63. How were you/ your family treated at home? **Please tick all that apply.**

(1) Local medical teas

(2) Infusion by the patient himself/herself

(3) Recommended Home Fluids (gruel, soup, rice water, yoghurt drinks, green coconut water, weak tea, unsweetened fresh fruit juice etc.)

(4) Oral Rehydration Salt (ORS)

(5) More liquids than usual

(6) Less liquid than usual

(7) Continue to feed the child

(8) Stop breastfeeding

(9) Continue breastfeeding (more frequently and longer each feed)

(10) Zinc supplementation

(11) Antibiotics

(12) Other (specify) ....

(13) Don't know

64. How long after diarrhea started did you/ your family get treatment? **Please tick only one.**

(1) Same day

(2) Next day

(3) 2 days after diarrhea started

(4) 3 or more days after diarrhea started

(5) Don't know / don't remember

Respondents from **Andeng Sang (Village Malaria Worker Project village)** → please go to **Question 65**

Respondents from **Srakak Neak (Non-Village Malaria Worker Project village)** → please go to **Question 66**

65. If Village Malaria Workers are trained to provide treatment for diarrhea, do you intend to seek them as **first source of diarrhea treatment? Please tick only one.**

(1) Yes

(2) No

(3) Don't know

Next I would like to ask you various questions about your/your family's treatment seeking behavior for ARI symptoms. The most obvious symptoms of ARI are having a cough and difficulty breathing.

66. If you/ your family show ARI symptoms, do you **usually** seek treatment outside home? **Please tick only one.**

    (1) Yes → please go to **Question 67**

    (2) No, treat at home → please go to **Question 68**

67. Where, outside home, do you **usually** go to seek treatment for ARI symptoms? **Please tick only one.**

    (1) Traditional healer

    (2) Regional hospital

    (3) Government health center

    (4) Village Malaria Worker/ Community Health Worker

    (5) Friend/ neighbor

    (6) NGO clinic or hospital

    (7) Private pharmacy

    (8) Drug seller

(9) Other (specify) ....

(10) Don't know

Finally I would like to ask you various questions about treatment-seeking behavior of your/ your family's most recent ARI-like episode.

68. Who in your household had ARI symptoms most recently? **Please tick only one.**

(1) Yourself

(2) Your spouse

(3) Your children (..................years old)

(4) Other family member (specify) ....

69. When was the most recent ARI-like episode?

....**days ago**

70. Did you/ your family seek treatment outside home? **Please tick only one.**

(1) Yes → please go to **Question 71**

(2) No → please skip to **Question 74**

(3) Don't know → please skip to **Question 76**

71. Where, outside home, did you **first** seek treatment for ARI symptoms? **Please tick only one.**

(1) Traditional healer

(2) Regional hospital

(3) Government health center

(4) Village Malaria Worker/ Community Health Worker

(5) Friend/ neighbor

(6) NGO clinic or hospital

(7) Private pharmacy

(8) Drug seller

(9) Other (specify) ....

(10) Don't know

72. What are the reasons for the **first provider preference? Please tick all that apply.**

(1) Quality of treatment provided

(2) Experience of health provider

(3) Provider is polite

(4) Good equipment

(5) Treatment being cheap

(6) Provider is nearby

(7) Other (specify) ....

73. Were you/ your family prescribed medicine? **Please tick only one.**

(1) Yes → please go to **Question 75**

(2) No → please go to **Question 75**

(3) Don't know → please go to **Question 76**

74. How were you/ your family treated at home?

....

75. How long after ARI symptoms started did you/ your family **first** get treatment? **Please tick only one.**

(1) Same day

(2) Next day

(3) 2 days after ARI symptoms started

(4) 3 or more days after ARI symptoms started

(5) Don't know / don't remember

Respondents from **Andeng Sang (Village Malaria Worker Project village)** → please go to **Question 76**

Respondents from **Srakak Neak (Non-Village Malaria Worker Project village)** → **finished, thank you so much!**

76. If Village Malaria Workers are trained to provide treatment for ARI symptoms, are you intended to seek them as first source of ARI treatment? **Please tick only one.**

(1) Yes

(2) No

(3) Don't know

Thank you so much for sparing your precious time for my research!

I deeply appreciate for your great contribution and cooperation!

