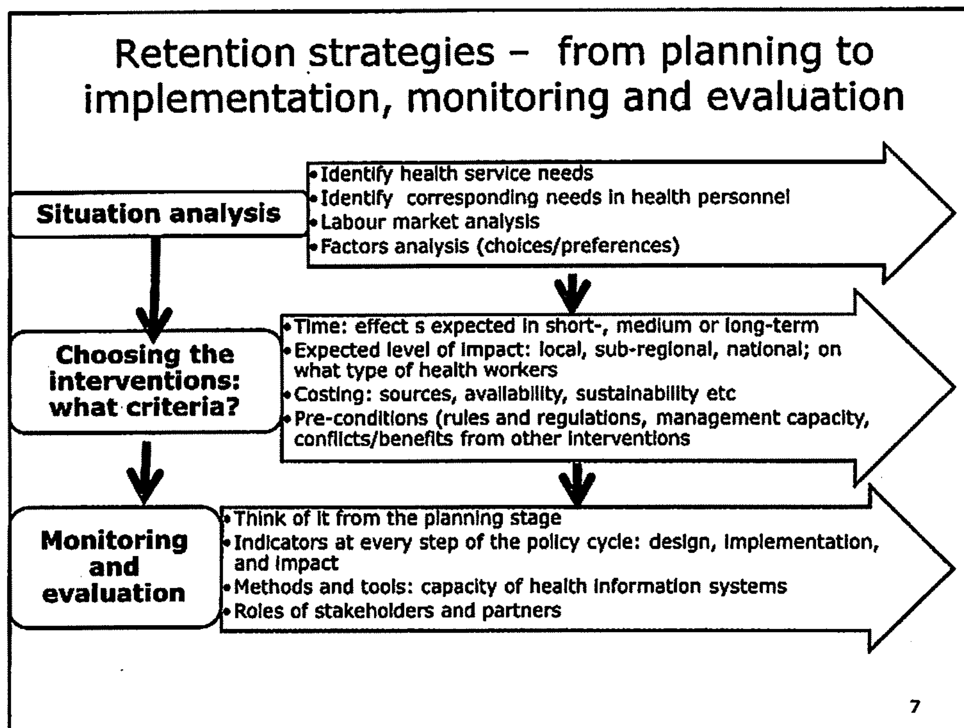
Plenary sessions: Key points (4)

- WHO draft code of practice on the international recruitment of health personnel
  - National and international migrations have major impacts on rural retention.
  - The importation of foreign workers in some rich countries to cover its own disadvantaged populations create problems to source countries.
  - The draft code needs to ensure two rights:
    - Individual professionals rights to leave
    - Right of populations to access quality health-care services,
    - There should be a net positive effect on the health systems of poor countries.
  - Actions:
    - The draft Code will be discussed at the WHO EB January 2010 and may be deliberated by Member States in WHA May 2010.

5

Draft recommendations - summary

Category of intervention	Examples
Education and continuous professional development interventions	Preferential recruitment of students with a rural background
	Medical and other health professions schools located in rural areas
	Clinical rotation in rural areas during medical or health-related studies
	Changes in curricula to reflect rural health issues
	Continuous professional development (CPD), including career paths
Regulatory interventions	Compulsory service in a rural area, alone or with incentives
	Scholarships in exchange of rural service (bonding)
	Producing new types of cadres (task shifting, substitution, mid-level workers)
Financial incentives	Rural or remoteness allowances, including other indirect financial incentives (housing, transport, children's schooling, etc.)
	Financial support for young doctors to open private practices in rural areas
	Performance-related pay
Management, workplace environment, social support	Improved working and living conditions
	HR management system, including improved supervision
	Reduce feeling of isolation through professional support networks, specialist outreach programmes, and telemedicine
	Social recognition measures



1. Education interventions

- Country experiences
  - Nepal: Social accountability framework for medical education : address priority health issues and respond to community needs
  - Thailand: Recruitment methods that favour students from rural background (quota system and Rural Doctor Program) are more likley to have better rural attitude and intentions to go in rural areas when graduate
  - Vietnam: Different recruitment approaches in favour of students from rural background (nominative enrollment for ethics, bonus score for entrance to medical schools for students from rural areas and enrollment by geograhhy) and upgrade training to higher level cadres
  - USA: Recruitment from rural background, loan forgiveness program, and support rural practitioners
  - South Africa: rural pipeline (selection of the right students; undergraduate training; postgraduate training, and support for health workers)

