as resources to formulate evidence-based policy and strategies on health professional education. That is necessary to bring about educational reforms for health professions. The merit of forming a network among like-minded countries can be found in the fact that each country can learn from each other good practices. ANHER could work as an indispensable knowledge base for evidence based policy making and furthermore could provide a momentum to facilitate the process of health educational reforms in each country. It would be important to identify such core problems as they could probably be the essential factors that we need to look at in transforming health education.

Professor Wanicha Chuenkongkaew

The scientific, social and economic changes transforming the healthcare environment. Survey of the just about to leave students and in service graduates was also conducted to assess their attitudes towards working in rural areas, job preferences and competencies. In Thailand, the initial phase of these situation analyses focused only on medical and nursing professionals. There were four main components of this situation analysis: a national level analysis, institutional, survey of medical nursing student who were just about to graduate and the graduate survey for medical doctors and nurses on attitudes on working in rural, remote or hardship areas.

Dr. Bipin Batra

Medical, nursing & public health education in India

Allopathic physicians are highly concentrated in urban (13.34) as compared to rural (3.28) areas. Nurses and midwives density is skewed between urban (15.88) and rural (4.13) areas. There is deficiency of public health specialists. Private to public school ratio in surveyed medical schools was 3:5. Inadequate emphasis on curriculum related to: health policy, comparative national health systems, health equity etc. Majority alumni preferred their first employment in the health services rather than academia, public sector rather than private sector jobs, employment in urban rather than rural areas.

Graduates preferred work place public academia, followed by health service in public sector and health service in private hospital and going abroad. Councils for medical and nursing education should proactively engage in advancing the reforms agenda. A dedicated expert group should be created to advance the agenda of competency-driven education for health professionals in the country.

Dr. Hou Jianlin

Nursing graduates: Attitude, competency and job transition across 5 Asian Countries

Self-administered questionnaire survey of nursing graduates in Bangladesh, China, India, Thailand, Vietnam was conducted. The following were the major findings of the survey: the importance of working in rural/remote/hardship areas was well recognized, lack of supporting environment and amenities and entertainment in rural/remote/hardship areas was a major concern, generally nursing graduates were confident with their competencies, nursing graduates with rural background are more likely to work in rural/remote/hardship areas, job transitions mainly occurred within private or public sectors, urban areas or rural/remote/hardship areas.

The survey revealed that of the 3500 nurses across the five countries, 25% wanted to go abroad after finishing their graduation. The ratio was high at 34% in India and at 11% in China. Thus, the country and its regulatory framework can influence the perception of its HRH on taking up further avenues in professional life. Another policy prescription for the governments could be to encourage recruitment of health workers from rural areas as retention is certainly better.

Dr. Pham Viet Cuong

Assessment of health professional education in Vietnam

Policies to expand the network of health science training system: upgrade infrastructure of universities, open universities outsides major cities, increase training quota.

Policies to recruit students from remote/disadvantaged areas: nominated student from ethnic group, target enrollment of medical students, scholarship for students from remote areas. Process: Policies to raise the quality of the health workforce through improving quality of pre-services and in services training: frame curriculum program for university degree, guideline on accreditation, continuing medical education. Output: policies for recruiting/ maintaining human resources for remote/rural areas, financial incentives for health staffs in remote/difficult areas, term based working in disadvantage areas.

Health Professional Education Reform activities in Vietnam: assessment results have been disseminated in meetings, seminars and workshops in Vietnam. Reports are submitted to Ministry of Health, and other stakeholders. May 6, 2014 World Bank and Government have approved a US$121 mn project for the Health Professionals Education and Training for Health System Reforms in Vietnam. The project will be implemented from 2014-2020.

Dr. Ahmed Al Kabir

Situation of Health Professional Education in Asia-Pacific: A case study of Bangladesh

The study assesses the situation of medical, nursing and public health professional education in Bangladesh. Both qualitative and quantitative data are collected from policy makers, program managers, academicians, graduates and under-graduate students. Uniform process and criterion are practiced for admission in all public and private medical colleges. The curricula are developed on the basis of client and community need, but it is over-burdened with content, mostly following the old learning paradigm of "memory" based, lecture-oriented approach. All public Diploma and B.Sc. nursing institutes follow a National Plan of Action for regulation of nursing education developed by directorate of nursing services, but it is not mandatory for the private nursing institutes to follow it. Additionally, there is shortage of qualified faculty and logistic deficiencies like books appropriate for curriculum. The public health education is less regulated and less defined in comparison with other medical and nursing education. The public health institutes are under the governance of MOHFW while the private universities are regulated through Private University Act, 2010. There is no unique accreditation body for public or private Masters of Public Health (MPH) programs. The curricula for public and private institutions are also not similar. However, all public MPH programs have started working under the umbrella of Bangabandhu Sheikh Mujib Medical University (BSMMU) using unified entrance examination and following a single curriculum.

