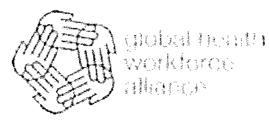

The 4th AAAH Conference
and
The 3rd meeting of the WHO expert group on "Increasing Access to Health workers in remote and rural areas through improved retention"

THE THEME:
"Getting committed health workers to the underserved areas: a challenge for the health systems"

Date: 23-25 November 2009
Venue: the Hilton Hanoi Opera hotel, Hanoi Vietnam

Provisional Program

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1. General objectives of the conference

This Conference aims to gain an in-depth understanding of the current situation and strategies to tackle the problems of inequitable distribution of health workforces, especially those in the underserved areas. It will also discuss and refine a set of draft global recommendations, initiated by WHO, to support countries in formulating and implementing appropriate, comprehensive and feasible interventions to get committed health workers to underserved areas. These draft recommendations will be further refined by the WHO expert group, with a view to launch the final recommendations in spring 2010. This conference will also allow more intensive networking and capacity building of institutes and researchers and policy makers interested in the area of human resources for health.

2. Specific objectives

1. To describe the current situation regarding the distribution of committed health workforces to underserved areas, including selection and pre-service education, continuous education, recruitment, regulatory measures, financial and non-financial incentives, working and living conditions, management environment, and social and spiritual motivation.
2. To understand the factors which encourage or discourage health workforces to go and continue to work in the underserved areas.
3. To learn experiences from different countries/continents concerning the distribution and retention of health workers in underserved areas, and to foster networking among partners.
4. To discuss a set of draft WHO recommendations for appropriate retention strategies that will support health workers in remote and rural areas

3. Pre-conference activities

Sunday 22 November 2009

Time	Content	Moderator
0900 – 1800	**Side meeting** on Framework for Country Collaboration and Actions	GHWA
1800 – 1900	**Registration** for the conference	VN host, AAAH Secretariat, WHO Secretariat

4. Program of the conference

In order to achieve the conference objectives, the conference is tentatively structured in such a way as to allow all participants to:

- Understand and learn from presentations on the overall picture of the issue.
- Expose participants to field trips which will provide a good insight into real issues affecting health workers in Vietnam and contribute to the discussion in parallel sessions
- Share country experiences through oral or poster presentations
- Actively participate in discussions during the sessions

Monday 23 November 2009

Time	Content	Moderator
0800 – 0830	Registration	
0830 – 1000	Opening address welcome participants by the Minister of Health of Vietnam, Dr. NGUYEN QUOC TRIEU	
	Short addresses (5 minutes each) by: • Dr Mubashar Sheikh, the Executive Director of GHWA • Dr Toomas Palu, Lead Health Specialist Country Sector Coordinator, Human Development, the World Bank • Dr Jean-Marc Olivé, Representative of WHO Country Office, Vietnam • Dr Suwit Wibulpolprasert, Chairperson of AAAH Steering Committee	Vietnam host
	Keynote Address (20-30 minutes) on the conference theme by Dr Lincoln Chen, President of the China Medical Board	
1000 – 1030	Coffee break	
1030 – 1200	**Plenary session**: Situation, factors and recommendations on "Getting committed health workers to the underserved areas" • Introduction to the WHO programme, presentation on the global situation and the work of the expert group by Dr Jean-Marc Braichet (20 minutes)	Dr Mushtaque Chowdhury

Time	Content	Moderator
	• Introduction to a WHO Code of practice on the international recruitment of health personnel by Dr Manuel M.Dayrit (10 minutes) • Regional situation and solutions: WHO Africa by Dr Magda Awases (10 minutes) • Human Resources in Health in Asia and Pacific: Summary of HRH Studies by Toomas Palu (10 min) • Overview HRH situation and health policy to address HRH challenge in Vietnam by Prof Le Quang Cuong (10 minutes) • Pursuing the National HRH Strategic Plan to its Full Implementation by Dr Mongkol Na-Songkha (10 minutes) • Q&A and discussion (20 minutes)	
1200 - 1300	Lunch	
1300 onward	**Field trip** - options as follows:- 1. A medical school (there are several programmes to recruit students from ethnic minorities or rural areas) 2. Provincial hospital 3. District hospital (recent policies in Vietnam on "financial incentives and rotation of the health workforce") 4. Commune health centre 5. District preventive health centre 6. Private hospital	
1900 onward	**Welcome dinner**	