8

1. Education interventions

- WHO recommendations
  - Consensus agreement by particpants on proposed recommendations
  - Additional recommendations
    - Community involvement in selecting medical students and other professionals
    - Rural medicine should be considered as a speciality for post-graduate training
    - Academic opportunities for rural practitioners
    - Exposure to rural health system in early years of medical education
    - Consider training programs for special cadres or non-physician cadres
  - WHO to consider proposing a research agenda and research tool kit to strengthen the evidence, particularly in developing countries
  - Inter-ministerial collaboration vital: involvement of ministry of education, ministry of interior

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1. Education interventions

- Challenges
  - Need stronger regulatory framework
  - Better quality of high schools in particular disadvantage areas
  - Telemedicine is quite high cost—affordability issues
  - Need for effective M&E systems to monitor progress
  - Unintended consequences;
    - Visa waiver program by USA
  - Availability of qualify faculty/teachers in provincial/state levels training institutes

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2. Regulatory interventions

- Country experiences
  - China: Health workers are willing to work in township rural health centres provided that work conditions and salary were satisfactory.
  - Vietnam: Project 1816, MOH approved in 2008, demanded qualified staffs in high level hospitals rotate to lower level hospitals in order to
    - Enhance treatment capacity in low-level hospitals
    - Reduce overload in central hospitals
    - Transfer skills and training to strengthen clinical competencies
  - Pacific Island countries
    - Highlights the need for further research and case studies on mandatory rural services in Asia Pacific region and elsewhere.
  - South Africa
    - One year compulsory service is pre-requisites for professional licensure.
    - "Community service is a good recruitment strategy, but a poor retention strategy".

11

2. Regulatory interventions

- WHO recommendations
  - Need to define "regulatory"- the whole spectrum of regulatory measures, including legislation, various governmental instruments such as policies and guidelines
  - B1 - proposed rephrasing:
    - As a recruitment measure, compulsory service can be introduced in order to improve geographical (rural) distribution of the health workforce *(in the short term)*
  - Need to capture the question of PPP. Not necessarily restricted to regulation alone, but dual practice can be an incentive to work in rural and underserved areas.
  - B3 needs to clarify and probably split in two recommendation.
    - 1. Scope of practice, this needs to be further developed and clearly defined
    - 2. Creation of new cadres who are more likely to serve in rural areas.
  - Acknowledged the strong linkages between education and regulation. Since keeping as two separate sections, need to differentiate clearly between education initiatives, such as clinical rotations as part of curriculum, and compulsory rural service.

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2. Regulatory interventions

- Conclusion and challenges
  - Consensus to support all recommendations. Need to investigate how to implement "compulsory measures".
  - Key msg. is important but precise wording of the recommendation not necessary
    - Countries should adapt according to their context.
  - The degree of compulsion and compliance varies according to political and societal context.
    - South Africa, compulsory service as pre-requisite for physician licensure
    - Interest expressed of linking compulsory service to licensing.
    - Need to engage other sectors, in particular education, finance, labour code, civil society, professional council. This requires strong political leadership.
    - More research required.
      - » Tanzania and Nigeria have over 40 years of experience with compulsory service and the Philippines shared many good regulation experiences,
      - » All these need to be documented, monitored and evaluated.

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3. Financial interventions

- Common messages emerge from three country experiences
  - Proven that financial incentive works well when combined with other interventions
    - Vietnam: working conditions + career advancement, in-service training
      - Vietnam calls for mandatory rural services by all professional graduates
    - Thailand: DCE indicates
      - Higher salary + better opportunity for specialist training + faster career promotion + less overtime works determines choices for rural hospitals.
    - Zambia:
      - Package of comprehensive incentives important : financial incentives + housing improvement + vehicle loans + improved work conditions
      - Variation of impact across cadres
      - Donor harmonization: key for successful rural retention

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3. Financial interventions

- WHO recommendations
  - Recommendations focus too much on extrinsic factors with little attention on the intrinsic factors
    - C1 recommendation:
      - outstanding issue on sustainability for the poor countries
    - C2 recommendation:
      - This recommendation should be totally revised
      - Recommendation is too narrow as it focuses only on doctors in general and in particular on unemployed and young doctors
      - Different point of view about the feasibility and role of "Private rural practice" which may create inequity
      - Recommendation may highlight contractual arrangement to hold non-state/private providers accountable, which should take into account the specific context of each country
      - Evidence from two countries is not enough to generalize

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3. Financial interventions

- WHO recommendations
    - C3 recommendation:
      - Participants felt uncomfortable on the term "low governance level"; consider to amend
        - » It should be replaced by.. In countries where there is a lack of transparency and confidence in health system
      - Quality / performance monitoring should be done by community not outside donors
    - C3 commentary
      - the P4P schemes should not only consider "quantitative" but also qualitative indicators which take into consideration the expectations of the population.