សូមពិនិត្យរករោគសញ្ញាគ្រោះថ្នាក់ជាដំបូង មុននឹងពិនិត្យបន្ទះ

១-កុមារមិនអាចផឹកបាន រឺមិនបៅដោះ

២-កុមារក្អួតគ្មានសល់រាល់ក្រោយពេលបៅរឺ ញុាំ

៣-កុមារក្តៅខ្លួនខ្លាំង រឺប្រកាច់ រឺសន្លប់

៤-កុមារមាន សន្លឹម រឺបាត់ស្មារតី

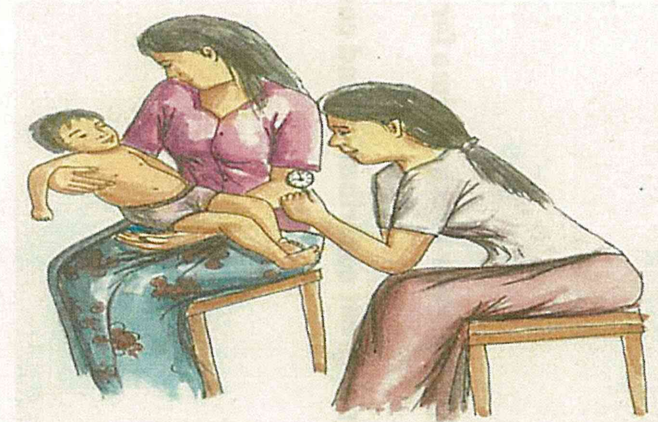
៥-ក្អក ហត់ពិបាកដកដង្ហើម រឺមានដង្ហើមផតទ្រូង

៦-រាក មានស្បែកពោះរលាយឺតណាស់

៧-រាកមានឈាម រាកជាប់រហូត រឺរាកយូរជាង ២អាទិត្យ

៨-ទារកអាយុក្រោមពីរ ខែ-ឈឺ

បើមានរោគសញ្ញាគ្រោះថ្នាក់ណាមួយត្រូវបញ្ជូនទៅមណ្ឌលសុខភាព ឬ មន្ទីរពេទ្យ ដែលនៅជិត ជាបន្ទាន់



ក្អក រឺពិបាកដកដង្ហើម

អាយុកុមារ	ចាត់ទុកថាមានចង្វាក់ដង្ហើមញាប់បើអ្នករាប់បាន
២ខែ ដល់ក្រោម ១២ខែ	ច្រើនជាង រឺស្មើរ ៥០ដង ក្នុង១នាទី ......47.48.49. 50 51. 52. 53. 54.......
១ឆ្នាំ ដល់ក្រោម ៥ឆ្នាំ	ច្រើនជាង រឺស្មើរ ៤០ដង ក្នុង១នាទី ......37.38.39. 40. 41. 42. 43. 44. ......

ការព្យាបាលជំងឺរលាកសួតដោយប្រើ កូទ្រីម៉ុកសាសុល (លេខ១១២០ មក្រ)

អាយុកុមារ	ថ្ងៃទី១		ថ្ងៃទី២		ថ្ងៃទី៣		សរុប
	ព្រឹក	ល្ងាច	ព្រឹក	ល្ងាច	ព្រឹក	ល្ងាច	
2-<12 ខែ							១២គ្រាប់
1-<5 ឆ្នាំ							១៨គ្រាប់

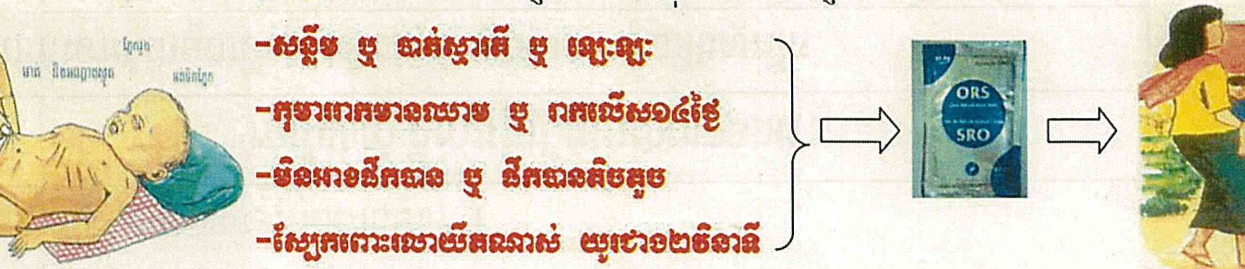
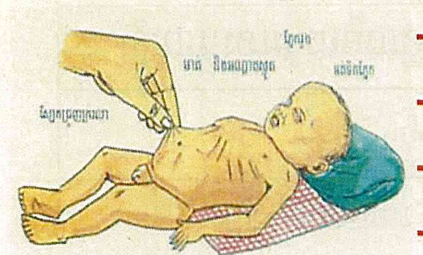
<u>បន្ទាប់ពីផ្តល់ថ្នាំសូម</u>

