and influence market force. Incentivization for career development and creation of employment opportunities and empowerment of people in under-served communities are the need of the hour.

A focus on primary health care can improve access, manage costs and expand coverage. Examples from Brazil, Thailand, Turkey highlight how their UHC coverage helped them do this. Ethiopia, Brazil, Bangladesh have demonstrated that their investment in local communities can provide results.

This is a time for a paradigm shift in health service delivery system to achieve UHC. There is a need for new skills and creation of new teams; bringing community-based primary health care and public health programs to the forefront. These changes will need to be complemented with an improved understanding of the health labour market in our march towards UHC.

Dr. Sameen Siddiqi

Option for countries in Eastern Mediterranean

UHC has been dominated by the health financing agenda to increase financial risk protection. The central of HW is to translate the vision of UHC into improved health care.

Although the population of 22 countries in the Eastern Mediterranean Region (EMR) is not big, they are quite diverged with different income levels. The burden of diseases is increasing in this region with the changing in demographical profile. Countries in this region also have limited HW capacity. WHO had used its framework to assess HW in different aspects. For availability, HRH density is 4.0 and 8 countries out of 22 classified as workforce crises with wide variation among countries in the regions and imbalanced skill mix. Accessibility is quite low in some countries due to geographic imbalances, retention issue, and internal/ external migration. For acceptability, there is gender imbalance and concerns related to cultural and linguistic barriers. For quality, quality and relevance of HPE, inadequate CPD delivery arrangement, and lack of effective performance management are concerns. In addition, there are HRH Governance challenges including lack of HRH plan/policies, limited evidence generation and analysis on HRH, weak HR management system, lack of coordinating among stakeholders, HRH educational systems that do not match with health needs, and inadequate retention strategies.

EMR has developed a strategic framework for HW development for this specific region to strengthen their HW. The framework consists of 4 domains: HW system, HW entry, active HW, and HW exit. The framework is designed not only to tell the countries WHAT to do but more important it provides guideline on HOW to accomplish their HW goal. The framework is inline with UHC framework and plans to develop HW in this region.

Dr. Ikumi Nakaita

UHC securing nurses: Experiences of Japan

Japan has achieved UHC 50 years ago but it is still facing with the shortage of nurses. In the last 50 years, the number of nurses is increasing in Japan but it is not enough to meet the population need and it became social issues. Therefore, two key fundamental polices to secure nurses has implemented including: the projection of supply and demand for nurses and the Act on assurance of workforce of nurses and medical experts.

The projection of supply and demand for nurses is an important tool for HRH policy. It has been developed every 5 years since 1974. There was 4 times the country faced with shortages of nurses. The first time was in 1960-1961 due to the reforms of health care system toward UHC, increased number of hospital beds, and change of nurse staffing system. The second time was in 1965 because of increased access to healthcare services due to UHC, enhanced health insurances benefit, and rapid increased of hospital beds but not increase nurses. The third time was in 1990 – 1992 related to qualitative deficiency induced by increased beds immediately and qualitative deficiency due to advancement of health care. Currently, nursing is shortage because of super aging and fewer children. As a result, health care demands increase, but the number of nurses decreases.

The Act on assurance of workforce of nurses and medical experts was established in 1992 to secure nurses and other medical experts to meet the public demand of healthcare service. It is also a description of the responsibility for securing nurses by Government at different levels; a framework to secure nurses and it designates the prefectural nurse centers to promote employment.

From Japan experiences, nurses will shortage when supply of nurses could not meet the rapid change of healthcare system. To solve this issue, the perspective and engagement of nurses in the policy formulation are needed.

Dr. Susie Parera

Human resource for Health: Sri Lankan experience

Sri Lanka has about 20 million populations, and the country has been successfully delivered good health outcomes with low cost to the population especially with MCH and communicable disease services. The investment of government to health care remains low, and the country is facing with the epidemiological transition where non-communicable diseases (NCD) are rapidly increased. Comparison with other countries, Sri Lanka has better HRH indicators, for example the number of doctor and nurses. However, disparities and lack of specialists, and primary health midwife are some issues that need to be fulfilled.

Considering increasing life expectancy and the need to address NCSs and injuries, the competencies of HRH need to change, additional health services would require more financing and human resources. Primary health care approach and the model of public health midwife and community public health program should be sustained and developed. The policy and plan for health and HRH should be built upon a system that has done well to address the newer disease burden. Sufficient number of PH midwife, clear job description, and expansion of other cadres at PHC using multi-tasking model is a likely way forward. Universal access to primary and secondary prevention strategies through community approaches is relevant to Sri Lanka.

Major issues or problems being discussed by participants

Although evidence supported effective primary health care, Dr. Akiko Maeda highlighted that evidence to better understand the political economic issues or structure aspects related to HRH and how we can prevent market failure is still needed.

Although Japan has produced projection for nurses every 5 years, with social, economic and demographic changes, it is difficult to correct projection to meet the balance between supply and demand for nurses. However, with the projection, Japan can better prepare and solve when face with nursing shortage.

