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.

Dr. Kawkab Mahmud

Qualified nurses through national license examination: Lessons from Bangladesh

Bangladesh face massive nursing shortage where the ratio doctor to nurse 2,5:1 (normally 1: 3 or 1: 4, and estimated the total shortage around 100 -200 thousand nurses. This situation is related to social social cultural barrier and also the less attention from government to provide adequate funding. The nursing training in Bangladesh has been developing start from diploma level in early 1970 to the Bachelor level by year 2006. Enactment of the BNC Ordinance in 1983 has led the rapid growth of private institution to produce nurses which also brought concern on quality and public private mix. There is singular national standartd for accredation, admissions, curriculum which apply to both public and private health professional education schools.

Accreditation of the institutes, both public and private is being done by the Nursing Council and Directorate of Nursing under MoHFW. The external evaluation is done annually for the first five years. There is wide variation in accreditation. Infrastructures are less in private. The faculty members are inadequate in private as the faculty members are visiting professors from public institutes.

Dr. Gantuya Sengee

The emerging role of medical schools for health sector in Mongolia

She presented a study concerning emerging role of medical schools in health sector in Mongolia, involved 1 public and 4 private medical schools. The study has a purpose to understand the role, strength and weaknesses of private health professional school to health sector. Her study found that in term of capacity of institutions, about 75% have entrance criteria and 6 out of 7 schools had included actions prevent school dropout to the school internal policy. In addition, all surveyed schools had policy for renewing of the training curriculum. All schools have a policy on financial incentive system, performance based incentives, and non financial encouragements. While the survey on students revealed that most of the students enrolled medical and nursing school by the General enrollment examination and those who studied in state owned schools consider school condition as 'good' or 'very good'

Dr. Susie Perera

The emerging role of private nurse training schools in Sri Lanka

Sri Lanka has economic transition from lower to middle income country which has consequence on the growing private health insitutions made available for those who can afford. This study aimed to elucidate the policy and regulatory environment within which public and private nursing schools are operating, to compare their instituional and instructional characteristics and to compare the perceived competencies, attitudes towards working in rural areas and job preferences of students graduating from public and private schools.

In Sri Lanka, the nurses trained in the private are registered with the Private Nursing Council and the assistant nurses are recognized by the TVEC. Some are not registered anywhere.

There is high variation in intake and output because there is no proper nurse projection plan. The intake is based on the needs and enrolled accordingly.

The issue of recognizing a training institute is important. The conceptual framework was developed. The Sri Lanka Nursing is instituted recently. TVEC develops the standards, regulated by the Nursing council. The ratio of trainer to student is fairly good.

Dr. Krisada Sawaengdee

The emerging role of private nursing schools in Thailand

Thailand face nursing shortage with a projected need 25 nurses per 10,000 population and estimated to have shortage of 40,000 nurses in 2020 due to new job opening and replacement. The challenge is how to increase production capacity to fill the gap of demand and replacing the large proportion of retiring nurses efficiently.

The study resulted some findings on nursing education environment (geographical distribution, rural recruitment, local hometown training), Characteristic of pubic and private schools and output of public and private schools. Production has increased in both private and public schools. In policy context,Thailand has conducted geographical distribution nursing schools, Rural recruitment, Local Training and Hometown placement. All schools had specific policy towards curricula review every 5 years as recommendation of regulatory authorities. Both public and private schools have similar teaching methods and no significant differences in teaching and learning facilities among MOH,MOE and private.

Dr. Andreasta Meliala

Emerging role of private health professional schools in Indonesia: Quantity and quality trade off

The growing of private health education institutions in Indonesia is much faster compared to the public ones. The private institutions see the education as opportunity which can be transform into active business. The study has found some variations in institution features, curriculum, faculty member, teaching method and also in student perception. Although the production of health workers has meet the minimum threshold set up by WHO, there is a real concern about the quality especially in private medical schools.

Major issues or problems being discussed by participants

Japan participant commented about the result of studies that private schools has not good performance and the need of regulation and policy. He shared Japan experience on publication of school performance which help people to choose the good school and wondered whether any other country applied similar method. Participant from Bhutan raised a coordination issue between MoH and MoE. Another issue raised by participant from Lao, is how to make priority over resources, whether to continue the production by public schools or to spend for deployment and shift the production responsibility to private sector.