Conclusion

Dr. Pak Tong Chol, the chairman , opine that in case of Bangladesh where capacity for health education is predominantly with private sector, regulation from government authorities becomes critical.

Professor Wanicha Chuenkongkaew : there is the need of a link between policy maker and policy movement.

Recommendation

Dr. Pak Tong Chol, the chairman

1. Most plans are under tables. The consultation with policy maker is very important. 'No more talk, no more guideline, but action.'
2. Encouraging health workforce to work in rural, remote or hardship area.
3. There is a need to incorporate public health curriculum into the training module for doctor, nurses, etc, to give them an orientation in public health practices and not just clinical exposure.

Parallel Session VII

Health professional education reform: ANHER movement

Potential moderator / lead speaker / speakers
Coordinator: Professor Pisake Lumbiganon/Professor Wanicha Chuenkongkaew
Chair/moderator: Dr. Phusit Prakongsai
Lead speaker: Dr. Gulin Gedik

Speaker 1: Dr. Kawkab Mahmud
Speaker 2: Professor Lei Zhang
Speaker 3: Professor Sanjay Zodpey
Speaker 4: Dr. Weerasak Putthasri

Key messages from the presentation by speakers

Dr. Gulin Gedik

Transforming health professional education

The transformative health professional education face a couple of challenges including environment, demographic (aging), globalization, increased mobility, free movement of students, health professional and patients, socio-economic change, advancement in science and technology, employment and practice scene, and student expectations. Health worker is also an aging group (mean age =55yrs) and 40% will retire in the next 5years. Therefore, how to replace this aging workforce is being concerned.

There are key challenges related to HPE and training in region included the increasing in health labour demand, inadequate HW planning, labour market imbalances, mismatch between education and health system needs, overspecialization and hospital based training, an integrated service delivery models, team approaches, the changing from facility based medical care to community based long term care, faculty capacities and retention of faculty, and infrastructure and institutional management challenges.

There are several initiative and the documents on global initiatives related to the education of health professionals such as global consensus for social accountability in medical school, CPD of medical doctors, transformative learning for health equity, and education of health professionals for the 21st century: a global independent commission.

Regarding to the transforming and scaling up the education and training of health professionals there is the need to concern about the sustainable expansion and reform of HPE and training to increase the quantity, quality and relevance of health professionals to contribute to population health outcomes and in doing so strengthen country health systems. Moreover, the vision of the transforming and scaling up the education is the greater alignment between educational and the health systems since there is no different on HRH and Education.

Intervention areas included education and training institutions (Faculty development, Curriculum development, Educational approaches (i.e.IPE, simulation, ladder programmes etc), and Admission procedures), accreditation and regulatory frameworks, financing and sustainability, monitoring and evaluation, and governance and planning.

There is regional initiative which is the Education Development Centres (EDC). The aims of the EDC are improving educational approaches, teaching strategies, strengthening faculty capacities, strengthening education regulation and accreditation, and enhancing over-all education governance and capacities.

Dr. Kawkab Mahmud

National license examination: A case innovation story from 5C

License examination (LE) is an assessment method which aims to assess nurse if there are ready to work as professional. This will dome after successfully completing education but before entering into the professional field.

Bangladesh did have licensure examination for diploma nursing which established in 2012. Prior to 2012, all nurses are registered permanent after passing final professional, a responsible authority is Bangladesh Nursing Council (BNC) under MoH&FW.

Regarding to country context, there are a gap ratio between MD-Nurse (Doctor: Nurse ratios= 2.5: 1 (should be 1:3 or 1:4)), total shortfall of nurses >100,000 – 200,000, the shortages of faculty (122 sanctioned posts for nursing instructors and 40 vacant, Teacher to student ratio=1:57), increasing demand for nurses (increase in chronic diseases, long-term care, hospitals)

There are growing in the number of nursing profession education institutes include the growing number in private sector. To ensure the quality of the growing, there are a singular national standards for accreditation, admissions, curriculum apply to both public and private HPE

Approaching to ensuring quality of nurses, there is a development on a National Plan of Action developed in 1994-2004 to be followed by all nursing institutes. These included DNS (MoH) for leadership for quality of nursing education, BNC (MoH) to regulate nursing education and practice-accreditation, licensure mechanism,

Competency-based and service oriented education and university affiliation is obligatory for BSC & post basic nursing.

There are policy guideline published such as the same curriculum for public and private. Moreover, the recommendation for improve the quality is that it should start from admission policies. National entrance examination should supplement the current admission criteria.

There is also self-assessment of in-service gradates. The results show that there were deficiencies regarding to undergraduate training included poorly addressed rural context, inadequate for managing critical clinical situation, mental health, Public health, need more IT training, more emphasis on specialties, specially managing difficult labor and delivery, and health administration

Therefore, for the LE need to consider the periodic re-assessment and need the follow up on the outcome of the process.

Professor Lei Zhang

CME/CPD practice and experience from China

Continuing Professional Development (CPD) is lifelong learning in professional.