Jirhandeh highlighted other important HW challenges such as new workforce, task shifting, and migration. The political economic and professionalism issues were also discussed. Transparency to allow all HWs work together as a team and politic economic issues are needed to address.

The quality of medical graduates that produce from mass production was also discussed. Dr. Sameen Siddiqi shared extreme examples of two countries. Egypt has high number of medical schools due to the purpose to export their graduates to work outside country while Morocco has few medical schools due to strict regulations. It showed that this issue has driven by policies.

Production and shortage of faculties were also raised by Professor Shiv Chandra Mathur. To produce more HWs, it needs more trainings and faculties.

Suggested solution

- To move toward UHC, primary health care, new skills, new model focusing on multi-tasking and new teams of health workers are needed.
- How to achieve HW strategic implementation and action is needed to focus.
- The projection between supply and demand of HW and evidence to prevent market failure are needed.
- The country needs to manage challenges related to HW, professionalism, political economic issues, and structural problems in constructive ways with win-win situation.
- Mechanism of regional alliances to share faculties, trainings, and resources is important to solve regional problems related to shortage of faculties.
- Motivation and internal drive of HWs are also important beside financial. Keeping spirit of committed HWs to work in rural area is needed.

Parallel Session I

Measuring HRH implementation according to national circumstances and needs

Potential moderator / lead speaker / speakers
Coordinator: Dr. Sarath Samarage
Co-coordinator: Professor Fely Marilyn E. Lorenzo
Chair/moderator: Dr. Yojiro Ishii
Lead speaker: Dr. Sangay Thinley (Dr. Gulin Gedik presented on behalf of Dr. Sangay Thinley)

Speaker 1: Dr. Ariel Pablo-Mendez
Speaker 2: Dr. Jose Francisco Garcia Gutierrez
Speaker 3: Dr. Susie Perera
Speaker 4: Dr. Tran Duc Thuan
Speaker 5: Dr. Dale Huntington

Key messages from the presentation by speakers

Dr. Gulin Gedik

Challenges in measuring HRH: data structure different in countries, e.g. some countries cannot provide data of employment; this caused data from countries cannot be analyzed altogether; types of HRH, some measures health workers working inside or outside health sector, some are not but only health workers inside health sector. Useful sources when measuring HRH: population censuses; but the ; censuses are given at different times thus the data may be 5 or 10 years earlier than the time of measuring. HRIS: starts from needs; time to get the data should be paid attention; maintenance of data; content of the system; keep in use by people to sustain the updates and make it useful; how to bring together stakeholders to use and support the system. Data quality: data corresponding to outcomes; data from known sources; coordination and harmonization of data is important; timely information should be validly provided.

Dr. Ariel Pablo-Mendez

Human Resources for Health measurement: Challenges and future vision

Changes in health and social protection systems. This will require increasing focus on the availability and accuracy of health workforce data and forward-looking, horizon-scanning exercises to support decision-making and improve efficiency, performance and productivity. WHO, OECD, EU and other bodies would inform the governance and effectiveness of health and social protection systems. The presentation reviews: 1) current challenges and opportunities in data and measurement, 2) emerging issues-future scenarios, big data, connected health and strategic intelligence, and 3) forward opportunities in relation to HRH data and inter-operability.

Dr. Jose Francisco Garcia Gutierrez

Human Resources for Health in the Americas: Moving towards Universal Health Coverage

The synergy between sustained economic growth and inclusive social policies explains the reduction in the number of people living in poverty and the easing of inequities in wealth distribution, along with parallel improvements in employment and literacy levels. The affirmation of health as a fundamental human right is also a central component of this agenda. The development of unified health systems, the renewal of primary health care (PHC), and the search for better integrated, people-centered, community-oriented models of health services represent core strategies for making this right a reality. It is clearer than ever that this ambition cannot be realized without a health workforce that is fit for purpose and fit to practice. Results from the ongoing final evaluation of the Regional Goals for Human Resources for Health 2007-2015. Regional and country experiences on strengthening capacities for planning HRH. Best practices in reforming health professional education to support better quality primary health care based systems and progress toward UHC. Experience learned from Latin America: measurement is important; heterogeneity (lack of regulation); boom in health input along with economic increase formed new gaps in HR to fulfill the jobs; universities cannot follow the step of health development; migration is not a problem in a universal health coverage world; universal access to health to reach universal health coverage.

Dr. Susie Perera

Human Resources for Health in Sri Lanka: Universal training needs in a developing scenario

Sri Lanka has a state lead program for development of human resources for health. Universal training needs in a developing scenario. Commitments of the third Global Forum made for HRH development Training needs: not only numbers; mechanism to identify universal training and do it; measuring mechanism to ensure it universal training given on needs to identify which service is needed universally. Key concern is the training quality that is dependent on systematic training needs assessment, trainer quality, quality of training infrastructure, up to date training curricula, appropriate teaching methods, method of monitoring training quality and methods for external review. HRH Strategic plan of 2009- 2018 identified the gaps in training and proposed several strategies to improve training capacity. After a considerable delay in its implementation, several attempts for improvement are now being made. HRH functions remain scattered amongst different sections within the Ministry of Health, although proposed organization reform to establish a central HRH coordination unit has received high level attention. Centralizing HRH coordination has relevance for improving training capacities. Further challenge is how technical areas such as training needs assessment, identifying methods of improving trainer capacities can be carried out. HRH specialty development is needed to drive the agenda in Sri Lanka. In Sri Lanka the state sector training capacities need universal improvement. Financing the improvement should come from the health budget as an underlying requisite for health improvement in achieving universal access to health.

