Health Assembly.
Transformative education

24. Transformative education is about enabling health professionals to better respond to people’s health needs. It involves changes in both what students are taught and how they are taught, and both instructional reform and institutional reform. WHO developed guidance on this in 2013.  

25. The 2016 review of progress on HRH found that “overall, SEA Region countries are in the early phases of implementation of transformative education”. In 2018, transformative education was still felt to be a relatively new concept, but there was more acceptance of the need for change in how health workers were trained compared with 2016. In 2020, all Member States of the Region report that they are working on this area.

26. National and international meetings are helping to clarify the concept. In 2019, two Member States – Bangladesh and Sri Lanka – had national meetings on transformative education, and Thailand has continued its annual “National health professional education reform forums” in 2018 and 2019, attended by other SEA Region countries. The theme of the 2018 forum was “Synergizing partners: the key for health system reform”. In 2019 it was “Creative accreditation for better quality education”. Both the topics are of interest across the Region. The SEA Region also organized an expert workshop on accreditation of health training institutions in 2018. It was found that Indonesia and Thailand have established accreditation systems and, more recently in 2019, both countries have been recognized by the World Federation for Medical Education (WFME).

27. In 2019, the first global symposium on health workforce regulation and accreditation was co-organized by WHO and the Educational Commission for Foreign Medical Graduates (ECFMG). Six SEA Region Member States attended, namely Bangladesh, Bhutan, India, Indonesia, Sri Lanka and Thailand. Some of the main messages captured by countries of the Region were:

- The main objective of accreditation and regulation should be improving the quality of health professional training and the quality and safety of health services.

- The international landscape on accreditation and regulation of the HWF is diverse. There is not one single model, and each country will have to strengthen or build up their accreditation and regulatory systems depending on their context and their priorities.

- Countries can, however, learn from the diverse experience across countries. More research, evidence and good practices are required internationally to guide countries and to show the link between accreditation and regulation and improvement of quality of care. A knowledge sharing platform is needed.

28. Most countries now have national standards for continuous professional development (CPD), although there is variation in the quality and how they are implemented. Further work is needed to understand the difference this is making to the quality of health worker performance. The

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Regional Office has recently received ethical clearance to conduct a regional study on CPD to better understand its situation in each SEA Member country.

29. There is also progress on other approaches. The most frequent are: interprofessional education, which has now been initiated in more countries than was the case two years ago but is still in its early stages; and use of information technologies in education, which is increasing. Curriculum adaptation is something all Member States do regularly, but some have begun to focus more on new teaching approaches.

30. One limitation to this progress is that there continues to be more attention accorded to unidisciplinary education, and a greater focus on medical education rather than on education of other health professionals such as nurses and allied health professionals.

**Improving health workforce data**

31. There is a continued momentum to improve HRH data in the Region. Most countries have been taking steps to improve national health workforce data, building on existing HRH information systems and using the WHO guidance on National Health Workforce Accounts (NHWA) and new information technologies. Globally, added impetus is provided by a specific health workforce target and indicator in the SDG monitoring framework (3.c.1).

32. Despite all this progress, recognized challenges persist with regard to HRH data: data is still often fragmented and of poor quality; there are difficulties in getting HRH data from the private sector; and there are issues of ensuring data security.

33. The messages from the 2017 HRH data workshop remain relevant today:

- It is critical to have a better understanding of the questions to which policy-makers seek answers before embarking on a major exercise to strengthen HRH information systems.
- Improving data is a political as well as a technical exercise; strengthening HRH information systems requires the involvement of stakeholders beyond ministries of health, and going beyond a technical focus on introducing new hardware and software.
- Systems develop gradually, and from the start should be designed in a way that allows progressive expansion beyond ministries of health alone.
- Better coordination among stakeholders within and outside ministries of health, regulation and innovative solutions to get the private sector to provide data are areas that need attention in the coming two years.

34. There is growing interest and experience in the Region in generating better data on staff workload. An increasing number of countries in the SEA Region are using the Workload Indicators of Staffing Need (WISN) tool developed by WHO. This management tool helps local facility or area managers make more evidence-based decisions on staffing. The WISN method determines how many health workers of a particular type are required to cope with the workload of a given
health facility and assesses the workload pressure of the health workers in that facility. WISN aims to help managers deploy staff to where there is greatest demand and/or need.

35. Five countries have conducted WISN training of trainers (Bangladesh, Bhutan, Myanmar, Nepal and Sri Lanka) and three have completed studies (Bangladesh, Bhutan and Myanmar) since 2018. It has generated managerially relevant information missing from routine information systems, and has also fed into high-level policy dialogues.