In 1978 concept of continuing medical education (CME) was introduced from developed countries. In response to this, the first regulatory document for CME in China entitled provisional rules on CME was released in 1991 and the CME committee was established in 1996. In 2000, the trial regulation CME was published and the National CME committee was established.

There are multiple forms of CME included training course, workshop, meeting, lecture, investigation, and distance learning.

CME has become one of the essential part of Chinese medical education and it has been playing a very important role in training qualified healthcare professional. Health care professional must obtain number of credits each year in order to remain credentialed, get promote, and continue working. The credits will record in the handbook and online.

According to the National Education Plan for rural doctors 2011-2020, China has set targets to train rural doctors in order to serve the country's huge rural population.

The plan called for the creation of a strict training mechanism for rural doctors to improve their education level, and ensure that 80% of such doctors earn the required CME credits, and 60% of them hold degrees from secondary technical schools or above by 2015.

Furthermore, 90% of rural doctors are expected to obtain the required CME credits and all of them should be qualified as medical practitioners by 2020.

Regarding to the GP training, the state council established guidance on GP system, "first diagnosis at primary level", in 2011. The overall goal of this is by 2020 there will basically be 2-3 qualified GPs for every 10,000 residents; GPs' service will be comprehensively improved to meet the needs of the general public for health care.

In summary, CME in china is well-organized and well-governed at both state and local level. There are still problematic such as unequal development, some program are not well designed, and sustaining stable fund raising mechanism not established

Professor Sanjay Zodpey

Education strategies in favor of rural retention of nurses and midwives: Lessons from Bangladesh, India, Thailand and Vietnam

The global shortage of nursing workforce is an obstacle in achieving the MDG. Almost half of the world's population resides in rural areas but has only 38% of the total nursing workforce to provide health care. South East Asia required a 50% growth in its nursing health workforce to provide optimal care to its people in 2006. India alone needs over two million personnel to fulfill its deficit. Mal-distribution of trained staff has aggravated the crisis. In Bangladesh, 15% of the population lives in four metropolitan areas and are served by 30% of nurses positioned in government sector.

In-service strategies and educational strategy have strong relationship to rural retention. Education is linked to rural retention through the following elements: preferential recruitment of students from rural backgrounds, selection of students willing to serve in rural areas, rotational service in the rural areas, curriculum including rural health issues and training in rural areas to improve competencies in to work in rural settings, compulsory placements in rural areas, and continuous professional development.

BRAC University introduced an innovative education program in 2013 to produce competent midwives to serve in the hard-to-reach and underserved areas through a "hub and spoke" educational model. Midwifery program serves as a hub and NGOs working in the hard-to-reach areas form the spokes/academic sites. Spokes/academics sites selected based on MNCH needs with poor MCH indicators. Student recruited from the local community. Local

organization is a partnership for the training. The training will emphasis on skills necessary to provide quality services at the community level.

In India, several courses have focused on skill development to increase retention of nurses in rural areas. The core of the intervention is drawing candidates who show willingness in providing services to the rural and remote areas. These results in appoint 10000 auxiliary nurse midwives within a time span of five years and were employed by the local government.

This intervention included revised 24 government schools for ANMs. 18 more schools were added in partnership with the private hospitals. The other activities include curriculum rrevision and systematic efforts to reflect rural issues.

Toward an improvement in Vietnam, the aims of the program are to have 60 institutions for bachelor education in nursing by 2020 both in public and private and to increase enrolment from rural areas by offers quota and financial aids. Also, there is the developed competency standards based on ICN standards incorporating rural issues.

Achieved considerable success in retention in Thailand included local recruitments in rural areas, subsidized education against compulsory rural service, placements in hometowns, rural trainings and service license only for public sector.

Dr. Weerasak Putthasri

Qualified doctors through national license examination: Country experiences

The objective of the paper entitled "Qualified Doctors through National License Examination: Country experiences" were to describe situation of license examination policy, translated into implementation and to ensuring the qualified doctors from country experience, including Bangladesh, China, India, and Thailand. 'Licensing Examination' is a potential tool to achieve 'Quality Assurance (QA)'.

In Thailand, in 2004, the Center for Medical Competency Assessment and Accreditation (CMA) under the Thailand Medical Council (TMC) required all medical graduates to conduct National Licensing Examinations (NLE). NLE content was based on knowledge and competencies listed in Standards of Medical Council of Thailand. The methods of assessment consisting of 3 parts as follows: (a) Pre-clinical Sciences, eligible for any medical students who have finished their preclinical years; (b) Clinical Sciences, another 2 more years of clinical years; and (c) Clinical Skills (OSCE), they must pass part 1 and 2 written exams and already graduated or at least have worked as externs under supervision. Furthermore, timing of the exams is of crucial. The exam is offered twice a year for part1 and 2; and 4 times a year for part 3 in the second half of the academic year. The results of examination in part 1, 2, and 3 indicated that the percentage of passing examine is quite varied year by year. .