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3. Financial interventions

- WHO recommendations
  - The recommendations on financial incentives are sensitive and must be very carefully written and cautiously implemented
  - To revise the draft recommendations and commentaries
  - "Demand side intervention" could be taken into account in order to improve access to care
  - Financial incentives must be combined with other interventions which reflect spiritual dimension and other intrinsic factors underpinned by sufficient resources and long term sustainability, and take into account the capacities to manage.
  - Strengthen as much as possible the evidence

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4. Working environment and management

- Country experiences
  - Bangladesh: living conditions (e.g. access to water) affect rural retention
  - Sri Lanka: Japanese management model (5S, QC, kaizen) improved job satisfaction and potentially retention (cultural fit)
  - Japan: bottom-up management approaches, involvement of communities
  - Mali – «bundled intervention»: rural doctors association; contracting mechanisms, invovlement of local communities, community medicine as a speciality.

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4. Working environment and management

- Consensus on all proposed recommendations, require clarification, re-wording and re-structuring around these themes:
  - HR Management systems at national/local level, including delivery/supportive supervision
    - Job descriptions and performance appraisals (defined at national level and applied locally)
    - Define HR competencies and specific training needs
  - Environment (work and living environment – need two separate recommendations)
  - Professional support: associations of rural practitioners (provide status, raising awarness and its impact)
  - Community support for families; active community participation
  - Service delivery, need to clarify whether access to health services or access to health workers?)

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4. Working environment and management

- Challenges
  - Vertical diseases programmes pulls staffs away from rural areas
  - Gaps in M&E and costing
  - HR management capacity
    - Closer to rural providers
    - Specialization in HR management ?
  - Focusing only on infrastrucutre improvement cannot solve some of the fundamental HR challenges
  - Avoid fragmentation, and improve intersectoral coordination in broad scope of all HR development, not only work environment

20

5. Social and spiritual motivations

- Country experiences
  - Bangladesh:
    - Many de-motivating factors when serving rural areas. But study produced some simple recommendations eg: taking "oaths" of service regularly, improving entertainment facilities
  - India:
    - Highlighted the need to build confidence in and motivation of health workers,
  - Sri Lanka:
    - 72% rural population, highlighted the need to develop bundled approaches with a focus on motivating health workers
  - Thailand:
    - What makes you serve in a rural hospital for 18 years? Many motivating factors such as social recognition by local and national level, engagement with media.
    - Duty + brain + heart and soul = continuous quality improvement and happy health workforce.
    - Need to strengthen civil society and communities.

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5. Social and spiritual motivations

- Consensus that recommendations still do not sufficiently reflect other important dimensions
  - Need to include more examples of intrinsic factors, social and spiritual motivation
  - Acknowledged that a recommendation on "how to" best motivate rural health workers is perhaps the hardest challenge for this document.
  - Many appreciated Maslow hierarchy,
    - Incentives are actually the lowest "pull factor" in terms of motivation.
    - Other important social dimensions and motivation factors need to be investigated

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5. Social and spiritual motivations

- Suggest several recommendations which may be included:
  - Awards, ceremonies – at local, national and international level?
  - Need to develop a social contract with the community – to help foster strong sense of belonging and accountability
  - Supportive supervision
  - Improve the social, but also formal recognition of health workers
    - Could develop rural health service as a specialty by its own?
  - Need to support faith-based organizations in many contexts as these are often key in providing health services in rural communities and can address the faith dimension of motivation.
  - Need to address the question of gender dimension in the recommendations

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6. External factors affecting retention in the Underserved Areas

- External factors have both positive and negative impacts on rural retentions
- External factors are diverse e.g.
  - Civil unrest, rising price of housing in urban areas → attracting work in rural area
  - Public sector reform, health sector → availability of HR supplies
  - PPP which encourage dual jobs, or discourage rural works
  - Decentralization
  - Changes in economic development e.g. tourism
  - Access to internet: could minimize the professional isolation
- Three main concerns
  - What information needed for the identification and analysis of important external factors?
  - How to accommodate factors identified in the selection of bundles?
  - how to monitor the current impact and its dynamics?

