	Bangladesh	China	Laos	Myanmar	Sri Lanka	Vietnam
						investment of CHC in hardship areas
13. Outreach support		Counterpart technical assistance between urban and rural areas	Supportive supervision to MNCH activities at District and health center			MOH Decision 1816/2008, staffs from higher to lower level support clinical services, also staffs from district to provincial hospital for clinical skill, but mostly from higher to lower levels.
14. Career development program		N/A		National health plan		Not specific
15. Professional networks		N/A	Medical association, specialist association, MOH website	National health policy	Very few professions have established networks for the benefits of their workers	No
16. Public recognition measures		Annual award for Excellent Village Doctor	National health worker award and Community health worker award	Public as well as private sector, regulations, Myanmar medical council law		NO

Annex 2 The key sets of policies selected for further assessment

selecting key policies	Bangladesh	China	Laos	Myanmar	Sri Lanka	Vietnam
A. Education						
1. Students from rural backgrounds			✓		✓	✓
2. Health professional schools outside major cities						
3. Clinical rotations in rural areas during studies						
4. Curricula that reflect rural health issues						
5. Continuous professional development		✓				✓
B. Regulatory						
1. Enhanced scopes of practice						
2. Producing new types of health workers						
3. Compulsory service in a rural area		✓	✓	✓	✓	
4. Subsidized education for return of service				✓		
C. Financial Incentives						
1. Appropriate financial incentives		✓	✓	✓		✓
D. Professional/personal support						
1. Better living condition					✓	
2. Safe and supportive working environment						
3. Outreach support		✓				
4. Career development programmes						
5. Professional networks						
6. Public recognition measures						

Note:

1. These policies were prioritized based on the agreement in the AAAH protocol development workshop, April 18th -19th, 2012 in Bangkok. Criteria for selection vary with regards to each country's policy demand. (See more detail in the country specific proposal)

2. Notably, in some policy domains, there can be a number of relevant specific policies. For instances, a case from Vietnam shows that in policy domain, C1 Financial incentives, there are at least three specific policies i.e. Decree 64/2006, Decision 75/2009 and Decree 54/2011. In this case, in the in-depth assessment process, the Vietnamese team will synthesize all these three policies together under the umbrella of C1 domain.

3. Some policies are a mixture of different policy domains. For instance, the compulsory rural service of new medical graduates upon graduation in Laos (health personnel development strategy by 2020 495/PM/2010) encompasses B3, A3 and A1 domains, or, the program in upgrading medical assistants to doctors in Vietnam will be assessed under the A1 and A4 domain. (See more detail in the country specific proposal)

4. Tentative policies that will be analyzed further across countries are:

    - A1- Students from rural background
    - A5- Continuous professional development
    - B3- Compulsory service in rural areas
    - C1- Appropriate financial incentives

Annex 3 In-depth assessment of three selected policies aiming at retaining health workforce working in rural, remote or areas where health workers are most needed.

Three selected policies	Assess the problem stream: Why these policies emerged?	Assess the policy formulation processes: How different actors, in what context, exert their powers, defending their position and influencing the final policy decision?	Analyze the policy contents: Did the intervention respond to the problem stream and guided by evidence? Is it feasible, acceptable and effective in solving problems?	Analyze implementation: How policies was implemented, scope, responsible agency. Are policy communications effective, relevant? Stakeholders engagement ensuring acceptability? Resource adequate to support implementation? Political, financial commitment? M&E system? Indicators for measuring progresses?	Outcome assessment: What are main outcome? in line with objectives, targets achievable? Deviation and unintended outcomes? Increased number of health workers staying in rural areas, mean duration of stay in rural post, turnover rates, unfilled post rate, health workforce density urban versus rural; job satisfaction of rural health workers, patient satisfaction, improved coverage of health services.
Policy one: describe the policy					
Policy two: describe the policy					
Policy three: describe the policy					

Annex 4 Objectives and methods modified by countries

Country	Objectives	Methods
Bangladesh	-	-
China	To guide China MOH to take further action on interventions of HRH rural attention.	Will be filled in later
Laos	-	-
Myanmar	-	-
Sri Lanka	To identify different incentive packages used by the public sector and recommend them for attraction and retention of doctors to rural areas in Sri Lanka (merged in to the common objective 3)	Will be filled in later
Vietnam	-	-