- ♦ បង្ហាញម្តាយពី របៀបកិនថ្នាំ និង លាយថ្នាំ ជាមួយទឹក រឺអាហារផ្សេងទៀត
- ♦ ម្តាយគួរតែ អោយកូនផឹកថ្នាំ កូទ្រីម៉ុកសាសុល លើកដំបូង នៅមុខអ្នក
- ♦ ថ្នាំត្រូវតែលេប អោយអស់ ទោះបីជាកុមារ បានធូរស្រាលហើយក៏ដោ
- ♦ បើក្មេងក្អួតចេញថ្នាំមកវិញ ត្រូវអោយវាលេបសារជាថ្មី នៅ៣០នាទីក្រោយពីវាក្អួត
- ♦ បើម្តាយរកឃើញ ស្នាមផតចូលក្នុងនៅផ្នែកខាងក្រោមនៃឆ្អឹងជំនីក្រោម រឺហត់ខ្លាំង ជាងមុនពេលលេបថ្នាំត្រូវប្រញាប់បញ្ជូនទៅមណ្ឌលសុខភាពជាបន្ទាន់ ។

ការណែនាំ ពីការធ្វើថ្នាំក្អកដោយខ្លួនឯង
១ -ខ្ញី,យកទៅដំាជាមួយទឹករួចហើយទុក ក្តៅអ៊ុន១ លាយនឹងស្ករផឹក
២ -ទឹកឃ្មុំ លាយជាមួយទឹកក្រូចឆ្មា នឹងទឹក ក្តៅអ៊ុន១ ផឹក

ចាត់ថ្នាក់ និង ការព្យាបាល ជំងឺរាក

១-កុមាររាកមានខ្សោះជាតិទឹកធ្ងន់ធ្ងរ កាលណាមានសញ្ញាយ៉ាងតិច២ក្នុងចំណោមសញ្ញាខាងក្រោម:

- សន្លឹម ឬ បាត់ស្មារតី ឬ ខ្សោះខ្សោះ
- កុមាររាកមានឈាម ឬ រាកលើស១៤ថ្ងៃ
- មិនអាចផឹកបាន ឬ ផឹកបានតិចតួច
- ស្បែកពោះលោយឺតណាស់ យូរជាង២វិនាទី

២-កុមាររាកមានខ្សោះជាតិទឹកមធ្យម កាលណាមានសញ្ញាយ៉ាងតិច២ក្នុងចំណោមសញ្ញាខាងក្រោម:

- ស្រេកទឹក
- ស្បែកពោះរលាយឺត
- ភ្នែករូង

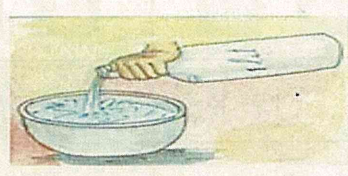
៣-កុមាររាកគ្មានខ្សោះជាតិទឹក : កុមារផឹកទឹកបានធម្មតា . ស្បែកពោះរលាលឿន

(មើលតារាងព្យាបាល)