24

6. External factors affecting retention in the Underserved Areas

Country experiences

- **Cambodia:** public service reform
  - Good opportunity to enhance quality of public services, including health service.
  - Challenges: brain drain of civil servants
- **Indonesia, Lao PDR and Thailand:** decentralization
  - Opportunity: to improve working condition, rural recruitment, flexibility in hiring health staff, incentives and management
  - Challenges: governance of local administrative organizations (LAOs), different capacity of LAOs in terms of financial and management
- **Tanzania:** several programs e.g. retention initiatives 2007-09, HRH strategic plan 2007-13, national multisectoral plan
  - Recruited retained and mainstreamed into government services
  - PPP in HRH are potential avenue
  - Incentive package is effective measure for retention,

25

6. External factors affecting retention in the Underserved Areas

Conclusion

- External effects should be taken into account when developing policies to improve retention in underserved areas
- These provide both opportunities and threats, which may change over time, to retention strategies
- Decentralization is major external factor impacting on working condition, career opportunity, recruitment and financing jobs ..
- ... But the impact of decentralization will depend on rationale (ideology vs public health concerns), how implemented and capacity of local government unit in terms of technical capacity and resources
- The economy will impact on ability to fund retention strategies

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Highlights from the fourth AAAH Conference in Vietnam

Story by Mrs. Nguen Huong, the AAAH Steering Committee, Vietnam

The people's health is the foundation for socio-economic development of each nation. Human resource for health is the most precious resources in the health care system in providing health care services for the population.

We are all aware of the crisis in global human resources for health. Many countries are facing the shortage of human resource for health, especially qualified staffs, mal- distribution, inappropriate skill-mix, and support system. Problems regarding human resources for health are hindering the technical and professional performance of the healthcare system and the roadmap in achieving the MDGs.

Globally, about 50% of population living in the rural and underserved areas are served by only 38% nurses and 24% of doctors. Therefore, it's required to get committed health workers to the underserved and rural areas in order to provide equitable access and quality health care services for populations.

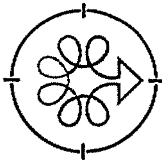
The AAAH/WHO Joint Conference with the theme "Getting committed health workers in underserved areas: a challenge for the health systems" was held in Hanoi, Vietnam from 23-26 November 2009. This was the fourth AAAH annual meeting and the third meeting of the WHO Expert Group. The Conference was organized by the Ministry of Health Vietnam, Asia-Pacific Action Alliance on Human Resources for Health (AAAH), and the World Health Organization, with support from the Global Health Workforce Alliance, the Rockefeller Foundation, the China Medical Board, and the World Bank. There were more than 150 delegates from 15 AAAH member countries, Africa, WHO experts and resource persons

The objectives of the joint conference are:

- 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.
- To discuss and refine a set of draft recommendations initiated by WHO, to support countries in formulating and implementing appropriate, comprehensive and feasible interventions to get committed health workers to underserved areas.
- To learn experiences from different countries/continents concerning the distribution and retention of health workers in underserved areas, and
- To foster networking and capacity building of institutions, researchers and policy makers in the area of human resources for health among partners.

During the Conference, the delegates have followed presentations made by WHO representative on the status of human resource for health in the world and in the region. Delegates from different countries have made 16 presentations and shared practical experience on issues relating to utilization and retention of health workforce working in the rural and underserved areas. Reports and discussions have pinpointed influencing factors and impacts on retaining human resources for health working in rural and underserved areas. Regarding to the retaining of health human resources to work in underserved areas, recommendations have been focused on training, policies, financing, and improvement of working environment and incentives for health workers. Also during the Conference, delegates joined the field trips to Vietnamese private and public health facilities.

After 3 days of working the joint AAAH/WHO Conference with the theme "Getting committed health workers to the underserved areas: a challenge for the health systems" has successfully completed.