In case of India, Medical Council of India (MCI) is a statutory body charged with responsibility of establishing and maintaining uniform standards of medical education and recognition of qualifications.

Standards of medical education vary across the several universities offering undergraduate and postgraduate programs in medicine. The National Eligibility Entrance Examination (NEET) is the eligibility-cum-ranking examination prescribed as the single entrance examination to various MD/MS and PG Diploma Courses under ambit of Post Graduate Medical Regulations 2000 (as amended) notified by Medical Council of India with prior approval of the Ministry of Health and Family Welfare, Government of India, NEET conducted annually, mandatory, for admission to postgraduate medical courses in each academic year. For the **NEET-UG,** the Central Board of Secondary Education conducted an All India Pre-Medical/Pre-Dental Entrance Test for admission to MBBS/BDS Courses.

In Bangladesh, there are formative and professional examinations. The in-course (card/item/term), and end-course (professional) assessments are set up for the students in each phase (1st, 2nd, 3rd & 4th phase) of the course. Formative assessment is done through results of items, card and term ending examination and class attendance. Oral part of the examination will be structured. OSPE / OSCE are used for assessing skills/competencies. After passing the final MBBS exam, students have to enroll for one year logbook based rotate internship program (11 months at medical college hospital and the rest at HC). Compulsory to complete Internship Training Program to get permanent registration for doing independent practice. To any Bangladeshi student who wants to study medical/dental course in a foreign university, he/she must take eligibility certificate from Bangladesh Medical and Dental Council before admission to foreign university because after the completion of study if he/she wants to practice in Bangladesh registration from BMDC showing that eligibility certificate will be needed.

In China, *'Law on Practicing Doctors'* has been enacted in 1998; China National Medical Licensing Examination (CNMLE) is a vocational qualification test to decide whether candidates are provided with the essential knowledge, skill and ability for practice. Foreigners graduated from Chinese medical schools and Chinese students graduated from foreign medical schools are eligible for application under certain regulations. Those examinees passed the examination got the qualification for practicing doctors or for assistant practicing doctors. Then, they may apply for registration with local health administrative departments of the people's governments at or above the country level.

Major issues or problems being discussed by participants

Delegated from Lao raise the concern on how to implement the technique and monitoring in control the quality of health care education. In response to this concern, Dr. Kawkab Mahmud mention the case study from Bangladesh that the plan should be initiative from the National level then health institutions have to follow this guidelines. For the criteria on quality assurance, there are essential information such as require number on the production, teacher, classroom, education facilities, classroom activities, and accreditation. This should be the collaborative work. There are three organization mandate this national regulatory include Ministry of Health, Nursing Council, and university. Moreover, Dr. Weerasak Putthasri mentioned that in Thailand there are many steps for accreditation start from opening the school, curriculum assessment, and each health institutions have to present self-assessment every year. Curriculum will be approved by the council. Only nurses have relicensed every five years.

Discussion

The act development in the national level; there is not easy to implement in the regional level. However, there is a need to build the capacity at the regional level. Moreover, the central committee should have authorized person or focal point who understand the deeply in the regional area that can put the agenda about capacity building in the regional into the action.

The problem in Pakistan has happened since the selection criteria; therefore, the council need to have a quick feedback.

Conclusion

In reform the health care professional training, more innovative and strategies should be implemented.

Recommendation

Qualification examination is one significant method in assure the quality of the health care professionals training. To make this process implement, the central authority committee is the major function.

Plenary Session IV

AAAH: Intersessional activities to generate policy-relevant research in HRH

Potential moderator / lead speaker / speakers
Coordinator: AAAH secretariat
Chair/moderator: Dr. Dale Huntington
Lead speaker: Dr. Viroj Tangcharoensathien

Speaker 1: Dr. Weerasak Putthasri
Speaker 2: Dr. Nilar Tin
Speaker 3: Dr. Andreasta Meliala
Speaker 4: Professor Masamine Jimba
Speaker 5: Mr.Naoyuki Kobayashi

Key messages from the presentation by speakers

Dr. Viroj Tangcharoensathien

AAAH intersession activities 2013-2014

Does it work and How to improve?

The lead speaker highlighted the discussions during the earlier sessions. He referred to the thoughts of the participants and support for the Reficé declaration. He reminded the audience that local evidence is vital in decision-making and that sometimes we cannot and should not wait for evidence since less than 10% of policy decisions are directly based on evidence. Most policy decisions rely on experiential evidence and we have to be prepared to grab the window of opportunity when it presents itself.

He outlined that list of areas which were the focus of the intersession activities through the AAAH. The 12 intersession activities undertaken were presented through 3 major questions; Does it work? What are the spill-over effects? And is it cost effective?