Discussion

The panelist responses are as follow:

- In response to the publication issue, Sri Lanka has no mechanism to link the performance with the media, would learn from Japan method. Thailand publish the result of the national licensing examination. Bangladesh said results are declared publicly but the standards of the diploma nurses are not examined as yet as it is not affiliated to any university. Indonesia publish the performance assesment result, but not mention the university.

  Sri Lanka: every country has coordination problem. Private sector benefit from the nurses graduates from private school. Nurses better remunerated in public sector.
- In response to the coordination issue and use of resources, Sri Lanka shared their experience tha, the nurses trained in public sector can work in the private health facility but the nurses trained in private institute cannot work in the public sector. India also highlighted that whatever status of the country what the policy maker think about the performance of private school. A unique experience shared by Iran is that Iranian medical school were run by MoH not MOE, however there are private schools with lower criteria enrollment.

Conclusion

All studies presented by the speakers recognize the important role of private health professional education institutions to contribute to the production of health workers. However, there is a critical concern about the quality of the products and the utilization.

Recommendation

- Countries shall made full benefit of the investment of private health professional education institutions in producing health professionals
- Licensure examination can be considered as one of qualification standard measurement.
- Education system should create accommodative environment to address the gap between quantity and quality of health workforce production.
- Projection of future health workforce requirement is strongly needed to ensure enough production of health professional.
- Opening new private schools should consider financial risk management plan to avoid consequences to students and ensuring that students receive quality educational opportunities at a reasonable price

Plenary Session V

The way forward and actions in Asia-Pacific countries
Coordinator: Dr. Suwit Wibulpolprasert and AAAH secretariat

Potential moderator / lead speaker / speakers
Chair/moderator: Mr. Naoyuki Kobayashi

Speaker 1: Dr. Viroj Tangcharoensathien
Speaker 2: Professor Shiv Chandra Mathur
Speaker 3: Dr. Akiko Maeda
Speaker 4: Dr. Gulin Gedik
Speaker 5: Dr. Vivian Lin
Speaker 6: Dr. Sarath Samarage
Speaker 7: Ms. Wanda Jaskiewicz

Key Note Speaker by Dr. Viroj Tangcharoensathien

Objectives; Critical comment on AAAH partnership, discussion and offer solution to strengthen AAAH, and What's next for AAAH countries.

He mentioned positive and negative factors affecting multicountry partnership. Some of them were strong leadership, shared interest, trust between partners, willingness to share resources, inclusiveness in decision making, investment in networking allowing time for investment.

Some of the negative factors were mentioned as lack of/over commitment, insufficient time/ funding for partnership activities, lack of relevant skills, low competency level, failure to manage risk, non-collective agenda setting, poor consultation, dominance by one partner.

Then he discussed if AAAH is it a genuine network? Honest assessment is vital and what limitation required.

AAAH is a partnership continuum, birth certificate Aug, 2005, participant from 10 countries and 5 priority actions for the first 2 years. Five priority action for first two years selected ; advocacy, information monitoring, capacity strengthening, knowledge generation and technical coordination

AAAH activities include conference, quarterly news letter, training workshop, intersession research. What the activities effective done by the AAAH? Evaluate it by the participants.

This will be a platform and expected to do institutional representation from the countries and take the messages from here to work at home-country.

AAAH is a platform, it cannot drive agenda at home, it serves as catalyst.

Inter-session activities: learning by doing; two themes agenda developed by all partners, research-in between conference the participant, just drive national agenda, initiative to change policies cross country paper authorship- icmje

Funding: mobilize on an ad hoc basis from multiple sources; Proud to be beggar network as no conflicts or resource among partners - no continuous partner - now pro bono services to run the network - should we continue with this funding model?

Governance: managed by a small secretariat which guided by steering committee, a focal point of each 16 countries as a coordinator between AAAH and agencies in country.

Strength of focal points: clear commitment, shown increased capacities through uneven across countries and weaknesses; critical role as change agent, if not competent, run risk of stagnation of Health workforce movement in country. How to minimize these weakness?

The way forwards through generating evidences and influencing policies on the same themes, survey among partners, confirms rural and retention and transformative scaling up professional education system are still relevant, emerging issues as financing education with equity, efficiency, and quality implication, response to challenges - NCD, international and domestic migration

He talked about objectives, strength and weakness of steering committee, the works, research works and how to strengthen institutionalization and sustain Health professional capacities at country level.