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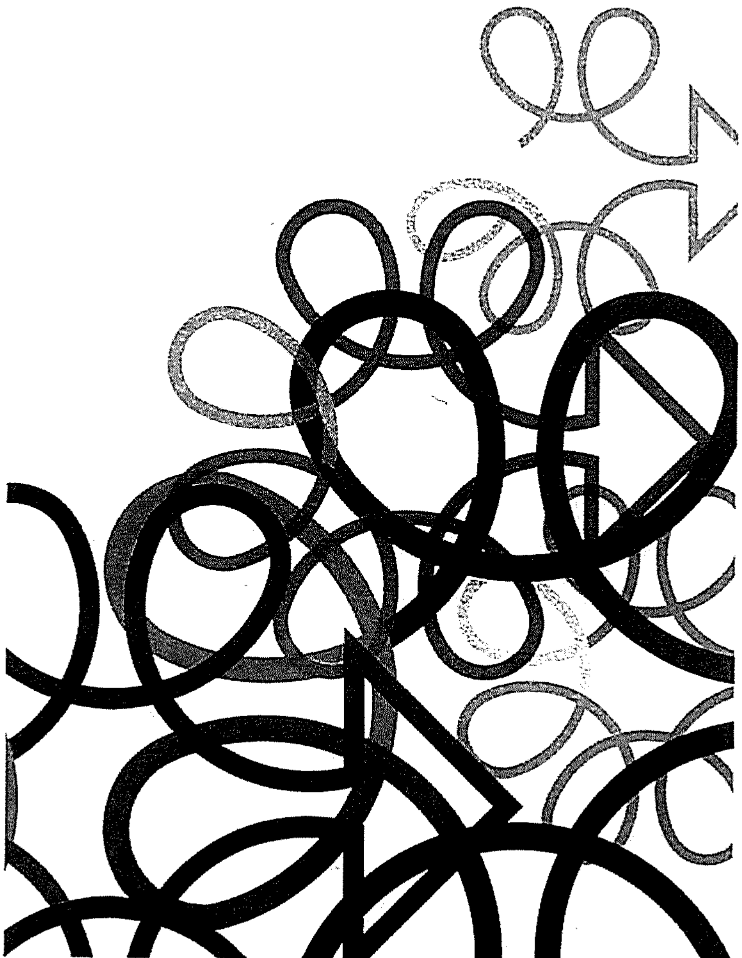

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The Second Global Forum on Human Resources for Health

25 - 29 January 2011, Bangkok, Thailand

Even though Human Resources for Health (HRH) have been identified as the single most critical constraint to the achievement of most health and development goals we continue to witness a global health workforce crisis. With only five years left until 2015 to achieve the Millennium Development Goals - there is an urgency for all stakeholders working towards human resources for health and health systems strengthening, to respond appropriately, efficiently and effectively.

Following the success of the first Global Forum on HRH in Kampala - which was the premier gathering for all concerned with the human resources for health crisis - the Second Global Forum on HRH is being convened by the Global Health Workforce Alliance, the Prince Mahidol Award Conference, the World Health Organization and the Japan International Cooperation Agency, supported by many other agencies, especially the Rockefeller Foundation, the China Medical Board and the World Bank. The Forum will be held in **Bangkok, Thailand from 25 - 29 January, 2011.**

FORUM THEME

The principal theme of the Forum is - **Reviewing progress, renewing commitments to health workers towards MDGs and beyond.** Building on this theme, the planned plenary sessions are:

- From Kampala to Bangkok: Marking progress, forging solutions
- Leadership, governance and coordination for universal access to supported health workers
- Innovations in HRH that support strengthening of Health Systems

FORUM OBJECTIVES

The Forum will build upon the successes achieved in Kampala and will provide a platform to review progress made in fulfilling the commitments outlined in the Kampala Declaration and the Agenda for Global Action. It will be an opportunity to further galvanize and accelerate the global movement on HRH towards achieving the Millennium Development Goals and Universal Health Coverage.

EXPECTED OUTCOMES

- Sustaining the global movement on HRH and sharing of knowledge and experiences
- Agreeing and understanding the progress made since Kampala through measured concrete examples of global and country actions
- Coping with new and emerging issues and challenges requiring action and response

FORUM STRUCTURE

The Second Global Forum will comprise of four core groups of activities:

- **Pre-conference:** *25-26 January* - side meetings; field visits
- **HRH main conference:** *27-29 January* - keynote addresses, thematic plenary and parallel sessions; HRH awards ceremony
- **Post-conference:** *29 January* - the forum of Alliance members, monitoring and evaluation of the forum and follow-up activities
- **Multi-day non-stop activites:** *throughout the Forum* - skill building workshops; market place; poster presentations

Reviewing progress, renewing commitments to health workers towards MDGs and beyond

HRH AWARDS

Health workers are the heart of health systems. With this in mind, the Second Global Forum on HRH will honor successful country case stories and individual health workers with prestigious HRH awards. This is the first time that such recognition will be conferred to human resource efforts.