The work in this area was a priority that was identified by the 6th AAAH conference in Cebu. This was the first ever such kind of research in several settings; involved policy makers in proposal development and encouraged key informant interviews. The progress of work was reviewed periodically until the reports were drafted. Since this work generated evidence and captured it in quality country reports, this information has great utility for decision-making. Most countries disseminated this through policy briefs, dissemination workshops and journal publications.

The policy uptake for this work varies and uptake depends on country context and political climate. It attempted to bridge a gap between policy formulation and implementation. The work has limited influence on the redesign of implementation where policies are in place. The examples of spill-over effects include the clearance of three new proposals related to retention were approved by Minister of Health in Lao PDR. There was also an increased quota for rural students. Similarly, Indonesia moved towards accreditation. But on a wider scale, the activities have fostered a sense of trust and comradeship among AAAH countries and created a critical regional social asset for collaboration. He also suggested that although a formal cost-effectiveness has not been undertaken, the creation of policy relevant research is an extremely important outcome.

The speaker stressed on participants to "Do your utmost, even in trivial things since this can lead to transformation."

Dr. Weerasak Putthasri

Managing intersession activities: What we learnt?

This presentation looked at the experiences, process of collaboration and the challenges encountered over the two-year period of the intersession activities.

The two goals of the intersession activities included the following: emerging role of private health professional schools; rural retention policies in Asia Pacific Region. The initial activities began in 2012 with 35 submissions from member countries leading to 12 proposals being shortlisted by external reviews for scientific soundness, engagement of policy makers and stake holders. A common protocol was drafted which was followed by the creation of detailed country specific proposals. These proposals were then submitted for funding to agencies. The progress of activities was regularly followed up and the preliminary results were presented in March 2013 and dissemination was a part of the PMAC 2014.

This work provided a platform for learning and sharing and capacity building. The work was driven by country's needs with a strong technical support from experts at all stages. This work had significant interaction with policy makers but still faced challenges in the process for securing funding. It also had to balance quantitative science needs VS a qualitative approach. Future activities will look at the scope of implementation and challenges and prioritize stakeholder involvement. He summarized the future with "As an action network, AAAH will keep moving forwards."

Dr. Nilar Tin

Myanmar experiences lesson learnt from policy mapping.

Dr. Nilar from Myanmar shared her experiences in doing policy-mapping exercise in Myanmar. The objective of research is to describe and analyze rural retention of HWF policies in Myanmar.

The research was implemented with three different research methods: (i) document review, (ii) Key Informant Interview-KII with key person and policy maker; and (iii) Focus Group Discussion-FGD with key medical and health staff. The research has gone through the standard process for example: IRB approval, development of guideline for KII and DGD. The research also had some funding from local agencies (WHO).

The research has found valuable results including the positive and negative influences of policy on health workforce, i.e. increasing salary, number of health facilities, etc.

Research results are disseminated in national workshop and recommendations are used for improving the policy for HWF in the country.

Dr. Andreasta Meliala

Enhancing research activities: Benefits for all agencies.

In Indonesia, many agencies with different responsibility involved in the process of HRH production and utilization. However, the HRH research is limited and often lack of collaboration among stakeholder in doing and using this kind of research. There is common ground among policy maker, researchers and donor in doing policy research but the integration is not well in many cases.

The Indonesian research on the role of Public and Private school in producing health professional was developed and implemented with collaboration of policy makers, agencies, schools and researchers. During the time of research, there is enabling factor (national mid-term development program, transition of government, project of accreditation, and new international supports).

Study has a good coverage including large sample size, urban/rural, students/staffs, public/private, public health/medical, not accredited/fully accredited. The finding and recommendation are made and they created many interests from government and they are expected to integrate in new policies in health education of the country.

There is also limitation such as the publication of research results is limited and take a long process.

Professor Masamine Jimba

Strength of AAAH for the capacity building of HRH research and policy making.

Strengthening capacity in doing research, apply research results in policy making and implementation of health services is an important aspect. It is very important for all countries that the need is not to collect and sharing evidence but need to emphasizing implementation at country level. The research results should be used in policy development, implementing and evaluating activities. It is not for publication only.

The network of AAAH has done great work to support country research, and it show many interested from countries in the regions. There are opportunities for the local influences, researchers not need to wait for the publication to share the results but should actively provide results for policy implementation as soon as possible. It is also need to think about the role of external agencies in making the influences of research bigger.

There are also challenges in doing multi country research including speed of writing, many assignments and time for research is limited.

Mr. Naoyuki Kobayashi

Mr. Naoyuki Kobayashi provided a general thought about the conference. It is impressive about the research on HRH have been done and share at this conference. Each country has shown different approaches in doing, sharing and using research results. Some countries may prepare policy briefs, national workshops, etc. to share results. Some countries have involvement of policy makers in/out health sectors, donor in doing research and they are all shown as good approaches.