AAAH is trust based networks - no financial and rules based, hared leadership, responsibility with small secretariat practicing -A- pariha- niya dhamma to prevent failure - regular meetings punctual start and adjourn meetings and voluntarism, committed

Discussants are

Professor Shiv Chandra Mathur

- Shared experience and self criticism is sign of growth what Dr.Viroj has shared. We have identified the weakness and strengthened.
- Intersession activities certainly require follow up. Should enhance the activities in between the sessions and see what we generate in between the sessions
- There is a need to enhance activity, we were wondering why do we meet., last time we had question on that, then it has been decided that, it depends upon the activities in between
- Another issue is visibility. It is important, putting a blog for the newsletter, 16 countries should contribute + outside.
- Country focal points- unless they active how we can carry this forward- identified on the trust basis - secretariat should evaluate the performances of the country. If needed to change take the liberty to change the focal points.
- Country focal point must update the info and participate in the blog, up to date the data etc.
- Funders should never feel frustrated on the outcome
- I see the total process, as a beginning of outcome, as JLI, then 3 forum, and now we are working 2015 agenda
- Failure on efforts to expand the AAAH members - failure from his side to improve the visibility and improve the membership, dream that AAAH would have 25 countries but still now 16 countries and hope AAAH will make more visible the network.

Dr. Akiko Maeda

- Thanks to all young people running behind the scene, whole city, WEGO company
- Make 3 comments
    - Comment 1- reflections on the values principles and vision behind the AAAH- democratic and inclusive association of the members - rapid development is not good development - needs nurturing and patience - self oriented organization- the core value of the UHC - self governance
    - Comment 2 - how to walk together for the next step; WB is reconnecting the importance of joint learning from each other. Learning and teaching to be shred systematically. Joint learning activity is at the moment is financing but should focus on HRH.
    - Comment 3 - how WB value the conference as a method of global sharing of experience for the health workforce e.g. Monitoring the WHO code of conduct on migration of HWF, need your feedbacks, how can we improve some of the global standards and information system.

Dr. Gulin Gedik

- AAAH is instrumental in modernizing the HRH community in ASIA pacific region.
- Sustainable Development Goals - SDG 3 is on HRH and it gives good leverage to go forward where there is a role for AAAH
- There is a good well connected community in the region and happy about the community and acknowledge the AAA contribution on it
- New era where issues should look at new ways- future health workers will be different from today from tomorrow. We have to look at them together about the new health worker
- This is a forum where we can contribute for the global agenda - like global strategy for HRH
- This meeting provide the support to provide consultation, need to continue to contribute the process, information development
- Two calls from HRH journal: 1. Investment of HRH, 2. Relevance and effectiveness of WHO code of practice
- We hope we will continue to contribute all together.

Dr. Vivian Lin

Reflect from personal experience as working in public health education and small secretariat

- AAA has been fantastic platform built through intersession activities
- Retention agenda is important - not only rural but also in the primary care
- Not enough references to inter professional education
- Transformational educational- how many of us are involved in the deans of medical schools / internationalization of AAAH is important
- Patient and family engagement - patient for patient safety - how bad is the organizational cultures, need to engage family members too. Serous issue on how we transform the health system where workers and patients are satisfied - there is a serious issue on leadership development. Need to think with all people and perspective of HRH in a broader perspectives-health, governance etc.
- There is need a conversation with the UHC commitment - like NCD, information and others where HRH is a core issue
- Health professional education is governed by clubs and how we change into social organizations to governed the education
- Is it helping to address the core business?

Dr. Sarath Samarage

- Associated with the AAAH since Beijing meeting
- Child need to grow and next two years will be critical
- SEARO out of 11 countries, seven are active - two to be brought to next especially - Maldives and Bhutan
- Partners are growing - WB, JICA and so on
- Making the use of the opportunity to meet all the HRH actors on once place in the region is a useful
- Develop a resource directorate by AAAH so that it can be shared among countries
- Training is important for leadership and it should be started
- Transformative education is an important area
- Funding is important for survival of the organization - generating the funds for AAAH and membership funds from the country
- AAAH may develop some TOR or guidelines for the focal points so that they can take the messages into the country

Ms. Wanda Jaskiewicz

- Has seen a great evolution since the last five years
- Moving forward not only in numbers also for quality
- Thanked the public consultations had as the pre event was great and unique on HRH Global strategy
- Active engagement of governments and universities with focal points is important for the network. There is a need for visibility of the AAAH
- Examples of partnership- ask for something in return when information is asked from the organization. put some conditions on them when partners ask for data
- Self-sustaining consulting arm? To support the funding
- Weaknesses- focal person?- not competent change agent ? Clout of the person should come from AAAH and its important .
- Impressed from intersession activities - especially on retention - how do you translate the evidence into action. More needed on implementation side and management side
- The research on the history and weaknesses and depth of evidences are very good and transparent.
- The next suggestion is to make on implementation research.