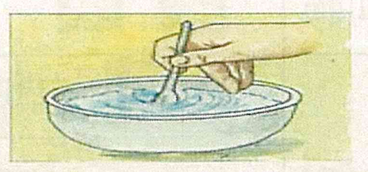
របៀបលាយម្សៅអូរ៉ាលីត្រ

១-លាងដៃអោយបានស្អាត

២-ចាក់ម្សៅអូរ៉ាលីត្រចូលក្នុងផ្តិល



៣-ចាក់ទឹកឆ្អិនចំនួន១លីត្រ



៤-កូរម្សៅអោយសព្វ

ព្យាបាលភាពខ្សោះជាតិទឹក ដោយប្រើ អូរ៉ាលីត

សញ្ញាខ្សោះជាតិទឹក	អូរ៉ាលីត	អាយុ របស់កុមារ			
		អាយុដល់ក្រោម៤ខែ	៤ខែដល់ក្រោម១២ខែ	១២ខែដល់ក្រោម២ឆ្នាំ	២ឆ្នាំ ដល់ក្រោម៥ឆ្នាំ
ស្បែកពោះរលាយឺត(តិចជាង២វិនាទី) ស្រេកទឹកខ្លាំង,ភ្នែករូង-រញ្ជុំរញ្ជូវ	គិតជាពែង ចំណុះ១៥០មីលីលីត្រ (រយៈពេល៤ម៉ោងដំបូង)	1-2 ពែង	3-4 ពែង	5-6 ពែង	7-8 ពែង
ផឹកទឹកបានធម្មតា	ក្រោយជុះរាកម្តង១	កន្លះពែង - ១ពែង			1-2 ពែង

របៀបផ្តល់ថ្នាំគ្រាប់ជាតិសង្កសី ២០ម.ក្រ ចំពោះកុមារដែលរាក រយៈពេល ១០ថ្ងៃ

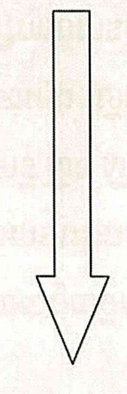
អាយុកុមារ	ថ្ងៃទី១	ថ្ងៃទី២	ថ្ងៃទី៣	ថ្ងៃទី៤	ថ្ងៃទី៥	ថ្ងៃទី៦	ថ្ងៃទី៧	ថ្ងៃទី៨	ថ្ងៃទី៩	ថ្ងៃទី១០
កុមារអាយុ ២ខែដល់ក្រោម៦ខែ										
កុមារអាយុ ៦ខែដល់ក្រោម៥ឆ្នាំ										

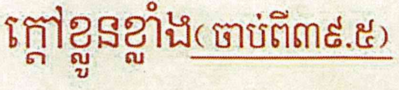
ចំណាំ :

- អូរ៉ាលីត ១កញ្ចប់ត្រូវលាយជាមួយទឹកដាំឆ្អិនចំណុះ១លីត្រ ហើយអាចទុកប្រើបានរយៈពេល ១ថ្ងៃ
- អោយក្មេងផឹកទឹកអូរ៉ាលីតតាមបរិមាណខាងលើ ។ អាចឱ្យវាផឹកបានច្រើនថែមទៀតបើវាចង់ផឹក និងបន្តផ្តល់អាហារដល់ក្មេង
- បើកុមារក្អួត ចូរផ្អាក១០ នាទី សិន សឹមបន្តឱ្យផឹកតទៅទៀត តែឱ្យផឹកយឺតជាងមុន
- បន្ទាប់ពីផ្តល់ទឹកអូរ៉ាលីតដល់ក្មេង ហើយពិនិត្យមើលតើវាមាន ខ្សោះជាតិទឹកទៀត រឺទេ ? បើមាន ចូរឱ្យបរិមាណដដែលឡើងវិញបើគ្មានទឹកអូរ៉ាលីត អ្នកអាចអោយក្មេងផឹកទឹកដូង រឺទឹកដាំឆ្អិន

ក្តៅខ្លួន តែធ្វើតេស្តគ្រុនចាញ់អវិជ្ជមាន

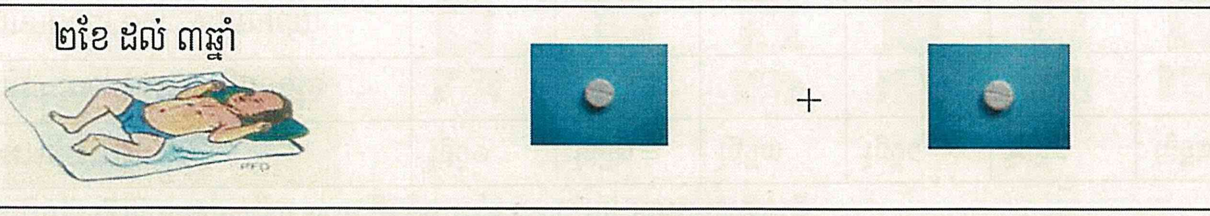
(ផ្តល់ថ្នាំប៉ារ៉ាសេតាមុល ១០០ មក្រ និងថែទាំនៅផ្ទះ)