Awards for Excellence (for case stories)

The Awards for Excellence will be given to case stories (preferably but not limited to those that commenced after February 2008), that demonstrate success in addressing health workforce issues based on one or more strategies of the Agenda for Global Action. (eg. innovative methods in improving the health situation through actions on the health workforce; improved access to the health workforce; innovative incentives and motivation for HRH; innovative education of HRH.)

Special Recognition Awards (for health workers)

This Award will recognize two categories of outstanding and dedicated health workers - medical doctors and nurses/midwives/community health workers. It will be awarded to health workers that demonstrate great dedication on certain specific public health issues; provide quality services in hardship areas; show outstanding innovative methods or adaptation of methods; and/or show continuous commitment for a sustained period of at least 5 years. Proposed candidates will be considered for participation at the Second Global Forum.

Submissions

Submissions for Awards for Excellence: Case stories should be no longer than 2,000 words - preferably, in a narrative nature, story telling, rather than a technical style. There is no specific format requirement for the case stories. A short video of no more than 10 minutes may be included in the proposal. Case stories can be submitted by countries, organizations or development partners.

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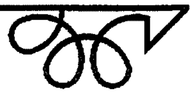

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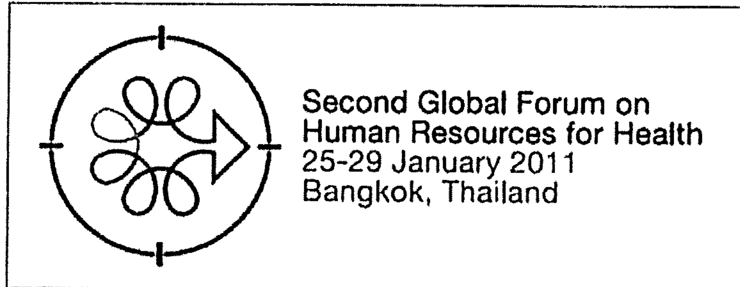

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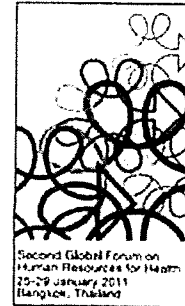

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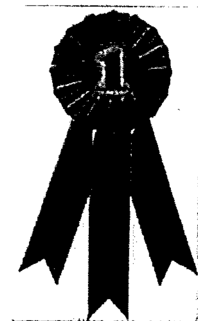

HRH AWARDS

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Kampala, Uganda, March 2008

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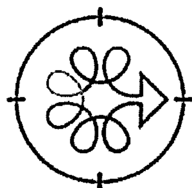

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WHO 西太平洋地域における
保健システム強化とプライマリヘルスケアの
地域戦略草案
V 1.9

WHO 西太平洋事務局・保健システム強化とプライマリ・ヘルス・ケア(PHC)のための地域戦略（案）..

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Boxes to illustrate examples from countries to be inserted in the text are being considered. If reviewers have suggested examples, please let us know.

WHO 西太平洋地域における
保健システム強化とプライマリヘルスケアの
地域戦略草案

戦略案の概要

世界保健機関（WHO）憲章によれば、“最高水準の健康の享受は人間の基本的人権の一つ”である。そのために必要な効率的、効果的なヘルス・ケア・システムは、いくつかの核となる価値基準によって支えられている。1978 年、プライマリー・ヘルス・ケア(PHC)のためのアルマ・アタ宣言は、そのような価値基準を提示した。平等性(equity)、社会正義、普遍性、住民中心主義、コミュニティの保護、科学的な健全性、自己決定、セルフ・リライアンス（self-reliance, 自立）である。一定の健康投資があった時、PHC の原則に基づく保健システムは、投資額を上回るよりすぐれた健康とよりすぐれた価値をもたらすと言われている。世界的にも西太平洋地域（WPR）においても、国によって、政治・社会状態や保健システム異なっている。しかしながら、差異があったとしても、核となる原則があれば、より効果的、効率的なヘルス・ケア・システムは構築できる。それを示すエビデンスも増えてきた。保健システムの国際規範について、エビデンスに基づいた確かな方向性が示されれば、それをもとに各国のリーダーたちも、利害がうずまく保健セクターの中で舵を取っていくことができる。また原則に基づいたガイダンスがあれば、各国の意思決定者は、そのガイダンスをもとに、最も望ましい効果的かつ効率的な保健システムをデザインし、実施していくことができる）。