Dr. Tran Duc Thuan

Health workforce monitoring: A case study of Vietnam

In Vietnam, HRH target: 2015 and 2020 goals; ratio of doctor and pharmacists as indicators. 4 level training, from secondary to postgraduate; secondary education provided at local government, the other 3 levels provided by central government. Service and employment: clinics, hospital, facilities and central facilities; 5 level system; commune, district, province, central. HRH change in last decade: increasing; nurse are trained by 3-5 year courses thus now the ratio has changed to nearly 2 to 1 (doctor to nurse) than 1 to 1 ten years ago. HRH measurement and monitoring: MOH design indicators to HRH measurement; data of education is managed by Ministry of Education; institute of the national level will collect data annually from the health sector; sources of data still need to be harmonized, some are not accurate. Some aspect of data show differences between each other and cannot be integrated to use. All categories of data need to be redefined under a unified standard to help the government work in the future, which will be cheaper and usable.

Dr. Dale Huntington

Critical issue in HRH implementation-dual practice

Asia Pacific Observatory, HR: jump back and forward among countries in the region; physicians have other jobs besides government ones; if this situation is weakly regulated there will be service weakness; but if powerful managed the accessibility will be weaker for some regions. The balance is important. 3 options of solution by government:1st: blind to it, allowing doctors to work part time jobs (not recommended); 2nd choice: ban it, strictly regulate, difficult to enforce, costly to government; 3rd choice: regulatory systems on it both practiced in public and private sectors to let the nurses and doctors to obey the systems. The implementation depends on how much service should be purchased by the government to ensure health security and welfare to people. It could be soft regulatory system to control under standards to monitor the deeds of health workers. The way forward: policy to be made through dialogue to stakeholders and health workers and analysis of current context.

Major issues or problems being discussed by participants

How to measure HRH performance practically was raised. There are different ways to measure and in those different methods would provide different in output. It depends on contexts of those countries and methodologies of the measurements.

Conclusion

There is no single of one method to answer the way of measurement. The countries need to suit themselves by the context of HRH data and health system.

Recommendation

There is the need to have data collection from the local HRH people how do the work and then bringing up the higher information in each level as routine work. However, it is challenge.

Parallel Session II

Addressing transnational issues and work towards strengthening health systems, including global HRH governance and mechanisms

Potential moderator / lead speaker / speakers
Coordinator: Dr. Kenneth Ronquillo
Co- Coordinator: Dr Cha-aim Pachanee /Dr. Mary Ruth Politico
Chair/moderator: Dr. Patrick Kadama
Lead Speaker: Dr. Randy Kolstad

Speaker 1: Dr. Eva Jarawan,
Speaker 2: Dr. Thinakorn Noree
Speaker 3: Dr. Nima Asgari Jirhandeh
Speaker 4: Dr. Diouf Ibrahima Souka Ndella

Key messages from the presentation by speakers

Dr. Randy Kolstad

Addressing transnational issues and work towards strengthening health systems

Key translational issues

- HRH issue varies with country context. Some of the common issues include-shortage, in general and specialty, gender imbalance (over-representation or women under-representing decision making role)
- Migration of health workers (several countries have almost 80% dependence of foreign trained workers)
- Code of practice

- Other issues include-demographic, macroeconomic, NCD, labor market, regional trade agreements

Considering the context he has addressed some strategies for thinking systematically for going forward. These are as following:

- WHO health system building blocks- but how do they interact with service delivery need to be comprehended
- Systematically as per political dimensions of HRH (e.g. task shifting, technologies, cross border medical issues like tracking TB patients migrating to Myanmar in South- east Asia)
- HRH strategies- but it is necessary to interpret and modify global practice into country context

Dr. Eva Jarawan

The future of global health workforce

She discussed on projection/future of global health workforce (HWF). The main issue she addressed were

- What is changed? - Mentioning a quote from the Lancet, Nov 27, 2004 and comparing the global challenges between 2004 and 2014 she brought the question as ' What is changed?'
- Globalization and HWF - a study findings from Professor Jim Buchan-funded by EU commission
- UHC and the HWF - UHC cannot be realized without HWF

What is the future like?
She mentioned that, if the current situation continues without any change then the projections on HWF will be

- Shortage of HWF most significant in LICs
- Widening of gap between supply/demand of essential services
- Narrowing of gap between supply/demand of number of HWF to provide essential services
- Production of HWF

Other trends?

- Emerging regional free market (EU, ASEAN, CARICOM)
- Economic transition & HWF - migration of doctors to Germany from Greece was higher in 2008 during recession; in UK slides new international nurses more nurses coming from EU than Non -EU countries after 2009
- Impact of free nobilities - what happens not known still.