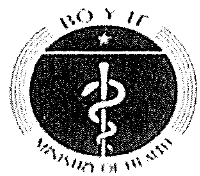
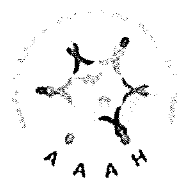
Tuesday 24 November 2009

<table>
<tr><th>Time</th><th colspan="3">Content</th></tr>
<tr><td>0800-0930</td><td colspan="3">Plenary session: contextual factors affecting HRH in underserved areas
• Introduction of WHO draft recommendations by Dr. Carmen Dolea
• Monitoring and evaluation framework for retention interventions by Dr Luis Huicho
• Costing the retention interventions by Dr Pascal Zurn
• Q&A and discussion
Moderator: Dr Ezekiel Nukuro</td></tr>
<tr><td>0930 - 1000</td><td colspan="3">Coffee break</td></tr>
<tr><td>1000 - 1300</td><td>Parallel session 1 Education interventions
Country presentations (1hr45 min)
• Towards meeting the health care challenges of rural Nepal by Arjun Karki
• First-year medical students in Thailand: rural attitudes and preferred workplace upon graduation by Kamolnat Muangyim
• Training and policy training health staff for disadvantaged areas in Vietnam by Dr Tran duc Thuan
• U.S. Strategies for Addressing Geographic Maldistribution of Physicians by Jordan Cohen
• Training professionals for rural health care - developing the pipeline in South Africa by Ian Couper
• Q&A and discussion
WHO recommendations (1hr15min)
• WHO expert group presentation by Ray Pong
• Open discussion
Moderator: Dr Manuel M Dayrit
Co-moderator: Kim Webber</td><td>Parallel session 2 Regulatory interventions
Country presentations (1hr45 min)
• A national pilot project of recruiting and retaining licensed doctors in township health centers in China: Supportive Evidence from the Un-registered Licensed Doctors Survey by Hong Zhang
• Presentation on Project 1816 on Rotation health workers to lower level of health care system in Vietnam by Cao Hung Thai
• The role and function of regulatory interventions to retain health workers in the Asia and Pacific Regions by John Hall
• South Africa by Steve Reid
• Q&A and discussion
WHO recommendations (1hr15min)
• WHO expert group presentation by Seble Frehywot
• Open discussion
Moderator: Dr Myint Htwe
Co-moderator: Jim Buchan</td><td>Parallel session 3 Financial interventions
Country presentations (1hr45 min)
• Factors discouraging and retaining medical doctors to work in underserved areas of Vietnam by Nguyen Bach Ngoc
• What makes doctors choose to work in rural area of Thailand: Discrete Choice Experiment to elicit doctors' job choices by Nonglak Pagaiya
• Human resources for health innovations in Zambia: a case study on the rural retention scheme in Zambia by Hilary Mwale, Solomon Kagulula and Mwansa Nkowane
• Q&A and discussion
WHO recommendations (1hr15min)
• WHO expert group presentation by Aly Sy/Marko Vujicic
• Open discussion
Moderator: Ass Prof Pham Le Tuan
Co-moderator: Eric de Roodenbeke</td></tr>
</table>