Annex 5 Request capacity support

Bangladesh	-
China	-
Laos	Consultant for policy analysis from AAAH
Myanmar	-
Sri Lanka	-
Vietnam	-

References

1. Gilson, L., et al., *Using stakeholder analysis to support moves towards universal coverage: lessons from the SHIELD project.* Health Policy and Planning, 2012. **27**(suppl 1): p. i64-i76.
2. Gilson, L., *Health Policy and Systems Research: A methodology Reader*. 2012: The World Health Organization and Alliance for Health Policy and Systems Research.

The Emerging role of Private Health Professional Schools in the Asia Pacific Region

19th April 2012

Background

The scope of this study covers six countries in the AP region which are members of AAAH: Bangladesh, Indonesia, Mongolia, Sri Lanka, Thailand and Vietnam.

Synthesise background situation on the size of public and private health professional schools and discuss nature of policy concerns: such as standard and quality of curriculum and training, public health competency and skills in response to health need of the country.

The situation in the six countries mentioned above are extremely diverse. The Sri Lankan market is experiencing a shortage of both doctors and nurses; the training of nurses is heavily dominated by the state sector with no formal mechanism for overseeing the production of nurses in the private sector, and no private medical training at all. By contrast in Mongolia there is a problem of overproduction of doctors, but a shortage of nurses and a shortage of trainee nurses. This imbalance is being worsened by the private healthcare education institutions which make upon 80% of the market but prefer to recruit trainee doctors rather than trainee nurses because they generate more income, for a longer period of time.

Bangladesh is experiencing an enormous and rapid expansion of private healthcare education provision. This has seen an increase of 65% in the number of private medical schools, a 240% increase in the number of private nursing schools, and a 300% increase in the number of private medical assistant training institutions in the period 2009-2012. Despite all of this Bangladesh still has a chronic shortage and imbalance of healthcare workers with almost twice as many doctors as nurses. Indonesia has a comparatively long history of private healthcare education and almost twice as many more private, than public, healthcare training institutions. Despite this long-term experience of private provision the market has failed to provide sufficient new healthcare workers, for example Indonesia has a proportion of only 4 doctors per 10,000 population, and the existing healthcare works are unevenly distributed.

Vietnam faces both a serious shortage of nurses in relation to doctors and a serious overall shortage of healthcare professionals. While there are private healthcare education institutions they still make up a comparatively small but developing part of the market. Thailand has a comparatively healthy balance between numbers of doctors and nurses but is having to adjust to the increasing role of private healthcare education institutions and changes brought about by the impending launch of the ASEAN Economic Community and its role as a hub for medical tourism.

These countries are also all being impacted, to a greater or lesser extent, by new trends of international migration, both inward and outward, of both healthcare workers and patients. These six countries are experiencing very different circumstances but share a common interest in gaining a better understanding of the ways in which private healthcare education institutions can contribute to proving a healthy supply and balance of healthcare workers.

Scope of study

	Medical schools	Nursing schools	Medical Assistant Training Schools
Bangladesh	✓	✓	✓
Indonesia	✓		
Mongolia	✓	✓	
Sri Lanka		✓	
Thailand		✓	
Vietnam		✓	

Goals

To better understand the role, and strengths and weaknesses, of private health professional schools in the context of the existing public schools. This aims to contribute to evidence-informed policy-making ensuring the best use of private institutions in the training of human resources for health.

Objectives: cross country

With these similarities, differences and related research interests, a common set of objectives emerge to facilitate inter-country learning across six countries in the Asia Pacific region, who are all members of the AAAH: Bangladesh, China, Mongolia, Sri Lanka, Thailand and Vietnam.

It should be noted that in assessing the emerging role of private health professional education, comparisons with the public education institutes are unavoidable.

These shared objectives are as follows:

At the national level, to assess and compare, over the period between 1990 and 2010, the following themes:

1. The number of public and private health professional education institutions and their production capacity, enrolments and graduates (including vacancy, attrition and completion rate where data allows, or ask this parameter where data is not available and survey is decided).