He concluded his talk by raising some key points on how to connect the research scientist to policy making process:

- Is research work is politically sensitive?
- Disclosure research works with partner/collaborator.
- Are your research results tangible? And independent?
- Link the research to external intervention (e.g. donor)
- International assistants are important

Discussion

The floor raised the following questions:

- AAAH's role in coordinating/ networking member countries with other networks and agencies in policy making
- How to overcome overlapping of policy issues for research
- Published findings may not be well recognized as those from the research conducted by development partners such as the WB, unless the findings are published in well-known international journals.

The panel suggested that to avoid overlapping, comprehensive literature review within own country should be conducted before deciding on research issues.

Publication is not only the outcome of the inter-sessional activities, but countries are expected to learn through the process and also to build up capacity of young researchers.

The Lao team shared their experience of involvement of policy makers from the beginning of the research process. Also, during the research such as when conducting interview, the Lao team also interact with different policy makers. In addition, policy makers also involve in the technical working groups.

International organizations are aware of what the AAAH member countries are working on and the organizations are working together to get common agenda interested to the countries.

Parallel Session VIII

Rural Retention Policy in the Asia-Pacific Region

Potential moderator / lead speaker / speakers
Coordinator: AAAH secretariat
Chair/moderator: Dr. Yojiro Ishii
Lead speaker: Dr. Gulin Gedik

Speaker 1: Dr. Lal B Rawal
Speaker 2: Ms. Yi Lina
Speaker 3: Dr. Phouthone Vongkonevilay
Speaker 4: Dr. Nilar Tin
Speaker 5: Dr. Thushara Ranasinghe
Speaker 6: Dr. Khuong Anh Tuan

Key messages from the presentation by speakers

Dr. Gulin Gedik

- In the Western Pacific region, the main concerns are on Equity and Quality.
- The distribution of the rural-to-urban population is heterogeneous - almost 100% in the smaller islands; sometimes variably spread within a country, e.g. 10% in Australia, sparingly distributed over a vast area.
- Working conditions vary (in terms of workload, inadequate referral capacities, ..etc) which leads to numerous concerns by health workers (in terms of family-needs and others).
- Recruiting in the rural area is a key element of the health labour market → questions remain on the appropriate incentives (economic, social, political) especially on the employer-side. Quota distribution are questionable to whether they are placed in the right place.

- The choice of interventions is governed by the effectiveness, relevance, acceptability, affordability and the complementarities with other interventions.
- In reviewing the evidence there are three settings to consider (underserved areas, potentially available services that need improvement, those with no interest) x three strategies (focusing on current stock, future stock, do with less of the possible stock) x four areas of action (education, financial incentives, regulation, service delivery).
- Education intervention include bonding (Aust, NZ), rural quota (Japan, PDR Laos), rural training hubs (NZ, Lao PDR, Cambodia), ladder type training (selected/funded by their communities → Philippines)
  - Regulatory → compulsory service after graduation (Lao PDR, Mongolia, Malaysia); special programmes such as doctors to the barrios, nurses to rural services, rural health team placement (Philippines); expanded scope of practice (Australia); 10 years moratorium for migrant doctors (Australia); Distribution of quotes to rural areas (Lao).
  - Financial → bonuses; annual subsidies to rural recruited doctors; financial support package to rural candidates.
  - Professional & Personal → Housing (PNG); National award for outstanding performance (Lao); urban doctors supporting temp support to rural areas (China)

In summary, actions to improve retention occur more as bundles of coordinated policy interventions rather than in single; individual circumstances and priorities vary and change over time (one intervention that work today may not lead to the same effect 5-10 years on); the issue of recruit-to-train locally is questionable to whether those remain local; retention is highly related to the service delivery model and it is specific situation rather than purely a workforce problem.

Dr. Lal Rawal

Rural retention policies of Human Resources for Health in Bangladesh

Retention of human resources for health (HRH), particularly physicians and nurses in rural areas of Bangladesh has been a major public health problem. Factors influencing attraction and retentions of health workforce are personal, family and community, financial aspects, career related, working and living conditions and bonding or mandatory servises.

The geographical imbalance of HRH indicates more than 72% rural population served by less than 20% of health workers. In addition, qualified health workers are working in the urban area and less educated workers are in rural areas. That result in the poor health outcomes in rural area.

Education of Highly qualified health workers are mainly provided in urban area.

The objective of this study was to explore the contents, actors, processes, and the context of existing government policies (policy-1: schools outside major cities, policy-2: compulsory services, policy-3: career development programs) aiming to promote retention of HRH in rural areas of Bangladesh.

There is no standard classification criteria for rural areas, and none policy clearly talking schools outside major cities. Although there is policy for 2-year compulsory service in rural areas, many physician bypassing this. There are tacit disinclination of non-health sector bureaucrats to facilitate career progression of health sector employees, fearing competition for authority.

Dispiet govements effors, there is still lack of policies or acts or regulations focused on rural retention of HRH.

Recommendations are as follows ; Political commitment; Formulate specific policies to RR of HRH; Revise current recruitment systems and deployment practice; Recognize public health as a formal element of health systems and Creation of nursing posts below upazila levels.