Time	Content		
1300 - 1400	Lunch		
1400 - 1700	**Parallel session 4 Working environment and management system** Country presentations (1hr45 min) • Designing an incentive system for the deployment and retention of public-sector health workers in rural and remote areas **Bangladesh** by Ahmed Al Kabir • Enhancement of rural health worker job satisfaction through introducing 5S, Kaizen and Quality Circle concepts in **Sri Lanka** by Udaya Isaac Ratnayake • 'Task shifting or task transformation: who cares management?' by Masamine Jimba • **Mali** by Salif Samake • Q&A and discussion WHO recommendations (1hr15min) • WHO expert group presentation by Jim Buchan • Open discussion Moderator: Dr Sarath Samarage Co-moderator: Grace Allen-Young	**Parallel session 5 Social and spiritual motivation** Country presentations (1hr45 min) • Revitalizing health for all: Developing a Comprehensive Primary Health Care model for **Bangladesh** by Taufique Joarder • Motivation of healthcare workers to combat child mortality in tribal areas: Lessons from **India** by Sudha Ramani • A case study on the education and training of family health workers to retain in rural communities in **Sri Lanka** by A. Pubudu De Silva • Q&A and discussion WHO recommendations (1hr15min) • WHO expert group presentation by Pawit Vanichanon • Open discussion Moderator: Dr Junhua Zhang Co-moderator: Kim Webber	**Parallel session 6 External factors that affect HRH in the underserved areas** Country presentations (1hr45 min) • **Cambodia [TBC]** • Viewing decentralization as an opportunity: in improving availability of health workers in underserved areas **Indonesia** by Anna Kurniati • Improving availability and retention of health workers in remote and underserviced areas: The **Lao** PDR experience by Kampasong Theppanya • A Case Study of Health Decentralization Reform in Thailand by Sutayut Osornprasop, the WB • **Tanzania** by Martins Ovberedjo • Q&A and discussion WHO recommendations (1hr15min) • WHO expert group presentation by Tim Martineau • Open discussion Moderator: Dr Toomas Palu Co-moderator: Dr T. Sundararaman (TBC)
1800	Outside dinner		
2000	Traditional perform: Vietnamese Water Puppets		

Wednesday 25 November 2009

Time	Content	Moderator
0830 – 1030	• Summary of the outputs and feedback from the previous day's parallel sessions. 10-15 min presentation by lead rapporteur • Open discussion	Dr Suwit Wibulpolprasert Dr Manuel M Dayrit
1030 – 1100	Coffee break	
1100 – 1200	AAAH – lessons learnt from the past, the present and the way forward by • AAAH secretariat – Pen Suwannarat • AAAH members • Comments from GHWA, WHO, WB, etc.	Dr Suwit Wibulpolprasert Dr Manuel M Dayrit
1230 – 1300	Closure of the meeting	Vietnam host
1300 – 1400	Lunch	

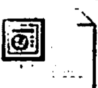
The 4th AAAH Conference
and
The 3rd meeting of the WHO expert group on "Increasing Access to Health workers in remote and rural areas through improved retention"

THE THEME:

"Getting committed health workers to the underserved areas: a challenge for the health systems"
23-25 November 2009
Hilton Hanoi Opera Hotel, Hanoi Vietnam

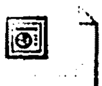
Monday 23 November 2009

Time	Content
0830 – 1000	Address by: • Representative of GHWA • Representative of WB • Representative of WHO • Chairperson of AAAH Steering Committee • The Strategic plan for the Decade of National HRH Development 2007-2016
	Opening address by the Minister of Health of Vietnam
	Keynote Address by Dr Lincoln Chen, President of the China Medical Board
1030 – 1200	**Plenary session**: Situation, factors and recommendations on "Getting committed health workers to the underserved areas" • Introduction to the WHO programme, presentation on the global situation and the work of the expert group by Dr Jean-Marc Braichet • Introduction to a WHO Code of practice on the international recruitment of health personnel by Dr Manuel M.Dayrit

	• Regional situation and solutions: WHO Africa by Dr Magda Awases • Regional situation and solutions: WHO SEAR and WPR by WHO SEARO/WPRO • Regional strategy on HRH by Toomas Palu • Overview HRH situation and health policy to address HRH challenge in Vietnam by Prof Le Quang Cuong 

Tuesday 24 November 2009

Time	Content
0800-0930	**Plenary session: contextual factors affecting HRH in underserved areas** • Introduction of WHO draft recommendations by Dr. Carmen Dolea • Monitoring and evaluation framework for retention interventions by Dr Luis Huicho • Costing the retention interventions by Dr Pascal Zurn
1000 – 1300	**Parallel session 1: Education interventions** Country presentations • Training of Physicians for improving rural health care in Nepal: Building bridges to address the urban-rural gap. by Arjun Karki • First-year medical students in **Thailand:** rural attitudes and preferred workplace upon graduation by Kamolnat Muangyim

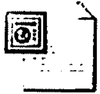


• Training and policy training health staff for disadvantaged areas in **Vietnam**
by Dr Tran duc Thuan
• U.S. Strategies for Addressing Geographic Maldistribution of Physicians
by Jordan Cohen

• **South Africa** by Ian Couper
WHO recommendations

• WHO expert group presentation
by Ray Pong

Parallel session 2: Regulatory interventions
Country presentations
• A national pilot project of recruiting and retaining licensed doctors in township health centers in **China:** Supportive Evidence from the Un-registered Licensed Doctors Survey
by Hong Zhang