បញ្ជូនទៅមណ្ឌលសុខភាព

ផឹកភ្លាម | ផឹកនៅផ្ទះ ៦ម៉ោងក្រោយ



២ខែ ដល់ ៣ឆ្នាំ

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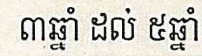

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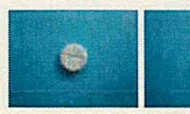
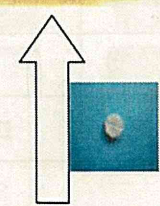
+ 



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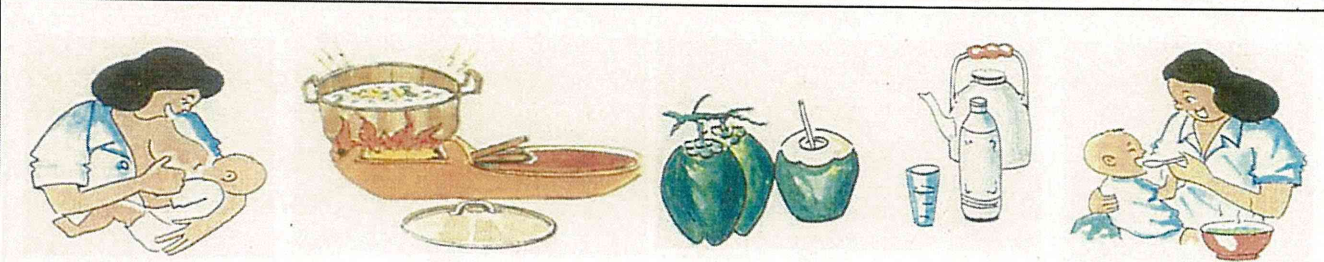

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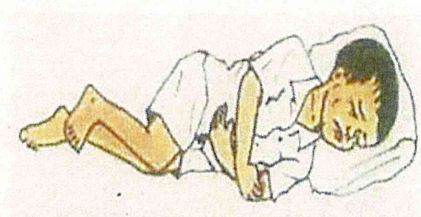

ឈឺធ្ងន់ជាងមុន

From Kampala to Bangkok: Reviewing Progress, Renewing Commitments

Outcome Statement of the Second Global Forum on Human Resources for Health Bangkok, 27-29 January 2011

The Second Global Forum on Human Resources for Health (HRH) in Bangkok reviewed progress and renewed the commitment to strengthening the global health workforce, restating that a robust health workforce is a core element of health systems in all countries, and critical to achieving the Millennium Development Goals (MDGs) and Universal Health Coverage, with the vision that:

All people, everywhere, shall have access to a skilled, motivated and supported health worker within a robust health system.

Key advances in health workforce development have occurred over the past three years since the First Global Forum in Kampala. The adoption of the WHO Global Code of Practice in 2010 on the International Recruitment of Health Personnel (the Code) was a major achievement. The 2010 proceedings of the United Nations High Level Summit on the MDGs, the launch of the Global Strategy for Women's and Children's Health, the European Union Global Health Strategy, the African Union Summit, and other events have added momentum to health workforce development.

The Global Strategy for Women's and Children's Health states that an additional 2.6 to 3.5 million healthcare workers would contribute significantly to the lowest-income countries reaching MDGs 4 and 5. Requirements to achieve universal health coverage in a wider range of countries would be higher. The progress report on the Kampala Declaration and Agenda for Global Action demonstrates some advances, as well as challenges requiring increased attention, in the priority countries most affected by health workforce challenges. The upcoming UN General Assembly sessions on HIV/AIDS and on Non-Communicable Diseases will provide further opportunities to highlight the vital role of health workers.

The participants of the Second Global Forum reiterate the principles of the Kampala Declaration and the Code as instruments for alignment and accountability at global, regional, national and local levels, and call upon all stakeholders to accelerate implementation in a comprehensive manner.

Major gaps must be addressed

Supply of health workers In many countries, particularly in Africa and complex emergency settings around the world, education and training capacity has to increase to match the growing demand for health personnel. Although supply is not a constraint everywhere, countries with shortages are encouraged to exploit the full range of public policies, including inter-country collaboration, that influence supply of and demand for the labour force, enhance pre-service training through the adoption of emerging best practices, and ensure that poor and marginalized people get equitable access to quality services.