Dr. Thinakorn Noree

Medical tourists in Thailand: What are the impacts on HRH?

Cover wide range of medical services; spas, traditional treatment is generally excluded

- History trend of MT
  18th century - taking the water in spas in Europe
  19th century - wealthy countries from less developed
  21st (new phenomenon) - change in destination and not reserve for rich
- Why patients move?
  Long waiting period (UK, Canada), Cost saving, comparable better quality services, unavailable services at home
- Medical tourism in Thailand
  1997- economic crisis- private hospital started to find a new market internationally
  2003- medical hub policy, Government aimed to promote health industry
  2006- 1.2 million international patients
- Polarized debate:
  - It may create substantial revenue
  - May create internal brain drain or international migration
- So does MT benefit the country? Findings from a study is mentioned as
  - So the study done in Thailand 5 private hospitals with 63% of total market share, 324906 medical records, 293 surveyed patient in 2012, largest data in the private sector of the world
  - Key findings 1 - Medical tourist are fewer that you think- medical tourist 44%, expat 315, vocational; 25%; it is due to double counting and misunderstanding

- Key finding 2 - Majority from regional movement UAE, Bangladesh; very small number USA, third line UK; Great variation of field of treatment among countries Australia- cosmetic surgery, US cosmetic, orth, eye

- Key finding 3 - Top 10 health problems in MT health exam, med consult, follow-up treatment- 37.1% - so little impact on health system; possible implication on HRH- high demand of cosmetic surgeon, cardiologist

- Key finding 4 - MT contribute more than thai and also they are also good tourist and spend a lot in tourism, and this is directly allocated to local people

- Recommendation

Estimation of medical tourist globally should be revaluated
Other countries are encouraged to conduct holistic assessment

Dr. Nima Asgari Jirhandeh

Implications of epidemic of NCDs on human resource planning

No actual data on NCD to make policy review.
If we want to decrease 25% mortality 4 options can be proposed depending on the Global targets (reduce alcohol consumption, physical inactivity) can be achieved by health promotion measures, 2/3 strategies by secondary prevention, only 1 by clinical/curative

Implications of NCD on HRH

- Changing health system focus on primary care, change in training staff, screening
- Change in services- health promotion, palliative care, other allied health HWF

Lancet health matrix data shows
As per DALYs top 15 causes-we expect to see classical NCDs, also not so classical NCD- low back pain, depression, road injury

But as per YLD (global years lived) top 15 differs from DALY; then it is mostly musculo-sketeletal

- What to do?
  - Move from health density production to health service based projection
  - Political acceptance and will
  - As ageing increased NCD burden

House model: the basis of HRH management for RVT2010
Health systems responding to health needs: Production, deployment and retention

Qualitative research

Target group- No working experience in DR, currently working in DR, once assigned and started working in DR but came back to urban area within 1 yr, non medical administrator in DR (Governor, mayors, other local stakeholders) medical administrator, responsible for HRH in MoH

Result

- Reasons to stay longer in difficult regions: Working environment, Satisfaction as professional HRH
- Reasons to leave: Working/living environment factor, Emotional factor

Conclusion and next step for Senegal

- There are different factors to influence on decision of HRH in DR if they stay longer or leave
- Some factors, such as distance, climate and cultures are not changeable easily. However we can mitigate those factors.
- There are still many rooms to improve in daily management of HRH itself. These effort will reduce the widespread of sense of unfairness among HRH working in DR
- Next step RVT2010

Issue/discussion

Moderator: Foundation for any system makes a good difference. It is same with the RVT2010 in Senegal

Dr. Drouf Ibrahima Souka Ndella question of HRH database is common amongst all the countries, but this is something we can resolve. It seems that one system is not compatible for all the countries.

We do have systems but we do not have the capacity to use them.

Dr. Thinakorn Noore: what would be the scenario in future on medical tourism with the change in policies? Do not have any guideline for now, but it is the starting point now.

To overcome people travelling out for medical, the developed countries have started to develop the capacity within the country. Therefore, while projecting the HRH for medical tourism, the country should focus on the diverse market and not only the host country.

Dr. Nima Asgari Jirhandeh with the paradigm shift of the diseases, we may have to think of a different cadre of HRH to provide the care at the home setting.

Numerous programmes including home based care giver and projection of HRH needs to be changed with the change in demography and disease pattern. The biggest determinants of NCD will be ageing. UK is facing difficulty in providing social services for the older population. To overcome NCD and aging, the countries need to think of horizontal collaboration of care and linking to secondary and tertiary care.