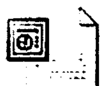


• Presentation on Project 1816 on Rotation health workers to lower level of health care system in **Vietnam**
by Cao Hung Thai
• The role and function of regulatory interventions to retain health workers in the Asia and Pacific Regions
by John Hall

• **South Africa**
by Steve Reid

WHO recommendations
• WHO expert group presentation
by Seble Frehywot

Parallel session 3: Financial interventions
Country presentations
• Factors discouraging and retaining medical doctors to work in underserved areas of **Vietnam**
by Nguyen Bach Ngoc



• What makes doctors choose to work in rural area of **Thailand:** Discrete Choice Experiment to elicit doctors' job choices
by Nonglak Pagaiya

• **Zambia**
by Hilary Mwale, Solomon Kagulula and Mwansa Nkowane
WHO recommendations

• WHO expert group presentation
by Aly Sy/Marko Vujicic

1400 – 1700

Parallel session 4: Working environment and management system
Country presentations
• Designing an incentive system for the deployment and retention of public-sector health workers in rural and remote areas **Bangladesh**
by Ahmed Al Kabir

• Enhancement of rural health worker job satisfaction through introducing 5S, Kaizen and Quality Circle concepts in **Sri Lanka**
by Udaya Isaac Ratnayake

- 'Task shifting or task transformation: who cares management?'
by Masamine Jimba
- **Mali**
by Salif Samake

WHO recommendations
- WHO expert group presentation
by Jim Buchan

Parallel session 5: Social and spiritual motivation
Country presentations
- Revitalizing health for all: Developing a Comprehensive Primary Health Care model for **Bangladesh**
by Taufique Joarder

- Motivation of healthcare workers to combat child mortality in tribal areas: Lessons from **India**
by Sudha Ramani

- A case study on the education and training of family health workers to retain in rural communities in Sri Lanka
by A. Pubudu De Silva

- **African country** (TBC)
WHO recommendations
- WHO expert group presentation
by Pawit Vanichanon

Parallel session 6: External factors that affect HRH in the underserved areas
Country presentations
- **Cambodia** by (TBC)
- Viewing decentralization as an opportunity: in improving availability of health workers in underserved areas **Indonesia**
by Anna Kurniati

- Improving availability and retention of health workers in remote and underserviced areas: The **Lao PDR** experience
by Chantakat Paphassarang

- Getting Committed Health Workers to the Underserved Areas: A Case Study of Health Decentralization Reform in Thailand World Bank
By Sutayut Osornprasop

- Tanzania
by Martins Ovberedjo

WHO recommendations
- WHO expert group presentation
by Tim Martineau

Wednesday 25 November 2009

Time	Content	Moderator
0830 – 1030	Summary of the outputs and feedback from the previous day's parallel sessions. by lead rapporteur	Dr Suwit Wibulpolprasert Dr Manuel M Dayrit

1100 – 1200	AAAH – lessons learnt from the past, the present and the way forward by • AAAH secretariat • AAAH members • Comments from GHWA, WHO, WB, etc.	Dr Suwit Wibulpolprasert Dr Manuel M Dayrit
1230 – 1300	Closure of the meeting	Vietnam

4th AAAH Conference:
Getting Committed Health Workers to the Underserved Areas: A Challenge for Health Systems

Hilton Opera Hotel, Hanoi, Vietnam
November 23-24, 2009

Keynote Address
Lincoln C. Chen, MD
China Medical Board, USA

OPENING WELCOME

This Conference is a milestone event, important for Asian and global health. One hundred and fifty (150) participants -- multi-sectoral and multi-stakeholders -- from more than a dozen countries are being brought together by an impressive array of partners. We acknowledge the hospitality of our Vietnamese hosts who have teamed with the dynamic AAAH network. Here, I convey my admiration for Dr. Suwit of Thailand who has tirelessly and adroitly built the regional trust and solidarity that characterizes AAAH. Asia, of course, is one key region in a series of alliances linked by the Global Health Workforce Alliance, represented here by Executive Director, Mubashar Sheikh. GHWA's Kampala Declaration confers legitimacy and adds impetus to this event, aiming "to assure adequate incentives and an enabling and safe environment for effective retention and equitable distribution of the health workforce." Last but not least is WHO – global in Geneva, Southeast Asia in Delhi, and Western Asia and Pacific in Manila. I salute Dr. Manuel Dayrit, the Department Director, who has demonstrated exemplary leadership in advancing WHO's normative, technical, and convening roles; I especially want to thank WHO's Dr. Carmen Dolea for enabling me to see the recent work of the WHO Expert Group. Finally on behalf of the China Medical Board, a private American foundation committed to professional education and research in Asia, I want to extend a special welcome to our Southeast Asian and Chinese collaborators.