2. The contextual environment for public and private health professional production and distribution in terms of (a) demand for health workforce in relation to growth in GDP, population and ageing, (b) the socio-political, regulatory and policy environment ensuring that the health workforce serves the population's health needs and expectations, (c) public/private domestic health workforce demand, and (d) international outward migration of the health workforce and inward migration of patients.

In a selected sample of public and private health professional schools, to assess and compare the following from:

3. The Institutes: Their sources of financing, (budget, tuition fee charged to students, research grants, post-grad training programs); number, qualifications,

and turnover of teaching staff; curriculum, training, accreditation and quality assurance; student recruitment modalities; and exposure of students to rural community health issues.

4. Final Year Health Professional Students: their background, recruitment modalities, study experience, source of financing, and employment intention on graduation and in five years' time.

Summary objectives and engagement by countries

Objectives	BAN	INDO	MON	SLR	THA	VNM
1. Assess and compare trend in number of public and private schools and their production capacities	✓	✓	✓	✓	✓	✓
2. Assess the policy context and other relevant environments	✓	✓	✓	✓	✓	✓
3. To assess the schools resources, curriculum, training modalities and student recruitment.	✓	✓	✓	✓	✓	✓
4. To assess job preference of the last year students about to leave the school	✓	✓	✓	✓	✓	✓

Objectives: country specific

In addition to cross country, a country specific objective should address its specific policy concern.

Bangladesh: Will consult -- may put to enhance the recognition of the undervalued professionals (nurse)
Indonesia: Will consult
Mongolia: No country specific objectives
Sri Lanka: No country specific objectives
Thailand: No country specific objectives
Vietnam: No country specific objectives

Methods: cross country

To respond to cross country objectives, the following methods were planned.

For objective one-- This includes review and analysis of existing relevant secondary data on chronological trends in the number of ALL public and private health professional schools including their production capacity (including number of enrolment and graduate) in the period 1990-2010 where data is available [in particular the most recent data from 2010]; geographical distributions of these schools should be provided: This can be plotted into a map. If there is no good historical data, a census survey of all institutions is recommended. From this analysis, researchers should assess and recommend how to improve the national HRH Information Systems and identify opportunities for future development.

For objective two--qualitative and quantitative methods are applied; these include the review of literature, synthesis of essential secondary data, in-depth interviews and focus group discussions where appropriate; evidence gathered from literature reviews and different key informants should be triangulated and verified to compare and contrast. Key informants should be identified from the most relevant and knowledgeable individuals in the field, or through use of the snowball referral technique; this will include the policy makers and regulators such as Government, MOH, MOE, professional councils; the public and private universities who are regulated; public and private organisations who employ graduates; representatives from student body, civil society organizations.

Analytical plans: for quantitative data, means and trend will be produced, for qualitative data, content analysis and quotations will be used.

Specifically the following indicators would be addressed:

Objective		Indicators	Data sources
2a	GDP PPP$ per capita growth between 1990 and 2010	% real term growth	WDI
2a	Demographic	% ageing population (>60yrs) % growth of population	WDI, PRB (Pop ref bureau), UNFPA
2b	The socio-political, regulatory and policy environment ensuring that the health workforce serves the population health needs and expectations,	Review of policy documents from different sectors: economy, health, employment, education as well as trade agreements, professional councils. Followed by assessment of how these policies were interpreted and implemented. Efforts should be given to assess the effectiveness of regulation/enforcement, identify gaps and the reasons they appear.	Interviews of key informants, convene focus group discussions where appropriate
2c	Domestic public and private demand for health workforce 1990-2010	Doctor, nurse density per 1,000 population, Number of public hospital beds Number of private hospital beds Number of private clinics (Where data is available)	National statistics
2d	Outward migration of health workforce and inward migration of patients 1990-2010	Number of doctors and nurses migrating out of the country Number of expatriate patients treated in-country	National statistics MOH records of outward migration Qualitative assessment by KI

For objective three--a sample of public and private medical/nursing schools have been selected, see matrix below. Qualitative method is applied; this includes the institutional assessment, jointly conducted by teachers and researchers; review of relevant documents, in-depth interviews and focus group discussions with key informants. Short and precise issues to be investigated are for example:

	Scope: the last 5 years where data is available	Data source
Sources of finance	Total in NCU and percentage distribution between different sources: budget, tuition, grants and other sources	Review of institutional financial records
Teaching	• Number by qualifications (Bachelor, Master,	Reviews of

staffs	PhD), Full time and part time arrangement • Staff turnover rate = number of staff leaving divided by total number of staff in a year, where did they go? • Dual teaching in public and private institutions • Staff incentives (career development, financial/nonfinancial incentives) and retention strategies, trend of expansion or contraction? • Teaching experiences, years	Institutional records
Curriculum and training	<u>Review curriculum</u>: • Weeks/hours student exposure to rural community health services, PHC, patient communication training, • What are the core-competency requirements and what are the modes of assessment? • Are public health topics covered in the curriculum? If yes, how intensively (hours/week) <u>Review training modalities</u> • Affiliation with other clinical sites for training: whom, how to select, for what? • Inter-professional training, describe…	Review of curriculum and interviews of key informants
Quality and accreditation	• If any external accreditation processes, by whom (professional councils, MOE) what is being assessed (school facilities, infra-structure, teaching staff), what are the results?, frequency of re-accreditation? • Describe the QA mechanism (internal / external/ student/ alumni/ users) regularity, results and who to use for improvement	Reviews of documents and interviews of key informants
Student bodies	• Percent distribution of various modes of recruitment? • Competency of rural students and provision of special tutorials for them? • Completion rate between normal stream and special recruitment stream students? • Student requirements for admission • Percentage of total students having obligations to complete mandatory rural services? • Origin of students enrolled: rural background, ethnic groups, gender? • Percentage of student paying tuition fees in public universities (ie. private wings in public university)	Reviews of documents and interviews of key informants

	Sampling methods	Sample size
Bangladesh	Stratified random sampling For Medical: Total 75 (public 22, private 53) For Nursing: Both diploma and bachelor: total 115 (public 59, private 56) For Medical Assistant Training Schools:	X % of total population

	Total 96 (public 8, private 88)	
Indonesia	Total 72 medical faculties (28 public, 44 private), two stage stratified random sampling methods	Tentatively 2 public (old and young) and 2 private medical (old and young) faculties
Mongolia	All 4 private and 1 public universities are enumerated (census)	4 Private nursing and 3 private medical colleges
Sri Lanka	Total 27 nursing schools (12 public MOH, at least 15 private) Non-proportional probability to size random sampling methods, less public and more private nursing colleges,	3 Public nursing MOH colleges, Around half of private nursing = 8 colleges
Thailand	Total 60 which have had at least 2 batches of alumni (Public MOH 29, Public U 17, Private 14) Two stage stratified random sampling, 5 geographical regions, 3 categories (Public MOPH, Public Universities, Private Universities)	Total 40 Nursing Schools: 13 Public Universities, 15 MOH schools, 12 private schools
Vietnam	Total nursing schools xx (public X, private 5) 2 purposive selected from (mountainous, Red River Delta) total 5 private nursing colleges (largest number of graduates) 4 comparable public nursing colleges will be selected	2 private, 2 public nursing colleges, + 2 public universities

For objective four-- a self-administered questionnaire survey will be applied among the final year health professional students who are about to graduate from the Education institutes identified in objective 3. In addition to socio-economic characteristics of students, the assessment includes rural attitudes, their immediate job preferences and job intentions 5 years in the future.

APPLY 5C common questionnaire, sharing with all partners, including electronic recognized questionnaire and software tools.

Due to the fact that the academic year is different in each country, interviews will be conducted with final year health professional students in the early or middle part of the final semester of their final year.

Methods: country specific

Bangladesh: Will consult -- may put to enhance the recognition of the undervalued professionals (nurse)
Indonesia: Will consult
Mongolia: No country specific objectives so consequently no country specific methods.
Sri Lanka: No country specific objectives so consequently no country specific methods.
Thailand: No country specific objectives so consequently no country specific methods.

Vietnam: No country specific objectives so consequently no country specific methods.

Budget

An indicative budget would be, US$ XXX.