Reliable and updated information There is a need for strong national capacity in all countries to regularly collect, collate, analyze and share data to inform policymaking, planning, and management. New benchmarks, beyond the density of physicians, nurses and midwives, will be required. Attention should be paid to aspects such as geographic distribution, retention, gender balance, minimum standards, competency frameworks, and reflect the diverse composition of the health workforce.

More attention to prerequisites for success

Leadership Leadership by all state and non-state actors at global, regional, national and local levels is required to focus action on the health workforce. An "all of government" response is essential to ensure coherent policies across sectors. The capability to plan and manage the health workforce should be enhanced, as relevant to the local context.

Collaboration and mutual accountability National health workforce coordination mechanisms should be established to foster synergies among stakeholders. These mechanisms, such as the Country Coordination and Facilitation approach, should build on existing frameworks and processes, and foster inclusive communities of purpose where best practices are shared. It will be important that HRH plans and budgets are linked with national health strategies, policies and plans. At the same time there is need for mutual support and accountability between different stakeholders, and between policy makers, service providers and the people.

Distribution and retention Suitable policies and strategies should be adopted to attract and retain health workers with appropriate skills mix in rural and other under-served areas, including the deployment of community-based and mid-level health providers. As relevant to country context, strategies may include tailoring education to practice in rural areas, financial and non-financial incentives, regulation, personal and professional support, career development, improvements in rural infrastructure, and partnerships between the public and private sectors.

Performance and quality The quality of services should improve through accreditation and compliance with appropriate national standards for educational institutions and individual health workers, in both the public and private sector. Performance and productivity will also be enhanced through the establishment of cohesive interdisciplinary care teams with effective supervision; competency-based curricula, reinforced through in-service training; enabling practice environments, including fair remuneration, appropriate incentives, access to necessary resources, and prevention of professional hazards; and supportive management practices.

Effective and functioning regulation Appropriate and flexible regulation, responsive to an evolving policy environment, and tailored to the national health system context, will ensure the quality and safety of care. The specific challenges of international migration should be addressed by putting in place the necessary regulatory, governance and information mechanisms, according to the provisions of the Code.

Invest for results

An adequate level of funding for health workforce development must be ensured through a combination of domestic and international resources. External contributions must be additional and complementary to domestic funding. Concerted action is required by development partners, global health initiatives and international agencies to provide predictable, long-term and flexible support, aligned to country priorities and national health plans. This will need to allow for investment in pre-service education, remuneration and improvement of working conditions of health personnel. Macro-economic policies that constrain investments in the health workforce should be addressed. The impact of investments could be maximised by supporting national efforts to establish robust health financing mechanisms for universal coverage. This should include closer links between resource allocation and needs, and support to community-based service provision as a key component of the health system. Better financial management mechanisms will foster accountability, and improve equity and efficiency.

The forum reviewed progress and exchanged experiences. It renewed the commitment to the Kampala Declaration and the Agenda for Global Action.

The task now is to take the momentum from Bangkok out into the wider world: to move together, from commitment into action, to translate resolution into results, and ensure that every person, whoever they are and wherever they live, has access to a health worker.

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The Second Global Forum on Human Resources for Health 2011: Conference Programme