Our purpose at this Conference is clear – how to get trained health workers into underserved, backward, disadvantaged areas. This equity mission recognizes the special disadvantage of peoples, often minority or indigenous populations, living in rural areas, areas of conflict or crisis, and more recently urban slums. To understand the whys, whats, and hows for achieving this mission, we will examine evidence, share our experiences, and network for future action. There will not be simply "talking!" We also have an opportunity to help craft "global recommendations" for a launch during the May 2010 World Health Assembly, at the same time when deliberations on a global code of practice on international recruitment may take place. Building on two earlier WHO Resolutions on human resources -- WHA 57.19 on migration and WHA 59.23 on scaling-up of trained workers, the 2010 recommendations will be drafted by a WHO Expert Group that will feed our AAAH conference deliberations into their meeting immediately afterwards.

THREE BASIC POINTS

It is never repetitive to underscore the huge importance of access to skilled and motivated health workers for achieving good health equitably shared. Despite an upsurge in rhetoric, human resources remains a neglected, under-appreciated, and under-financed engine for health improvement. Shortage is a key constraint, but the shortages are often due to -- or exacerbated by -- severe mal-distribution. In other words, the problem may be less the total number of trained workers but more what types of workers are trained, where they are located, and what they actually do! Severe mal-distribution, it should be noted, harms not just the disadvantaged populations but also well-to-do groups. A converse of low density is the other-side: excessive concentration of overly specialized (and highly paid) professionals which can cause unnecessary tests and procedures, over prescription of drugs, iatrogenic diseases, and wasted higher costs – plaguing the rich and poor alike!

Secondly, mal-distribution is a commonly shared problem in all countries -- but each country is also unique. All market-based economies have labor markets where professionals and other workers have occupational mobility. (Only one or two authoritarian regimes today dictate exactly where each worker must work!) We have to acknowledge that most professionals (including most of us here) seek urban-based middle-class professional work and lives. There is nothing wrong about these personal and professional preferences. What need fixing are the biased institutions, inequitable policies, and perverse public subsidies that worsen health imbalance and inequity?

Even though problems may be shared, each country has its own unique national legacy. Some problems come from deep historical processes, like leftover colonial practices and structures. In many countries, remote regions also contain ethnic and cultural minorities who retain traditional health beliefs and practices. Due to historical forces, these peoples have been pushed into remote mountains, hills, arid lands, and recently into urban slums – that are further handicapped by weak economic and infrastructure bases. In some cases, the challenge may be less "retention" where some people never had trained health workers to lose and more training local workers or incentivizing urban workers for rural service. Moreover, today's worker situation reflects past educational investments; workforce development has a long lag time of about one generation. From a menu of strategies each country may chose options that suit its situation. The approach cannot be "one size fits all." But the approach also cannot be "any size will do!" To craft successful policies for specific national contexts, the sharing of experiences is invaluable: "better to learn from somebody else's mistakes than your own!"

In parallel with in-country mal-distribution are imbalances across nations. Whereas European and North American countries enjoy more than 10 doctors-nurses per 1,000, some of the poorest countries with higher burdens of disease may not have even 1 doctor-nurse per 1,000. This global inequity is magnified by the migration of skilled personnel from poorer to richer countries. Mal-distribution within and across countries can be seen as an inter-linked continuum. Ironically, the importation of foreign workers in some rich

countries, like the USA, is due to its desire to cover its own disadvantaged populations – fixing one problem to create another or the international transmission of workforce problems!

Thirdly, what to do, I would argue, is mostly known. The challenge is how to do it successfully in specific contexts! The WHO Expert Group has developed four categories of strategies: education, regulation, financial incentives, and management and social systems support. These are based on the commonly accepted framework of "push-pull" factors. Workforce strategies aim to dampen the "push" out of and to enhance the "pull" into remote areas.