Expected outcomes

A better understanding of the contributions of public and private health professional education institutions to health system development will be reached. This will be understood in the light of the ongoing contextual environment in particular government policies, economic situation, increased demand for health personnel at country, regional and global levels and in some case, the regional free trade agreements, public and private employment opportunities. With this better understanding, and the joint assessment by the schools and outside researchers, it is hoped that this study will result in positive reforms and policy coherence in response to the health needs of the population among different policy actors in health professional education.

DRAFT

WHO initiative on transforming and scaling up health professional education and training

Report of the second meeting of the core guidelines development group

The Pan American Health Organization, Regional Office of the World Health Organization

20-22 March 2012

Washington DC, USA

CONTENTS

1 BACKGROUND

Severe shortages of health professionals have left millions of people without access to appropriate health services. Estimates indicate that in 2006, an additional 2.4 million doctors, nurses and midwives were needed. Focusing on the workforce shortage alone will not resolve the crisis. In many settings, both rich and poor, the education of health professionals has been isolated from health service delivery needs and has not adapted to match rapidly changing population health needs.

Systematic failures in health professional education and training include: the mismatch of health professional competencies to population and local health needs; poor teamwork and weak leadership, including leadership for health system performance; the preference for a hospital focus which dominates over the needs of primary care; health worker and gender imbalances; and professional silos or segregation.

More health professionals are therefore needed, but not more of the same. A transformation of health professional education should put population health needs and expectations at the centre and should be directed by the reality of health service delivery. This is the focus of the guidelines that are being developed by the WHO initiative on transforming and scaling up health professional education and training.

The preparation of the guidelines process began in 2009 with an extensive scoping of the literature on health professional education, gathering expert opinion through the formation of a large reference group that met three times in 2010, and building consensus that culminated in the first meeting of the core guidelines development group in Divonne, France in May 2011. The guidelines are being developed in parallel with a strong implementation platform with the Medical Education Partnership Initiative (MEPI), the Nursing Education Partnership Initiative (NEPI), PEPFAR, and other partners. In addition, the secretariat is engaging additional multi-sector stakeholders and civil society to galvanize support for a global advocacy movement around the need for health professional education and training reform.