<table>
<tr><th colspan="8">Tuesday 25 January 2011</th></tr>
<tr><td>09:00-18:00</td><td colspan="7">Side meetings/skill building workshops</td></tr>
<tr><td>18:30-20:00</td><td colspan="7">Reception & Launch of the KD AGA report and the UA report</td></tr>
<tr><th colspan="8">Wednesday 26 January 2011</th></tr>
<tr><td>07:00-18:00</td><td colspan="7">Field visits</td></tr>
<tr><th colspan="8">Thursday 27 January 2011</th></tr>
<tr><td>09:00-10:30</td><td colspan="7">Opening Session & Key note Address</td></tr>
<tr><td>10:30-11:00</td><td colspan="7">Break</td></tr>
<tr><td>11:00-12:30</td><td colspan="7">Plenary session 1: From Kampala to Bangkok: Marking progress, forging solutions</td></tr>
<tr><td>12:30-14:00</td><td colspan="7">Lunch</td></tr>
<tr><td>14:00-15:00</td><td colspan="7">Plenary session 2: Have leaders made a difference?: how leadership can show the way towards the MDGs?"</td></tr>
<tr><td>15:00-15:30</td><td colspan="7">Break</td></tr>
<tr><td>15:30-17:30</td><td>1. Coherent leadership for health workforce solutions</td><td>2. Serving in the frontlines: personal experiences and country strategies for retention of HRH in rural areas</td><td>3. Will the WHO Global Code stop the brain drain? What will it take to succeed?</td><td>4. Do GHIs contribute to equity in access to HRH?</td><td>5. Economic fluctuations, universal health coverage and the health workforce</td><td>6. Overcoming HRH crisis in conflict and post-conflict situations</td><td>7. High Level Roundtable: Working together for health workers (Private Meeting)</td></tr>
<tr><td>18:00-20:30</td><td colspan="7">Welcome Dinner</td></tr>
<tr><th colspan="8">Friday 28 January 2011</th></tr>
<tr><td>09:00-10:00</td><td colspan="7">Plenary session 3: Professional Education for 21st Century</td></tr>
<tr><td>10:00-10:30</td><td colspan="7">Break</td></tr>
<tr><td>10:30-12:30</td><td>8. Building Capacity to Translate HRH Evidence into Action to Sustain HRH Policy, Decisions and System Strengthening</td><td>9. Innovative solutions for strengthening HRH information systems</td><td>10. Scaling up HRH towards equity</td><td>11. Seeking the stamp of good quality? Imperatives of HRH regulation and accreditation</td><td>12. Financing health worker education and training</td><td>13. Dedicated Spirit: The Charm and Charisma of HRH</td><td>14. The UN Secretary General Global Strategy for Women's and Children's health: will anything be done about the workforce?</td></tr>
<tr><td>12:30-14:00</td><td colspan="7">Lunch</td></tr>
<tr><td>14:00-15:00</td><td colspan="7">Plenary session 4: Making HRH Innovation Work for Strengthening Health Systems</td></tr>
<tr><td>15:00-15:30</td><td colspan="7">Break</td></tr>
<tr><td>15:30-17:00</td><td>15. Building capacity to generate evidence in HRH action oriented research</td><td>16. Innovative education and training for HRH</td><td>17. HRH situation and trend in developed countries and their potential implications to developing countries</td><td>18. Trade in health services and impact on HRH</td><td>19. Self reliance to health and well being through local resources and knowledge</td><td colspan="2">20. Skills mix to achieve universal access to essential health care: a family health worker in every village?</td></tr>
<tr><th colspan="8">Saturday 29 January 2011</th></tr>
<tr><td>09:00-10:30</td><td colspan="7">Synthesis: summary conclusion & next steps</td></tr>
<tr><td>10:30-11:00</td><td colspan="7">Break</td></tr>
<tr><td>11:00-12:30</td><td colspan="7">Closing session of the 2nd Global Forum</td></tr>
<tr><td>12:30-14:00</td><td colspan="7">Lunch</td></tr>
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Provisional Conference Program as of 1 December 2010

2nd Global Forum on Human Resources for Health
Prince Mahidol Award Conference 2011
Provisional Conference Program

1. Background

In accordance with the Kampala Declaration (KD), the Agenda for Global Action (AGA) is built around six fundamental and interconnected strategies, based on previous actions and commitments. The AGA is a synthesis that specifically highlights challenges and the need for change which reflects the essential continuum of planning, training, deployment and retention. The purpose of AGA is to translate political will, commitments, leadership and partnership into effective actions.

The six interconnected Strategies are:

1. Building coherent national and global leadership for health workforce solutions
2. Ensuring capacity for an informed response based on evidence and joint learning
3. Scaling up health worker education and training
4. Retaining an effective, responsive and equitably distributed health workforce
5. Managing the pressures of the international health workforce market and its impact on migration
6. Securing additional and more productive investment in the health workforce

Almost three years of implementation of policy and strategies have passed, these having been adopted by the Kampala Declaration at the first-ever Global Forum on Human Resources for Health, which was held on 2-7 March 2008 in Kampala, Uganda. In addition, there are a number of World Health Assembly Resolutions and WHO Regional Committee Resolutions which call for immediate action to solve this global crisis.