To assess national situations, I have developed a *"10-point equity check list"* for problem diagnosis and solution options:

Some are *educational policies*:

(1) Are training institutions located in disadvantaged regions?
(2) Are student admissions and graduates from these communities?
(3) Is the training curriculum appropriate in theory and practicum?
(4) Is there compulsory rural service (admission, subsidy, specialty training)?

Some are *health policies*

(5) Does the worker mix match practitioner skills with the desired deployment? What about nurse practitioners, physician assistants, community workers?
(6) Does country import foreign workers to cover its disadvantaged populations?
(7) Are rural workers accorded professional status and career development?
(8) Is rural service promoted through incentive salary payments?
(9) Are there family benefits, e.g. schooling, housing, transport, city visits, etc?
(10) Are rural workers supervised and backed-up, including IT linkages?

CALL FOR ACTION

I look forward to the many contributions at this Conference through the sharing of experiences to improve the "global recommendations." The four categories by the WHO Expert Group of education, regulation, incentives, and systems support offer a good framework upon which to build. To stimulate conference exchange, I would call for three actions.

Getting the skill-mix right! The skill-mix or composition of health professionals, shaped by medical education, is probably the most powerful long-term driver of worker-population match. Educating more will not necessary solve the problem of mal-distribution. Countries like India, China, Mexico, and many others suffer from acute shortages in disadvantaged regions while unemployed graduates languish in the cities. According to Dartmouth's David Goodman in the United States, only 1 physician settles in a low density area for every 4 physicians who concentrate in high density areas. For many disadvantaged populations, the training a local worker is probably the most practical immediate solution. Deploying a highly skilled professional to these

communities, while desirable, requires powerful public policies and significant public financing to swim against the tide of the professional "middle-class" syndrome.

We must become more adroit at understanding the skills and capabilities of different workers, matched to a country's epidemiology and social economy. Some have argued for task shifting, community health workers, or health teams. These over-simplify the core challenge of the skill-mix. Most crash programs with local workers "crash." Some basic functions (e.g. immunizations and DOTs) can be handled by briefly trained worker if backed by strong supervision and support. Such vertical systems I call "directive systems" because they direct communities to only a few selected beneficial technologies and services. Integrated health systems that respond to a range of patient complaints require workers with more education because these professionals must use more sophisticated skills to navigate a more diverse range of complaints. The late Jose Louis Bobadilla labeled some of these professional functions as "clinical overhead" – diagnosis, referral, problem-solving, and palliation that require skill, time and costs. Such horizontal systems I call "responsive systems" because they must respond to diverse presentations. An optimal balance of these directive and responsive systems will change with a country's epidemiology and social economy. The role of medical education is to anticipate its skill-mix production to feed properly the workforce pipeline for the future.

Advancing research, monitoring, and evaluation – To succeed, we must be able to diagnose the real problems and accelerate effective solutions. The 1990 Commission on Health Research Development described research as performing four health functions: (1) to understand the true nature of the changing problem; (2) to develop tools and technologies; (3) to accelerate interventions; and (4) to advance basic knowledge. An example of properly diagnosing problems was reported in the last October Lancet Series on human resources in China. Most recognize that China's mal-distribution problem is severe across China's major provinces -- Eastern coastal better off than Western provinces. While this is true, the Lancet analysis showed that 80% of China's inter-county inequality in the distribution of doctors and nurses comes from *within* the provinces, not *across* provinces. Just producing more workers in provincial capital cities cannot solve China's mal-distribution problem; critical are intra-provincial deployment policies. A partnership must be developed between central and provincial governments so that provincial policies fulfill national health goals. In human resources, our evidence base for this type of research is very thin. Also under-developed are M&E metrics. Without tracking progress, we have no idea of what is working and what is not working. And gaining credible evidence will not be easy. The problem is that the Cochrane criteria developed from clinical trials are not entirely relevant for the study of interventions in free-living populations. These invariably require quasi-experimental designs that cannot (and should not attempt) to achieve the scientific rigor based on the natural sciences. Parenthetically, I was pleased to learn that WHO has established a "Guideline Review Committee" to grade the quality of evidence in all of its recommendations.