WHO 西太平洋地域事務局における保健システムのビジョンはユニバーサル・カバレッジ（universal coverage,すべての人に保健サービスを）である。そして質の高い保健サービスを提供することによって、よりすぐれた健康成果(outcome)を得ようとしている。

保健システムの目標、あるいは期待される健康成果は以下の通りである。

(1) 健康の改善—絶対的なレベルでしかも平等に
(2)社会的、経済的なリスク 保護
(3) 住民に対しての高い応答性（responsiveness）
(4) 効率化

PHC 志向型の保健システムは、効果的・効率的にこれらの目標を達成できる。

PHC を新たに見直そうという動きが今世界各地で起こっている。*World Health Report 2008-Primary Health Care, Now More than Ever* の中でも明確に言及されている。同レポートによれば、PHC 実現のためには以下の４つ改革が必要である。

(1)健康を平等にいきわたらせるためのユニバーサル・カバレッジの改革

(2)人びとを中心に据えた保健システムのためのサービス提供改革
(3)権威ある機関への信頼をさらに高めるためのリーダーシップ改革
(4)コミュニティの健康を促進し保護するための公共政策の改革

これらの改革が強調しているのは住民とコミュニティの重要性である。そしてこの PHC によって、世界における古今の公衆衛生課題にとりくんでいこうとしているのである。

WHO による保健システムの定義は、"健康を促進し、回復し、維持することを主要な目的とするすべての組織、人、活動"というものである。保健システムは'システムを全体としてみる'アプローチによって認識される必要がある。保健システムの個々のパーツは、過度に強調されてはならない。無視されてもいけない。理想は、すべてのパーツのバランスがとれている状態である。保健システムをある種の分析フレームワークを用いて個々のパーツにわけ、個々のパーツを理解することは有益ではある。しかし、保健システムは全体として取り扱うべき複雑なシステムであるということを忘れてはいけない。一つのパーツを他のパーツから分離させてしまうことはできないのである。ここに示す地域戦略書の作成にあたっては、すでに公開されている *Everybody's Business – Strengthening Health Systems to Improve Health Outcomes* で使用されている分析フレームワークを用いている。そこでは保健システムに期待される４つの成果を生み出すのに重要な、６つのコンポーネントが用いられている。６つのコンポーネントが取り扱うテーマは以下に示すとおりである。

サービスの提供：サービス提供モデルの定義、マネジメント、統合的サービス提供パッケージ、医療の質／患者の安全、インフラ

保健人材：人材の調達、パフォーマンスの改善、移民や人材の減少（退職、定年などによる）のマネジメント

保健情報：国家戦略計画、情報の有効利用、重複した情報収集の回避、対象集団別の情報収集・分析、保健システムパフォーマンスのモニタリング、国のニーズにかなった研究、情報技術の適正使用

医薬品と技術：合理的な選択、合理的な使用、適正価格の設定、持続可能な予算付け、アクセスの保証、首尾一貫した供給とマネジメント、品質保証、製造能力、安全性の改善、研究補助

財源と社会的保護：投資額の増加と公共支出、援助の有効性、効率化、前払い制とリスク・プーリング（risk-pooling, リスクの蓄積）、供給者への支払い方法、社会的弱者へのセーフティ・ネット、政策策定に必要なエビデンス、モニタリングと評価

リーダーシップとガバナンス：政策フレームワークと保健計画、保健セクターのマネジメント、説明責任と透明性、情報の作成と解釈、保健セクター外での連合体(coalitions)の設立、援助の有効性

PHC が有する価値に裏付けされた強固な保健システムは、きわめて効果的かつ効率的に健康成果を改善し、かつその成果を平等にもたらす保健システムでもある。

WPR の各加盟国は、PHC が有する価値を基盤とした保健システム発展のために積極的に取り組んでいる。各加盟国は、このビジョン達成のための道筋をどのようにとるかを決めなければならない。

WHO は、このビジョン達成のために、必要に応じて技術協力を行い、かつビジョン達成のための支援も行う。

西太平洋地域に属している人々は、生涯を通じて、最善の健康状態を保つ権利を有している。西太平洋地域の加盟国は、この理想を徐々に実現させるための活動にとりくんでいる。