Parallel Session III

Global context challenging for international migration of health workers

Potential moderator / lead speaker / speakers
Coordinator: Dr. Krisada Sawangdee
Chair/moderator: Dr. Phusit Prakongsai
Lead speaker: Dr. Jim Campbell (Dr. Siyam Amani presented on behalf of Dr. Campbell)

Speaker 1: Dr. Amani Siyam
Speaker 2: Dr. Akiko Maeda
Speaker 3: Dr. Reka Kovacs
Speaker 4: Dr. Krisada Sawangdee
Speaker 5: Dr. Arjun Karki

Key messages from the presentation by speakers

Dr. Amani Siyam

The WHO code of practice: A roundtrip

Dr. Amani Siyam discussed the WHO Global Code of Practice and some selected findings on the implementation of the code at the national level. Adoption of the Code is one of the WHO agenda to address HRH shortage which is a critical problem particularly in the Subsaharan Africa where there are only 4% of health workforce but its global burden of diseases is accounted for 25%. The Code was adopted by the 63rd World Health Assembly in 2010 and it provides voluntary principles and practices for the ethical international recruitment of health personnel and the strengthening of health systems. Since the adoption, monitoring of the implementation of the code is conducted. However, there is a low level of implementation in all WHO regions, although the European Region has the highest number of countries with designated national authorities and reporting.

She reiterated the key challenges on the implementation which included

- Multi-stakeholder engagement at national and sub-national levels, in the public and private sectors involved in decision-making processes on health personnel migration and international recruitment
- The lack of coordinated and comprehensive data on health personnel migration
- The lack of a shared understanding of the nature of the connections, at country level, between workforce migration, current and future health workforce needs, and short- and long-term workforce planning which could hamper the Code's implementation

Dr. Akiko Maeda

Globalization of the health labour market

Dr. Akiko Maeda enunciated about the WHO Global Code Practice which aims to establish and promote voluntary principle for ethical international recruitment of health personnel. However, its application has yet to come to the mainstream. The code should serve as a reference for member state establishing the legal framework for international recruitment of health personnel and facilitate international discussion and cooperation on such matters as part of strengthening of the health systems. This requests sufficient improvement in data collection of HRH for better planning and coordination.

She highlighted the impacts of globalization on health labour market. It was shown HW migration has decreased in 2008 due to global financial crisis, but has since covered and showing robust trend of migration to high income countries which are gripped with the twin problems of aging population and aging HW. It is pertinent to note that the extent of reliance on foreign health workers in OECD countries is very high, as at 36-39% in the UK and NZ and 23-26% in Australia and USA, respectively. The impact of new political arrangements was captured in the case of migration of international nurses to the UK. It is seen that post 2008 the migration trend is picking up with the pre dominant share of nurses from within EU countries. Earlier, non EU countries used to export nurses to UK. It was highlighted that the present analysis of mobility is restricted to a small segment of clinical professionals, but in reality there are associated migration of various skill mixes. It was interesting to note that health professionals even prefer to move from urban areas in origin countries to rural areas in advanced countries.

She suggested that migration/mobility could not be addressed successfully or "solved" as a standalone policy challenge: it is part of the broader dynamic of workforce mobility at global, national and local levels.

Dr. Krisada Sawaengdee

Application of the WHO Global Code of Practice on International recruitment of health personnel: Thailand's experience

Dr. Krisada Sawaengdee shared Thailand's experience on implementation of the WHO Global Code of Practice. The International Health Policy Program (IHPP) is appointed as the designated national authority. Some kick-off activities have been done such as multi-stakeholder consultation, translation of the code into Thai language and developing of a 5-year action plan (2011-2014).

The key success factors for the implementation of the code in Thailand are the existence of a national mechanism for advancing HRH agendas, the sub-committee on code implementation comprises all stakeholders with their full participation and an understanding of the code, capacity to mobilize domestic resources, and the evidence based policy formulation. However, there are remaining challenges such as violation of the code, a need for legal framework to licensing recruiters and its enforcement difficulty.

The code is one small component of a comprehensive package of HRH, it is an important instrument to contribute to ensure that health workers are available and accessible to all. To achieve objectives of the code, all stakeholders need to actively participate in the implementation process. It is very important to provide a platform for regular and continuous dialogue and encourage multi-stakeholder cooperation on issues related to international migration and recruitment.

Dr. Reka Kovacs

Experiences of European countries with health workforce migration

Dr. Reka Kovacs shared experiences of European countries with health workforce migration. The European Commission has come up with the action plan for the EU health workforce which has the component of improving health workforce planning, recruitment and retention, anticipating skill needed and international ethical recruitment. The EU has come up with the joint action plan which is a 36 months project to promote collaboration among member states in meeting out the expected shortage of one million health workers by 2020 in Europe. The prominent receivers of HRH like Ireland, UK, Finland have shown the commitment to the WHO Global Code of Practice. The decision of Germany to make no direct recruitment of health care personnel from the 2006 WHO list of critical shortage countries is laudable. They have also implemented the idea of Triple Win Migration which is beneficial for the source, sending countries and the migrants. The example of Moldova (non-EU) entering into bilateral agreement in the field of health personnel migration was shared. EU is concerned with the implementation of the Code in relations to the non-EU countries. She reiterated the need for creating awareness on the WHO Global Code of Practice and to work out the various principles for implementation.