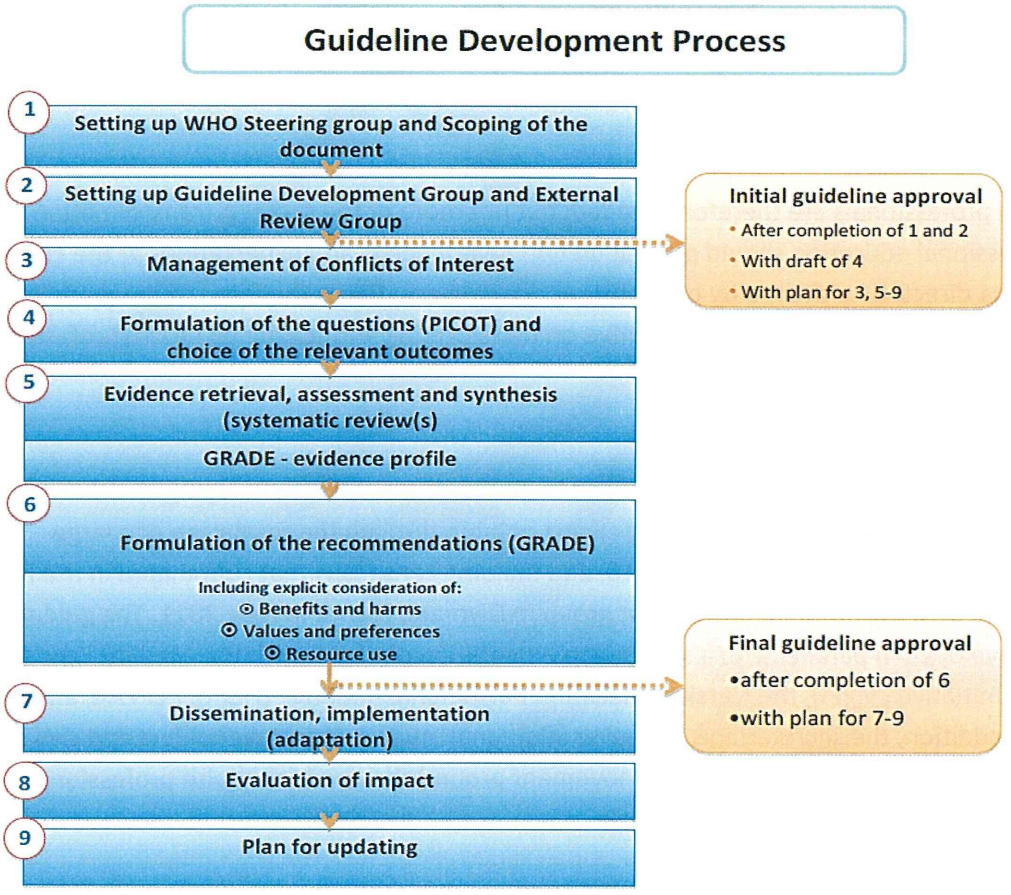
The WHO guideline development process

A WHO guideline is any document that contains WHO recommendations about health interventions, whether clinical, public health or policy. A recommendation provides information about what policy-makers, health-care providers or patients should do. It implies a choice between different interventions that have an impact on health and that have ramifications for resource use.

The process of developing WHO guidelines encompasses synthesis of all available evidence; formal assessment of quality of evidence; consideration of resource use and costs; and consideration of values and preferences. The formal assessment of quality of evidence includes the use of a transparent system for assessing evidence and rating recommendations following the GRADE methodology. This process links evidence to recommendations and explains the reason that

judgements were taken at each step along the way. By design, the process is steered by the WHO secretariat with the support of the core guideline development group that includes content experts for specialties involved, methodologists and representatives of potential stakeholders and that maintains a geographic and gender balance.

The figure below highlights the ten-step process for developing WHO guidelines.



The second meeting of the group was called to address step number 6 above.

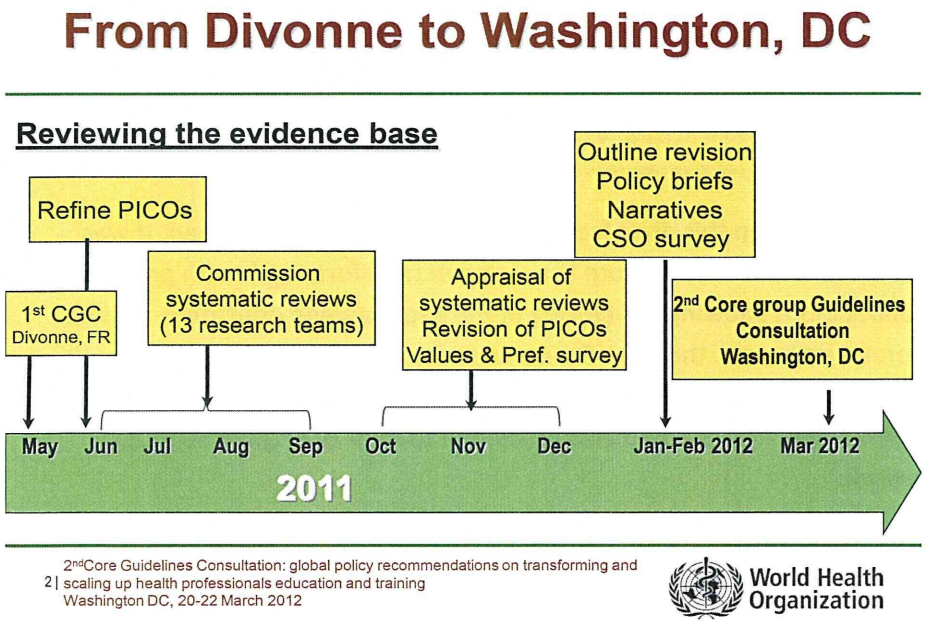
Within this process of WHO guideline development, the role of the core guidelines development group is:

- to advise on the priority of questions and scope of the guideline;
- to advise on the choice of important outcomes for decision-making;
- to comment on the evidence used to inform the guideline;
- to advise on the interpretation of evidence, with explicit consideration of the overall balance of resource use, values and preferences, benefits and risks;

- to formulate recommendations, taking into account diverse values and preferences according to GRADE.