Discussion

Professor Masamine Jimba

- Congratulated the award winners. AAAH brings in HRH practitioners to the forums and request to continue the same. As I learn from them I don't ask anything from AAAH but I contribute to AAAH
- Volunteerism was important-civil servant is important- more and more people like awardees are needed, what are our strategies to identify them.

Dr. Lao Wong

- Rural retention is a problem not only in Lao, Cambodia, but not in Australia. The another issue is that, European I want AAAH to convey the message to the member states to make high level commitment among the member states.
- We learn a lot on labor market and transformative learning but how to connect it in practice
- All people are talking about UHC, but few discussions on MDG, we need to discus on how we can make it MDG.

Answer

Professor Shiv Chandra Mathur learning from all the participants the country should remain in the centre, there are diversity among the member of AAAH- demographic, political, so AAAH cannot be an answer.

Dr. Akiko Maeda Transformative learning-economic drive to do the hospital based learning-has to address the learning community based learning- highly specialized learning should be discouraged. How civil society can ask for the market failures to achieve UHC. Move from narrow specialized training to transformative learning on team based learning. These are valid research questions where we can bring in evidence

Dr. Vivian Lin MDG and UHC-world has moved from MDG to UHC-post 2015 agenda-there is wide range of issues addressed. LAO has taken very positive steps-which is encouraging.

Dr. Iqbal from Pakistan - Happy that extending the membership from EMRO countries- Pakistan, Iran shold be allowed
Professor Shiv Chandra Mathur written to Regional office about it

Dr. Susie Perera Sri Lanka, Transformative learning is needs-SRL education system is not fully geared to take this change for Primary care. Some countries have taken the initiatives and we can learn from others as rapid assessments. May be important to get a group together to addressing the issue before the next sessions. This is a cross cutting issue between education and health.

Recommendation

To achieve AAAH goals, we need strong commitment from funders, competent focal point from each counties contribute, effective intersession activities, and strong leadership secretariat team to move forward on the same theme.

3

Annex 1, 2

Annex 1
Result
Prioritizing AAAH Intersession Activities for 2015-2016

Background

The Steering Committee of the AAAH has decided to convene a biennial conference, and accomplished intersession works in 2013-2014 concentrated on generating evidence for policy decision in two thematic areas: assessment of selected rural retention policies; and the role of private health professional education institutes.

Objective

To prioritize and planning for the 2nd wave of inter-session activities in 2015-2016, by soliciting views from all partners.

Methods

- Survey was conducted by using on line web based (Monkey Survey tool), during the period of October 2014.
- Each respondent reflects their own perspective, not representing his/her organizational positions.

Results

A total 57 respondents had completed survey,

1. **Your organization's responsibility, select one most appropriate**
   [18, 31.6%] Academic/teaching
   [13, 22.8%] International partner
   [12, 21.0%] Country policy maker

   [11, 19.3%] Research
   [3, 5.3%] Health care provider

2. **Your role in the 8th AAAH conference in 2014, select one most appropriate**
   [22, 38.6%] Invited speaker
   [19, 33.3%] Participants
   [10, 17.6%] Country focal point
   [6 , 10.5%] Member of Steering /Organizing committee

3. **Please score your priority area**
   [score 1-3 for the their important priority, 3 is the most followed by 2 and 1 respectively]
   [2.65] Area 1 Health workforce retention
   [2.60] Area 2 Health workforce education transformation
   [2.56] Area 3 Health workforce policy and planning

4. **In your perspective across the 16 recommendations on increasing access to health workers in remote and rural areas** through improved retention, WHO 2010, what relative 'Policy Relevant' of each intervention in your Country and Region?
   [5-Very Relevant, 4-Relevant, 3-Somewhat Relevant, 2-A little bit Relevant, 1-Not Relevant at all]