Dr. Arjun Karki

Overcoming health workforce migration: Perspectives from Nepal

Dr. Arjun Karki from Nepal made a forceful plea for examining the adverse impact of international migration of qualified health labour force from less developed and poor countries to the developed world. It is very difficult for the governments to withstand the strong Pull factors of advanced countries. Thus about 36% of doctors from Nepal have emigrated of which 73% moved to the US. By way of suggestion, he indicated that if there could trade sanctions to protect local industry, then similar sanctions could be thought of in checking HRH migration in national interest. Compensation for developing countries must be provided under the WHO Global Code of Practice on International recruitment of health personnel. The example of circular mobility of HRH from the countries of Sudan and Pakistan to Ireland and between Canada and the Philippines was also discussed as a sustainable practice and beneficial to both the origin and receiving country. The problem is further compounded by inter-migration within the country from rural to urban areas. Another 37% Nepal doctors are therefore in the capital region.

An important finding for him was that students from rural backgrounds are twice as likely to stay in rural areas in the country. Thus governments must come up with suitable regulations to check attrition of HRH to prevent misuse of government resources spent in arranging medical education. There is in this context need to also regulate mushrooming of private medical colleges who seem to produce doctors only for the private sector.

Suggested solution

- To achieve objectives of the code, all stakeholders need to actively participate in the implementation process and a platform for regular and continuous dialogue should be provided
- Improvement of data on health workforce migration to be used for health workforce planning and policy making
- Migration/mobility cannot be addressed successfully or "solved" as a standalone policy challenge: it is part of the broader dynamic of workforce mobility at global, national and local levels.
- Multi-stakeholder engagement at national and sub-national levels in decision-making processes on health personnel migration and international recruitment

Parallel Session IV

Multi-sectoral partnership to support sustainable competent HRH development

Potential moderator / lead speaker / speakers
Coordinator: Dr. Busiri Suryo Winoto Tritarayati
Co-coordinator: Ms. Anna Kurniati
Chair/moderator: Dr. Busiri Suryo Winoto Tritarayati
Lead speaker: Dr. Tomohiko Sugishita

Speaker 1: Dr. Tchaa Kadjanta
Speaker 2: Ms. Hiroe Ono
Speaker 3: Ms. Wanda Jaskiewicz
Speaker 4: Professor Shiv Chandra Mathur

Key messages of the session from the presentation by speakers

Dr. Tomohiko Sugishita

New horizon of HRH partnership as post 2015 agenda

JICA commits to support the community health including the human resources for health (HRH) at global, regional and national level. The spirit of partnership has been continously developing since the movement of primary health care in 1978. Then, JICA continued to the health for all, health system strengthening and now the universal health coverage (UHC). Achieving UHC in this post 2015 development agenda requires commitment of all stakeholders to listen to people's voice and to rethinking on health system in a more creative and systematic ways. This paradigm shift cannot be achieved by using single effort of national health sector, but also demanded by transformative learning and dialogue approach including federal government, local government, partners, private sector, academics, civil societies and mass media.

Dr. Tchaa Kadjanta

Partenariat multi-sectoral pour supporter un développement soutenu des ressources humaines compétentes

Francophone countries has established a network consisted of 10 countries (Benin, Burkina Faso, Burundi, Cote d'Ivoire, Guini Conakry, Niger, Mali, Congo, Senegal and Togo). The purpose was to help spreading good practices among French speaking countries in Africa. Synergi among members can be translated into by using all resources together in more efficient way, as some countries partnering with JICA while other countries connected to other partners. Some examples include the tool on mapping remote areas developed by Senegal. This tool can be used by other countries and the tool yielded the creation of training center for cross countries.

Ms. Hiroe Ono

Experience from malaria control in Myanmar

Building the community health workers (CHW) for malaria control should be based on the community preference. It could be comprised of various occupations including farmer, grocery shop staff, teacher, and etc.). Key effective factors for malaria control by CHW were collaboration with partners, ownership of local government, and recognition of CHW, designed consideration of workload, reporting and referral system, supply management system, and monthly monitoring. However, to maintain CHW motivation after malaria cases reduced, and to operationalize in national program, we need to develop a sustainable approach in stable system.

Ms. Wanda Jaskiewicz

Best buys for scaling up health workforce education & training

Capacity plus has supported efforts in scaling up health workers. Some strategies developed with aims to improve school management and to review production capacity (consisting of 9 core elements: educators, students, management, infrastructure, materials and equipment, curriculum, clinical practice, quality assurance, and partnerhip and exchange). The bottleneck and best-buy approach has been used to enable schools to identify and analyze the whole or part of the core elements to prioritize interventions and estimate costs.

Professor Shiv Chandra Mathur

Sustainable competent HRH development: Multi-sector partnership

In India, multi-sector partnership in HRH includes central government, state government, PPP, private agencies, as HRH is multisectoral movement. Within the public system, the partnerhip may comprise of medical education, health department, and AYUSH department. Therefore, it is not merely the functioning of all program within health department, but also to integrate with other departments, such as women and child development, labor, public health, engineering, and environment.

Major issues or problems being discussed by participants

Indonesia participant commented that partnership may be built based on the scarcity of resources, and the rapid changing of organization means that advocacy to leaders in other sectors must be continously conducted which is not always easy. She and the participant from Lao DPR expressed their concerns about how to ensure the successful efforts to sustain the partnership with all stakeholders in order to maintain good support for HRH development. Other comments were from a participant from India, who have particular interest on the people engagement using bottom up approach.