2 INTRODUCTION TO THE SECOND MEETING OF THE CORE GUIDELINES DEVELOPMENT GROUP

This report is a summary of the second meeting of the core guidelines development group (the Gore Group), which took place 20-22 March 2012 at the Pan American Health Organization, Regional Office of the World Health Organization in Washington DC. After the opening remarks, the first task was to review progress since the Core Group first met in Divonne, France in May 2011. As illustrated in the figure below, the PICO questions were refined and a number of systematic reviews were commissioned. After these were received and assessed by the WHO secretariat to determine the quality of the evidence, the secretariat decided to revise some of the PICO questions and to reduce the total number of questions from 50 to 25 by reformulating them. This was done in collaboration with the Core Guidelines Group. The final set of PICO questions was proposed by a small working group which was a subset of the Core guidelines Group. The PICO questions were then shared with the full core group by email, together with the revised outline of the guidelines, which included the definition of transformative scale up of education and training that was formulated during the May meeting. On receipt of the evidence from the systematic reviews, in order to compensate for the lack of available research evidence for some of the PICO questions for the outcomes of interest (quantity, quality and relevance), the secretariat looked for additional evidence and provided the Core group with policy options (in the form of policy briefs) and literature reviews. The link to the WHO guidelines on the retention of health workers in remote and rural areas was also seen as important, as was the use of evidence from the values and preferences survey that had already been commissioned.



The objectives of the second Core Group meeting were:

- to achieve consensus on the main products of the initiative (global recommendations and policy options);
- to review the findings from the systematic reviews and other evidence gathered;
- to finalize decision tables and agree on draft recommendations;
- to decide on next steps for finalizing the recommendations;
- to discuss strategies for launching and translating the recommendations into action.

The draft implementation framework shown in the table below was developed to be used as a point of reference during discussions on drafting the recommendations and policy options; to facilitate an understanding of how the recommendations relate to the outcomes of interest; and to provide a decision-making framework at country level and for partners and donors.

GOVERNANCE and IMPLEMENTATION • Political commitment and leadership • Formal collaboration and shared accountability between MOH and MOE • Alignment of education plan with HRH and health systems national plans • Strengthen HRH information systems • Platforms for implementation					
	PRE-ENROLLMENT	**STUDENTS**	**PRACTITIONERS**	**FACULTY**	**INSTITUTIONS**
EDUCATION	• Preferential selection of students from underserved background (Q,q,R) • *Barriers to access higher education (R)*	• Competency-based curriculum/curriculum reforms (q,R) • Ladder education programmes (q,R) • Inter-professional education (q,R) • Use of ICT, simulation methods (q,R)	• Continuous professional development (CPD) (continuous medical/ nursing education) (q,R) • Specialization/ residency programmes (q,R)	• Roles of Teacher (q,R) • CPD (q,R)	• Infrastructure (books, teaching materials) (q,R) • Location of schools closer to services/ community-based education/integrate education with practice (R)
REGULATION	• Admission criteria (Q,q,R)	• Compulsory service - bonding (Q)	• Certification/ Licensing (q,R) • Scope of practice (q,R)	• Career paths (q,R)	• Accreditation (Q,q,R) • School governance (q,R)
FINANCING		• Scholarships, loans, grants (Q)	• *A practice/ management issue, not relevant for education system*	• Systems of recognition and rewards (q,R)	• Sources of financing • Partnerships

Table 1. Mapping of the recommended interventions to improve the education of health professionals
NOTE 1: Q= quantity; q=quality; R=relevance
NOTE 2 : *italics means issues not covered by the original systematic reviews and PICOs*

Based on feedback from the Core Group this draft framework will be further developed. It was suggested that an attempt could be made to capture the vision of transforming health professional education and to add feedback loops showing the closing of the gap between education, service delivery and practice. Several members of the Core Group were unclear about the decision-making process that cut the number of PICO questions from 50 to 25 and requested that this be explained in more detail. In addition, some suggested it would also be helpful to map all original 50 PICO questions on to the framework.

3 Summary of working group presentations and discussions

After a presentation reviewing the Grade methodology and the process for completing the decision tables and the recommendations, participants split into small groups whose work was then