	Mean	Rank
A5 Continuous professional development for rural workers	4.26	1
A1 Recruit students from rural backgrounds	4.24	2
A4 Curricula that reflect rural health issues	4.24	2
A3 Clinical rotations in rural areas during studies	4.22	4
D2 Safe and supportive working environment	4.22	4
D4 Career development programmes	4.12	6
D1 Better living conditions	4.06	7
C1 Appropriate financial incentives	3.98	8
B3 Compulsory service	3.96	9
A2 Health professional schools outside of major cities	3.90	10
B2 Different types of health workers	3.88	11
B1 Enhanced scope of practice	3.80	12
D3 Outreach support	3.74	13
B4 Subsidized education for return of service	3.72	14
D6 Public recognition measures	3.66	15
D5 Professional networks	3.66	15

5. **In your perspective across the Eleven recommendations on Transforming and Scaling Up Health Professionals' Education and Training, WHO 2013,** what relative 'Policy Relevant' of each recommended intervention in your country and Region?

	Mean	Rank
1. Design and implement continuous development programmes for faculty, teaching staff relevant to the evolving health-care needs of their communities.	4.29	1
4. Adapt curricula to the evolving health-care needs of the communities.	4.24	2
11. CPD and in-service training of health professionals relevant to the evolving health-care needs of their communities.	4.20	3
2. Mandatory faculty development programmes that are relevant to the evolving health care needs of their communities.	4.08	4
8. Streamline educational pathways, or ladder programmes, for the advancement of practicing health professionals.	3.96	5
7. Targeted admissions policies to increase the socioeconomic, ethnic and geographical diversity of students.	3.94	6
10. Accreditation of health professionals' education where it does not exist and strengthen it where it does exist.	3.92	7
9. Inter-professional education (IPE) in both undergraduate and postgraduate programmes.	3.88	8
5. Apply simulation methods of contextually appropriate fidelity levels in the education of health professionals.	3.87	9
3. Innovative expansion of faculty through recruitment of community-based clinicians and health workers as educators.	3.83	10
6. Direct entry of graduates from relevant undergraduate, postgraduate or other educational programmes into different or other levels of professional studies.	3.47	11

6. Health workforce policy and planning, a few potential cross-country collaborative research there are four potential areas of collaborative research. Please check only one most important item in your perspective,

[17, 34.0%] Documenting good practices in health workforce policy and planning
[15, 30.0%] Assessment for improvement of inter-sectoral collaboration
[12, 24.0%] Assessment for improvement of health workforce
[6, 12.0%] Understand the determinants and consequences of generalists and specialist

7. Do you have any comment or suggestion for AAAH inter session activities?

Issue

1. Transformation and scaling up of health education in health work force needs to take into account individual community and country and relate it to global
2. New ways of "producing" doctors directed to work in rural and disadvantaged areas. For example, the experiences of Cuba, Venezuela and Bolivia or the Mais Medicos Project in Brazil.
3. please note that I answered question 5 and 6 from the perspective of what I feel is most important/relevant for countries to consider. I vote strongly for the next intersession activity to be on evaluation of strategies to increase access to health workers in rural and underserved areas (retention) as information on evaluation of effectiveness is lacking. Also, the last intersession top for AAAH was on education. Thank you for the opportunity to respond to the survey.
4. AAAH intersession activities, it is most important for health management and training and should learn and exchange the experiences from other countries.
5. Health care provider's perspective on how to improve a service delivery to patients

6. Improve and promote inter-sectoral collaboration and alignment of health development partners and stakeholders inside of country, not just at AAAH Conference.
7. Leadership Development and Governance of HRH

Alternative method

8. Documentary film of good practices can be demonstrated

Strengthen research

9. Needs further research to assess all aspects of rural retention of HRH in Bangladesh-comprehensive research also requires for HPE to assess all aspects of WHO recommendations
10. After data collection, it takes time for data analysis and paper writing. A support team may visit each country to support their writing process.
11. The activities should be well managed and continuous and lead to real good recommendations or actions published in international journals.
12. Urge the AAAH member countries to participate more in the intersession activities. Documenting good practices in HWF policy and planning and distribute to ministerial level of member countries directly as well as through focal points.

Intersession management

13. All countries shall be given the same opportunity to join the intersession activities and not be limited to certain countries. The more countries involved will result in enrichment of the finding
14. More collaborative activities for intersession research with young recruits will be a critical mass of people developed in the area of HRH in the region
15. Intersession studies needs transparency. They should not be kept limited to selected individuals particularly in context of large countries!