Discussion

According to Dr. Tomohiko Sugishita, to succeed the partnerhip, we must ensure all stakeholders to supporting each other, knowing each other, and having a common understanding. Therefore, it is not because of the limited resources, but more to share different talent team. Sustanability should start from a systematic thinking, to work together and reach more productive and synergy for the system which is called "Progressive Universalism".

Ms. Hiroe Ono viewed that to build a sustainable partnership, stakeholders should share clear common goal and not to overload in one's burdenn. Ms.Wanda Jaskiewicz responded that institutionalised the process of leadership is important, so the membership should not be based on individual, but also organization needs to avoid difficult transition. Advocacy of messages is needed to convince all other stakeholders why they have to support. Based on his experience, Dr.Tchaa Kadjanta responded that sharing the same perception from the very beginning without any political interest can be long lasting as we also share the long term goal. Professor Shiv Chandra Mathur said that usually when we focus to overcome one health issue, then other healthissue emerge. Hence, we need to change our organization culture in managing health issues.

Conclusion

As concluded by the Chair of the session, achieving the UHC in the coming future is not impossible. However, all aspects, including planning, education, deployment, professional development, and management and policy, in relation to the improvement of quantity and quality of health workers, must be taken into account. All stakeholders must work together to invest in human resources for health development.

Recommendation

- Community shall be considered among the integral part of the multisectoral partnership, and can play the central role for HRH development in the health system.
- The goal to achieve UHC must become a shared mission for all stakeholders, and therefore we need innovative actions based on systematic thinking.

Plenary Session III

Reforming health professional education to produce competent health personnel responsive to population health needs and health systems

Potential moderator / lead speaker / speakers
Coordinator: Professor Pisake Lumbiganon/ Professor Wanicha Chuenkongkaew/Dr. Piya Hanvoravongchai
Chair/moderator: Dr. Nima Asgari Jirhandeh
Lead speaker: Professor. Masamine Jimba

Speaker 1: Dr. Patrick Kadama
Speaker 2: Professor. Yang Ke
Speaker 3: Professor. Wanicha Chuenkongkaew
Speaker 4: Professor. Sanjay Zodpey
Speaker 5: Dr. Andreasta Meliala

Key messages from the presentation by speakers

Professor Masamine Jimba

Reforming professional education for successful outcomes under limited evidence

- Highlighted the PMAC's contribution and the initiatives taken so far in terms of transformative education in 21st century
- He explained the type of recommendations (conditional vs. strong) in terms of health professional education. He further emphasized the needs for developing strong evidence base for inter-professional education. He also raised the issue that the evidence so far available is mainly from the developed countries. The evidence on HRH and transformative HPE is mainly coming from the developed countries
- He highlighted the needs for training the teachers for quality education so they could provide good quality education.
- He also highlighted use of evidence base coming from different sources, such as rumour vs. RCT. We should not wait until we obtain results from the RCT

Dr. Patrick Kadama

MEPI at the African Centre for Global Health and Social Transformation - ACHEST

- He provided a brief introduction of MEPI where, George Washington Univ. works together with them on the education. The program mainly covers the English-speaking and French-speaking countries of Africa. In this program, the students are individually chosen by the university according to the needs. The trainings are focused on behavioural change, encourage ownership, sustainability and sharing lessons, and learn from regional and global networks.
- He emphasized needs and importance of partnership within the region and inter-regions

Professor Yang Ke

Transformation of education of health professional in China

- China medical education reform and innovation initiative launched in May 2011 aim to conduct studies provide the evidences for policy making
- The results found that China is the largest producer of HRH, established a vast and complex system of HPE; HPE is improved in term of quality, numbers, major, and institutions; there are reform of education curriculum
- Issues of concern
  - Mismatch between HPE and demand of HP;
  - Dilution effect on quality
  - Outdated curriculum
  - Ethical professionalism challenges by narrow technical training

- Insufficient collaboration across sectors
- Integration of medical schools into university may not be always good for HP

- She highlighted the issue of rapid increased population, their expectation for quality health care, their lifestyle and current systems. These have changed the way of providing education to their kids as well
- Tertiary hospitals have reasonable income as they can earn necessary fund from drugs, equipment and other related care. She revealed the bitter truth that the primary health care system in China has been facing fund crisis for the past 3 decades. This is due to rapid development of technology, which has led to the increased cost, increased expectation and limited resources allocation etc.
- Effective prevention and management of NCDs and related problems have been issues in Chinese context. The technologies identified so far have not been able to address NCDs issues yet
- She further highlighted the needs for professional ethics among the teachers and to improve teaching learning process. She also emphasized the needs for competency based teaching learning to the medical education to the teachers. Some of the initiatives include training to Medical doctors, MD program, and MPH etc. which are now underway

Professor Wanicha Chuenkongkaew: ANHER

Reforming of Health Professional Education (HPE) to produce competent health personnel related to population health needs and health systems

The projection of the shortage of HRH in the region is shown, as well as the global shortage

A crisis in HPE
- Students starving
- Prehistoric pedagogy
- Faculty fleeing
- Institutional inadequate
- Investment insufficiency
- Accreditation

The presentation involved 3 levels of the HPE movement; the level of global movement, the level of regional movement (ANHER), and the level of national level (Thailand)

(1) The global level of HPE movement

The Global Independent Commission on Education of Health Professionals for the 21st century was established and launched its independent report in December 2010; subsequently, there were several movements for a reform in HPE in many regions to meet the needs of societies and population health. Recently, the global toolkit for health professional education assessment is released on October, 2014.