To way forward, comprehensive assessment and further strong evidence is required.

Ms. Yi Lina

Some practices of HRH rural retention policies in China

National healthcare reform was launched in 2009. Reform goal is to establish a nationwide basic healthcare network to every Chinese people by 2020. One of its five priorities was to enhance health care service area. Primary health facilities have been improved by 2011 and a number of high quality HRH are required in rural area.

The current quantity of HRH is 9.12 million in total. 51% of HRH consits of registerd doctor, assistant doctor, and registered nurse. This shows the imbalance of workforce quantity. In 2010, urban area had 7.62 health professiona per 1000 population, while, rural area had 3.04 per 1000 population. In 2012, the gaps are increased, 8.54 per 1000 population in urban areas and 3.41 per 1000 in rural area.

In 2011, **China's National Guideline for Mid-long Term HRH Development (2011-2020)** launched by MOH. As major HRH rural retention policies, several policy interventions are implemented such as counterpart technical assistance between urban and rural areas, rural recruitment at township level, capacity building for selected rural health professionals, and contracted medical students with benefit package. Provincial case study shows the obvious improvement in increasing number of profession in rural area. For the rural retention, sustainability of policy intervention, coordination among stakeholders and evidance for supporting research are helpful to reach required goal.

The research of HRH training, evaluation, flowing of health workers and incentive to HRH are planned for future.

Dr. Phouthone Vangkonevilay

Analyses of health workforce retention and attraction policies in Lao PDR

Issues and challenges in Laos are shortage of health staff (0.6 qualified health staff per 1000 population), imbalance of health staff distribution, limited quota from the goverment, health staff preference to work in urban area, insufficient self-confidence in newly graduates and insufficient training. The Lao government has developed a number of policies to address this key component. However, enforcement of the implementation of these policies remain weak.

The objectives of the study are to make a chronological inventory of policies, to analyze three selected sets of rural retention policies and to recommend options for improving rural retention strategies.

The study found that low awarness of policies in policy makers and implements and policy initiatives and starategies are not sufficiant to operation and guide implementation. Institutional capacity for regulation, enforcement and translation of policy into effective implementation is very limited. Also, policies and decrees are not funded and lack of policy M&E system using real-time and accurate HRH database.

Policy recommendations for the MoE instruction on recruitment students from rural areas are strengthen dissemination of the decree to poor districts; develop appropriate intensive or pre-university curriculum (bridging course) to improve basic scientific knowledge and foreign language for rural student and

develop M&E system and officially assign specific organization to responsible on the decree implementation. Policy recommendations for the Prime Minister decree on civil service of the Lao PDR are strengthen dissemination of the decree to poor districts; add indicators on decree on civil service of the Lao PDR to HRH database of the DOP; strengthen HRH database at provincial level; further development of policy implementation instruction and define means or condition to ensure the decree is reinforced and applied to all civil servant equally. Policy recommendations for the Prime Minister decree on financial incentive for civil servant are strengthen dissemination of the decree to poor districts; Pilot the decree reinforcement for health staffs; and define M&E system and responsible organization at MoH, provincial and district level.

Dr. Nilar Tin

Policy mapping and analysis on rural retention policy in Myanmar

Finding

- Desk review of documents from 1980 to 2009 found that compulsory entry into force after internship, 1995-1999 that there is a choice between Permanent and 3 years(1 ½ yr in State Hospitals and 1 ½ yr in remote SH)
- **A5:Continuous Professional Development**
  - Most TMOs regarded post graduate (PG) trainings as professional development
  - However, the TMOs in middle aged having >15 years service did not wish to attend PG for many reasons:
  - Yet some developed themselves by self learning
- **C1 Financial Incentives**
  - The Ministry of Finance and Revenue (MoFR) set up notification in February 2013 to provide salary plus regional allowance equal to salary for all staff working in the hard-to-reach and socially difficult (109) townships over the country

Suggestion

- Train medical doctors for attitudinal improvement starting from year one: (ethics, willing to serve the community)
- Operating referee system and mentoring students level by level
- Revitalize hostel system at university to get junior-senior peer education that costs a lot of attitudinal change
- Promotion-to be fair–Assign right person–right place not according to vacancy at senior post not aligning

- Counting the service at HTR areas in promotion/PG entrance– should be strengthened
- Providing facility
- Support from local authority
- CPD for Basic Health staff should be thought of
- Recognition and appreciation
- Locating local people to their native places

Discussion

- A policy setting- considered at the highest level authority and guidelines were distributed down the line and this was not seen while mapping the policy ending up in directives or notification
- Very few were circulated in the newspapers, some were lingered in the ministerial office level and some at the directorate level
- Policy documents found to comply WHO recommendations on but not so strong
- The best retention strategies appear to be those that combine financial and non-financial incentives
- A systematic, specific and sustainable rural retention policy and plan should be developed
- Rural retention of BHS is also very important as they are the first line cadres of HWF; thinking of bundled strategy with Myanmar's SE context