The way forward

36. Looking forward, proposed actions that need to be initiated by Member States include:

- Use the COVID-19 window of opportunity to increase the public resources dedicated to improving the availability, distribution and performance of health workers.
- Protect health workers during the COVID-19 outbreak by providing with access to PPE and other commodities and training along with psychosocial support.
- Maintain political leadership to accelerate progress on implementing HRH strategies that include actions to address transformative education and rural retention, and that reflect service delivery needs and advance UHC.
- Continue to explore accreditation as a useful approach to creating a culture of quality in educational institutions and programmes for health professionals.
- Ensure that interventions used to improve rural retention include a combination of rural retention interventions that are co-ordinated and sequenced, and that address the country-specific challenges.
- Improve the monitoring and impact assessment of rural retention interventions.
- Maintain the improvements in HRH data and use it to track progress and for evidence informed policy making.
- Strengthen HRH governance by reinforcing the capacity of existing HRH units.

37. The following include proposed actions that can be initiated by WHO:

- Increase HRH policy and planning expertise in the Region by conducting one-week executive online course on HRH leadership and management. This executive course will use the WHO curriculum that will be finalized soon.
- Facilitate exchange of experiences between countries through existing regional networks, and other formal and informal means.
- Conduct training on improving monitoring and impact assessment of rural retention policy interventions.
- Support improved documentation of the impact of interventions on transformative education through case studies and technical briefs on key topics.
• Support Member States in updating the medical, nursing and other health professional curriculums to better reflect changing needs.

• Provide technical assistance to Member States as requested, both on overall HRH policy and planning, and on more specific areas such as development of an HRH information system.

• Monitor and evaluate progress on the Decade of Strengthening HRH through the fourth progress report in 2022.

Conclusions

38. In the past five years, several overarching goals, strategies and plans – such as the SDGs, UHC, WHO’s Global Strategy on HRH; the UN High-Level Commission on Health Employment and Economic Growth, the International Year of the Nurse and the Midwife initiative, the SEA Region’s Flagship Programme on UHC with a focus on human resources for health and medicines, and the SEA Region’s own Decade on Strengthening HRH – have collectively helped sustain a clear and compelling focus on the critical elements of the HRH agenda. Against this backdrop, the mid-term review has found encouraging, albeit variable, progress being made by Member States, with further relevant actions being planned.

39. Most recently, the COVID-19 pandemic has stressed the critical importance of having an adequate and well-prepared health workforce to respond to health emergencies and maintain essential health services. Countries should use the COVID-19 pandemic as a window of opportunity to advocate and get more financial resources to increase the availability of health workers and fill the gap.

40. As the 2020 mid-term review reveals, the availability of doctors, nurses and midwives in the SEA Region has increased by one fifth since the Decade began. Almost all Member States have improved the overall availability of doctors, nurses and midwives during this time. Nine countries are now above the first WHO HRH threshold of 22.8 doctors, nurses and midwives per 10 000 population set in 2006 compared with six countries in 2014. However, there remains more to do, as only two countries have reached the current WHO threshold of 44.5 doctors, nurses and midwives per 10 000 population, derived as the basic density needed to achieve the SDGs (Fig. 2). Based on projections, it is estimated that an additional 1.6 million doctors and nurses will be required in the countries of SEA Region by 2030.

41. For the first time, 10 countries have reported on the availability of primary health care workers. This is a considerable achievement, given the different types of primary health care workers across countries of the Region. Data do seem incomplete in some cases but experience suggests that it will progressively improve over time.
42. Rural retention interventions have shown positive results in the SEA Region. Countries have all been implementing bundles of rural retention interventions, in some cases for many years. Positive impact has now been documented in six country case studies in the region (Bhutan, India (Chhattisgarh state), Indonesia, Myanmar, Sri Lanka and Thailand). Interventions have to be coherent, coordinated, measured and sustained over time if the benefits are to be maintained.

43. There is growing regional experience on transformative education. There is progress on a range of approaches, such as on accreditation of health training institutions and regulation, continuous professional development, interprofessional education, curriculum adaptation, faculty development and use of modern information technologies in pre-service education.

44. There is a definite improvement in the completeness of HRH data reported by Member States. The investment in better HRH data is paying dividends for policy-makers. In addition to better data on the more traditional descriptors of worker density, production and distribution, there is growing interest in analysing health labour markets, and facility workloads, to improve health workforce governance and management.