(2) The regional level of HPE movement by ANHER

The ANHER is established in April 2011 as a network of five Asian countries including Bangladesh, China, India, Thailand, and

Vietnam. The network aims to develop and strengthen the HPE in Asian region by sharing strategies and policy movement on evidence based reform of health professional education with respect to the national's socio-economic and cultural status, as well as, domestic health service system. Situational analysis to identify health needs, strengths weakness and gaps has been done simultaneously.

(3) The national level of HPE movement by Thailand

The National Health Assembly Resolution was established in December 2012 as a mechanism to develop national strategies. The HPE national strategy (2014-2019) has been approved by the National Health Commission. The National Commission is moving these strategies forward by many activities. The annual interprofessional transformative education conference will be commended. The first annual conference will be held on November 17-19, 2014.

Professor Sanjay Zodpey

Situation of public health education in the region and its challenges

- Highlighted the importance of transformative education in South east Asia region
- Current changes including increased population, aging, and rapid increasing problem of NCDs has led to the development and implementation of transformative education
- He also provided the current situation of PHE in the region and also emphasized the needs for changing from traditional approach of teaching to the pedagogy training
- As the needs for PH professional increased the number of public health schools in SEA regions are also increasing. Further, as the number of schools increased, we need to look at different aspects of improving PHE including the institutional and educational aspects
- The challenges in HPE include
  - Governance: having appropriate regulatory mechanism in the country, particularly looking at the accreditation of the public health programs. Infrastructure, partnership, quality of the teachers etc. are other challenges within the governance issue
  - Course/program: program quality, specialized training, limited opportunities etc.
  - Curriculum and competency: how curriculum can be transformed into competency based teaching and learning. Multi-disciplinary thinking, curriculum and teaching etc. Learning and case study based teaching would be another options
  - Faculty: well trained faculty, faculty recruitment, and faculty resource sharing etc. Pedagogic skills to be given
  - Evidence for action:
    - Tremendous needs for conducting research to generate strong evidence base, which can be used in the context of education

Dr. Andreasta Meliala

Transformative education, Indonesia experience

- Dr. Andreasta Meliala highlighted the needs for transformative education in health sector. Relevance and quality of education are few key aspects to be considered for transformative education in health
- Some facts as highlighted by Dr. Andreasta Meliala include:
  - Growth of private schools (>60% schools in Indonesia by private sector)
  - Quality of medical education
  - Ratio of teachers and student
  - Commitment to apply the learning and experiences
  - Clear vision and mission in selection of students
- He mainly highlighted the current situation of health education system, how challenging it is and needs for reforming it in order to improve quality education and leading to the transformative education
- Since the regional burden of diseases is increasing, the need for transformative education is important. Further capacity to achieve UHC is also needs a careful attention
- Capacity to handle the health problem is to be considered so that the health workers could be trained

Major issues or problems being discussed by participants

The participants of the session highlighted the use of technology (Professor. Shiv), how important is it to improve doctor- patient relationship to improve service delivery leading to the improved health outcomes.

The example was given that the technology in Indonesia is mainly used for higher education. Further, the participant highlighted that the HPE problems are quite same in all regions including Africa and Asia. The challenge is how we can move forward making some changes and implementation of best practices to improve HPE in this 21st century.

Parallel Session V

How to integrate health systems context to health profession education design: Country experiences

Potential moderator / lead speaker / speakers
Coordinator: Professor Masamine Jimba
Co-coordinator: Professor Fely Marilyn E. Lorenzo
Chair/moderator: Professor Fely Marilyn E. Lorenzo/Professor Masamine Jimba
Lead speaker: Dr. Tomohiko Sugishita

Speaker 1: Dr. Jay N Shah
Speaker 2: Dr. Outavong Phathammavong
Speaker 3: Dr. Himanshu Nalin Negandhi

Key messages from the presentation by speakers

Dr. Tomohiko Sugishita

Health systems management as a transformative learning model

This presentation highlighted health system management as a transformative learning model focusing on system thinking to achieve UHC and shared experiences of training in African. There was predictable irrational that behind people mindset as Dan Ariely from Duke University said that the hidden forces shape our decision. Therefore, think out of the box is needed to lead the system. For example, instead of waiting the patients to come to see us as doctors or nurses, we should go to see the patients. To lead and manage health systems, hard skills and soft skills are important. Hard skills (Pedegogy) focusing on "what to do" are knowledge related to professional, certification, legal, and regulation while soft skills (Andragogy) focusing on "How to do" are leadership, management, teamwork, and communication skills.

Dr. Sugishita shared experience and lesson learned about the training project "Whole Systems Approach" to build new mindset and business culture among health managers in Africa. For this training, there are core consecutive competencies for change.