Dr. Thushara Ranasinghe

Policy analysis of attracting and retaining doctors to rural and underserved areas in Sri Lanka

Finding

- Human resources in the health sector has made a immense contribution for positive health outcomes in Sri Lanka ; some are best among developing nations
- Results of KI- Six key thematic areas are most related with the findings of policy review analysis: *Social Capital , Issues faced by the doctors working in the rural areas , **Merit List***
- ***Private Practice,** Policy Awareness, Policy Recommendations*
- **Three key policies**
  - **Educational –**A1- Students from rural backgrounds – district quota system found admissions- 40 % on merit and 55% on district quota system, Remaining 5% of the available seats each year allocated for 16 educationally disadvantages districts proportionate to the population size , Identified by University grants commission
  - **Regulatory** –B1-Enhanced scopes of practice- dual practice (private practice) by allowing to carry out private clinical practice –after their working hours
  - **Regulatory** –B3- Compulsory service in a rural area- merit list: Compulsory at least 2-4 years in one station, Rural and underserved stations are advertised- priority given to filling them.

Conclusion

Overall social policies have contributed to rural development, *education and health sectors,* Merit based compulsory service and targeted education has been successful, Indirect financial incentives (Dual practice or private practice) has increased the scope of practice, Study limitations, Complexities involved-Lack of a proper definition for rural area/underserved area , Lack of information sources and data reliability, Did not capture the views of the doctors left rural areas without assuming duties or resigned due to rural deployment

Recommendation

Measure effectiveness of the policies by a survey among doctors working in rural areas

Dr. Khuong Anh Tuan

Rural retention policy for Human Recources in Vietnam

Current situation : Increase number of health staff in population, more professionals have been open at university level: medical technician, nurse, midwives, nutrition and 70% of CHS having doctor, and unbalanced workforce among areas.

Finding

- **Education : Low quality of HRH: poor knowledge and performance** according to not clear instruction for implementation, lack of standardization, accreditation system, Lack of enforcement, M&E, training curricular is not based on rural health need and no pre-service training
- **Regulatory :** Different type of health worker at PHC with professional tasks and responsibilities and weak mechanism and enforcement of HR motivation for rural area
- **Financial incentives:** Income of health professional is increased by 50%-70% of basic salary and plus other allowance (>100% depend on the field of working), but not well implementation in some provinces/health facilities depending on capacity of local government and health care facilities in term of economic status or health facilities revenue
- **Professional and personal support:** Improve infrastructure and medical equipment of health facilities at primary care level (757 facilities: 591 dist. hosp., DHC), Project 1816: rotation of health professional and technical support for lower level health facilities, but weak implementation due to local capacity (for CHS), no social encouragement and support for VHW, and GAP between HR capacity and available infrastructure, medical equipment)

Current movement

- To improve quality of HP via education by review and develop curricula for medical education and continuous training , reduce and tend to limit the program for specialist, and develop a policy for pre- service training
- Regulation for developing policy for compulsory services in rural areas

Challenge

1. Tied by other laws; education, examination and treatment, associations and unions
2. Lack of budget and budgeting mechanism for medical education and training.

Final thought

- There is a need to do more to move the agenda forward and would require time to unfold as it involves human choices.
- Beyond evidence, there is a need for actions, weaker implementation capacities are a common problem and requires attention.
- It is feasible to generate a stand-alone publication of the studies. Rural retention is still a continuing interest for the intersession activities alongside the work on the transformative education.

Parallel Session IX

Emerging role of private health professional schools in the Asia Pacific Region

Potential moderator / lead speaker / speakers
Coordinator: AAAH secretariat
Chair/moderator: Dr. Nima Asgari Jirhandeh
Lead speaker: Dr. Pak Tong Chol

Speaker 1: Dr. Kawkab Mahmud
Speaker 2: Dr. Andreasta Meliala
Speaker 3: Dr. Gantuya Sengee
Speaker 4: Dr. Susie Perera
Speaker 5: Dr. Krisada Sawaengdee

Key messages from the presentation by speakers

Dr. Pak Tong Chol

Emerging role of private health professional schools in the Asia Pacific Region

The growth of the private health professional education institutions has been mushrooming in many countries especially in SEAR region, however most of these institutions have no compulsory service mechanism for the fresh graduates to serve rural and remote areas. It is recommended to the policy planners that the private health professional schools need be directed in such ways to elicit health workers towards universal health care. On the other hand, these institutions shall also address the health labor markets, to maintain a balance between the requirment of both public and private sector. WHO has issued the Guidelines for Transforming and Scaling Up Health Professionals Education and Training, which is expected to help countries in making balance between the manpower requirement and production, standard of education quality, transformation of curricula and educational process that meet the needs of health service delivery. WHO will continue to provide technical support through providing a training strategy and teaching moduls to be used by all public and private medical schools.