Strengthening the health system – My final point is obvious but nevertheless worthy of highlighting. Solving the workforce challenge should be measured by the overall performance of the health system. The workforce is an exceptional systems input, as

human agency controls and modulates all other health system inputs – financing, information, technology, operations, and infrastructure. In the health system, the health worker is a necessary but alone insufficient condition to improved systems performance. The WHO Expert Group recommendation, therefore, that its strategies not be viewed singly, but rather as "bundles" for long-term sustained improvements of the health system. In workforce improvements, patience and persistence are essential because of the lagged pipeline effects of medical education and training. There are also plenty of opportunities to leverage workforce improvements as part of national health reform. While health reform mostly focuses on financing, workforce is an equally important dimension. Indeed, some have suggested that national reforms cannot succeed without workforce reform. There are strong arguments for establishing national health workforce commissions as focal points of intelligence, promotion, and the convening of stakeholders involving membership of diverse constituencies, including government departments (health, education, and finance), professional associations, the academy, and non-governmental organizations. Finally, it should not be forgotten that health workers are the twin parts of the human agency of health systems. Julio Frenk has underscored that people or communities play at least five roles in the health system -- as patients, consumers, financiers, citizens, and co-producers. So community participation in worker selection, training, and support are critical human interfaces. In these interactions, workers should not be viewed simply as "functionaries," dutifully conducting their assigned tasks. Health workers are people, who properly trained and motivated also drive health systems as innovators, educators, motivators, and leaders.

These calls for action – skill mix, research, and health systems – will not have much effect without strong political commitment. Implementing a bundled set of strategies will require strong political commitment to engage stakeholders, incentivize the key actors, to overcome vested interests, and to address what Manuel Dayrit has called "the bigger picture" of human resources, health systems, social determinants, and multi-sectoral and multi-stakeholder engagement. Coming out of this conference, each country will carry forward its own action agenda as part of a global movement. But let's together exploit the opportunity for a global movement. When delegates praise the recommendations and the possible Resolution on the global code of practice at the May 2010 World Health Assembly, I would like to hear: "Oh yes, that happened because of Hanoi!"

I look forward to exciting exchanges at this Conference. Thank you.

Conference summaries

Joint WHO-AAAH conference

"Getting committed health workers to the underserved areas: a challenge for health systems

Hanoi 23-25 November 2009

1

Plenary sessions: Key points (1)

- Globally, 50% of the world's population are rural,
  - Yet only 38% of nurses, 24% of doctors are serving them.
  - In parallel with in-country mal-distribution are imbalances across nations, magnified by the migration of skilled personnel from poorer to richer countries.
- HRH contributes to human, social and economic development
  - Essential for achieving health MDG, yet neglected: under-researched, under-appreciated and under-financed.
  - Governments all over world struggle to get committed health workers to underserved areas, a few country experiences were shared:
    - Several Regional Committee resolutions, national strategies and rural retention schemes in Africa countries.
    - The prioritization of health system development at the grassroots level in Vietnam.
    - The Strategic Plan for the Decade of National HRH Development in Thailand, 2007-2016.

2

Plenary sessions: Key points (2)

- Getting committed health workers to underserved areas.
  - No "one size fits all" solutions, country specific policies, strategies and actions are needed.
  - HR is viewed in the context of HSS, revitalizing PHC
  - Major impacts from external environments: macro-economic, labour market, public sector reforms and decentralization
    - Pose both opportunities and threats
  - Effective interventions require
    - Political commitment and leadership
    - A bundled set of interventions
    - Multi-stakeholder and multi-sector engagement and participation at national, provincial and local levels from planning process to implementation and evaluation
    - A comprehensive and evidence based HRH strategy which covers all cadres of health workers is required, in response to local needs and priorities
    - Coordinating mechanisms important
    - Information Management Systems important for effective HRH management

3

Plenary sessions: Key points (3)

- Further actions
  - Invest in research capacity and networks to generate the knowledge for evidence base policy decision.
    - One needs better evidence for the review of global recommendations,
    - Standardized methods and core indicators for M&E facilitate exchanges of information and the sharing of experiences among countries.
  - Continue the work of the expert group,
    - Task forces that bring together researchers and policy makers to review specific gaps, follow up results of implementation, improve the evidence are important
  - Piloting/scaling up some of the recommendations
    - Specific to country problems and needs
    - Empowering and technical support to countries in their implementation

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