The 2nd Global Forum on Human Resources for Health will be held on 25-29 January 2011, in Bangkok, Thailand, in collaboration with the 2011 Prince Mahidol Award Conference. The overall objective is to accelerate the global movement on HRH towards achieving the Millennium Development Goals and universal access to essential health care. In addition, it was agreed at the joint planning workshop among the co-hosts of the Forum on 3-4 December 2009, that the Global Forum will be a combination of technical and policy elements while also focusing on evidence-based actions, existing gaps and how to overcome them. It is the intention of the conference to be crafted along the line of the KD and six strategies of the AGA. It is envisioned that the deliberations will review the development and progress made, and identify challenges met in mitigating global HRH crisis. It should be organized to best support of global movements towards better HRH to achieve universal coverage.

Countries are the indispensable players in solving the human resource crisis, thus, priority shall be given to engage speakers and participants from countries to share experiences and lessons

learned. Speakers from international development partners should also play a role in terms of sharing policies and strategies at the international and global levels which have an impact on implementation at the country level. The ratio of country to international partner speakers is proposed to be 3:1.

2. Theme of the forum

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

3. Structure of the Main Conference Program

The 2nd Global Forum on HRH / Prince Mahidol Award Conference 2011 will have 5 main activities, including:

- Side meetings,
- Capacity building workshops,
- Field visits,
- Marketplace,
- Main conference program.

The main conference program consists of the Plenary and Parallel sessions, in addition to the opening, closing and official dinner sessions. The proposed content of the sessions is based on the structure and contents of the Kampala Declaration (KD) and the Agenda for Global Actions (AGA), as well as the results of the on-line survey carried out by GHWA.

4. Conference Program

Tuesday 25 January 2011	
09.00 – 18.00	Side meetings / Skill building workshops (Please see details of side meetings and skill building workshops in item 5)
18.30 – 20.00	GHWA Reception and Report Launch
Wednesday 26 January 2011	
07.00 – 18.00	Field trip 1. Wat Pra Baht Nam Phu: The Buddhist Temple that Cares for Full-blown AIDS Patients 2. Pra Nang Klao Hospital: Humanized Health Care Volunteers 3. Phnomsarakam Community Hospital: Pay for Performance to Increase Job Satisfaction and Retention 4. Ban Paew Hospital: The First and Only Autonomous Hospital in Thailand 5. Uthong Hospital: Combination of Conventional and Alternative Medicines 6. Taladjinda Health Center and Sampran Hospital: Community Participation Siriraj Hospital: The Role of Medical School in Developing Human Resource for Health
Thursday 27 January 2011	
09.00 – 10.30	**Opening Session & Key note Address**
10:30 – 11.00	Break

Provisional Conference Program as of 1 December 2010

11.00 – 12.30	**Plenary session 1: From Kampala to Bangkok: Marking progress, forging solutions**
12.30 – 14.00	Lunch
14.00 – 15.00	**Plenary session 2: Have leaders made a difference?: how leadership can show the way towards the MDGs?**
15.00 – 15.30	Break
15.30 – 17.30	**Parallel session 1:** Leading towards health workforce development at country level: what will it take? **Parallel session 2:** Serving in the frontlines: personal experiences and country strategies for retention of HRH in rural areas **Parallel session 3:** Will the WHO Global Code stop the brain drain? What will it take to succeed? **Parallel session 4:** Do GHIs contribute to equity in access to HRH? **Parallel session 5:** Economic fluctuations, universal health coverage and the health workforce **Parallel session 6:** Overcoming HRH crises in conflict and post-conflict situations **Parallel session 7:** High Level Roundtable: Working together for health workers (by invitation)
18.00 – 20.30	Welcome Dinner hosted by the Royal Thai Government
Friday 28 January 2011	
09.00 – 10.00	**Plenary session 3: Professional Education for 21st Century**
10.00 – 10.30	Break
10.30 – 12.30	**Parallel session 8:** Building Capacity to Translate HRH Evidence into Action to Sustain HRH Policy, Decisions and System Strengthening **Parallel session 9:** Innovative solutions for strengthening HRH information systems **Parallel session 10:** Scaling up HRH towards equity **Parallel session 11:** Seeking the stamp of good quality? Imperatives of HRH regulation and accreditation **Parallel session 12:** Financing health worker education and training **Parallel session 13:** Dedicated Spirit: The Charm and Charisma of HRH **Parallel session 14:** The UN Secretary General Global Strategy for Women's and Children's health: will anything be done about the workforce?