Conclusion

1. It is clear that the first priority area is heatlh workforce retention (score 2.65 out of 3), while the other two areas, health workforce education transformation and health workforce policy and planning get equal prioirty (score 2.60 and 2.56, respectively).
2. The top three priorities for retention are: Continuous Professional Development for rural workers, Curricula that reflect rural health issues, and Recruit students from rural backgrounds.
3. The top three priorities for transformation of health professional education are: faculty development through design and implement CPD for faculty, teaching staff relevant to the evolving health-care needs of their communities, adapt curricula to the evolving healthcare needs of the communities and CPD and in-service training of health professionals relevant to the evolving health-care needs of their communities.
4. Note that curriculum reform reflecting health needs of population are common both for better retention and relevant education reforms
5. Continued survey, until 30 October 2014 to gain more samples is urged to all participants to AAAH Weihai conference to come up with a robust analysis and plan for 2015-16.

Suggestion

1. Detail assessment of country status in both areas: rural retention and transformative health professional education. in each of the recommendations, scope of implementation. achievements and challenges
2. From the assessment, prioritize with a widest stakeholder involvement in both areas, this is to gain ownership and engagement in priority setting.
3. Solicit high level policy support for reforms, development of plan of actions, activities, targets and indicators, scaling of good practices and minimize the gaps.
4. Report progresses to the 9th AAAH conference at the end of 2016

Reference

WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention, WHO 2010

	Quality of Evidence	Strengths of Recommen-dation
A. Education		
A1 Students from rural backgrounds	Moderate	Strong
A2 Health professional schools outside of major cities	Low	Conditional
A3 Clinical rotations in rural areas during studies	Very low	Conditional
A4 Curricula that reflect rural health issues	Low	Strong
A5 Continuous professional development for rural health workers	Low	Conditional
B. Regulatory		
B1 Enhanced scope of practice	Very low	Conditional
B2 Different types of health workers	Low	Conditional
B3 Compulsory service	Low	Conditional
B4 Subsidized education for return of service	Low	Conditional
C. Financial incentives		
C1 Appropriate financial incentives	Low	Conditional
D. Professional and personal support		
D1 Better living conditions	Low	Strong
D2 Safe and supportive working environment	Low	Strong
D3 Outreach support	Low	Strong
D4 Career development programmes	Low	Strong
D5 Professional networks	Low	Strong
D6 Public recognition measures	Low	Strong
	13 Low **2 very low** **1 Moderate**	**8 Conditional** **8 Strong**

Source: http://www.who.int/hrh/retention/home/en/index.html

Eleven recommendations on transforming and scaling up health professionals' education and training, WHO 2013

Recommendations	Quality of evidence	Strengths
I. Faculty Development		
1. Design and implement continuous development programmes for faculty, teaching staff relevant to the evolving health-care needs of their communities.	Moderate	Conditional
2. Mandatory faculty development programmes that are relevant to the evolving health care needs of their communities.	Low	Conditional
3. Innovative expansion of faculty through recruitment of community-based clinicians and health workers as educators.	Low	Conditional
II. Curriculum Development		
4. Adapt curricula to the evolving health care needs of the communities.	Low	Conditional
III. Simulation methods		
5. Apply simulation methods of contextually appropriate fidelity levels in the education of health professionals.	Moderate	Strong
IV. Direct entry of graduates		
6. Direct entry of graduates from relevant undergraduate, postgraduate or other educational programmes into different or other levels of professional studies.	Moderate	Conditional
V. Admission procedures		
7. Targeted admissions policies to increase the socio-economic, ethnic and geographical diversity of students.	Low	Conditional
VI. Streamlined educational pathways and ladder programmes		
8. Streamline educational pathways, or ladder programmes, for the advancement of practicing health professionals.	Low	Conditional
VII. Inter-professional education		
9. Inter-professional education (IPE) in both undergraduate and postgraduate programmes.	Low	Conditional
VIII. Accreditation		
10. Accreditation of health professionals' education where it does not exist and strengthen it where it does exist.	Low	Strong
IX. Continuous professional development (CPD) for health professionals		
11. CPD and in-service training of health professionals relevant to the evolving health-care needs of their communities.	Moderate	Conditional
	4 Moderate 7 Low	9 Conditional 2 Strong

Source:
http://apps.who.int/iris/bitstream/10665/93635/1/9789241506502_eng.pdf

Annex 2

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