

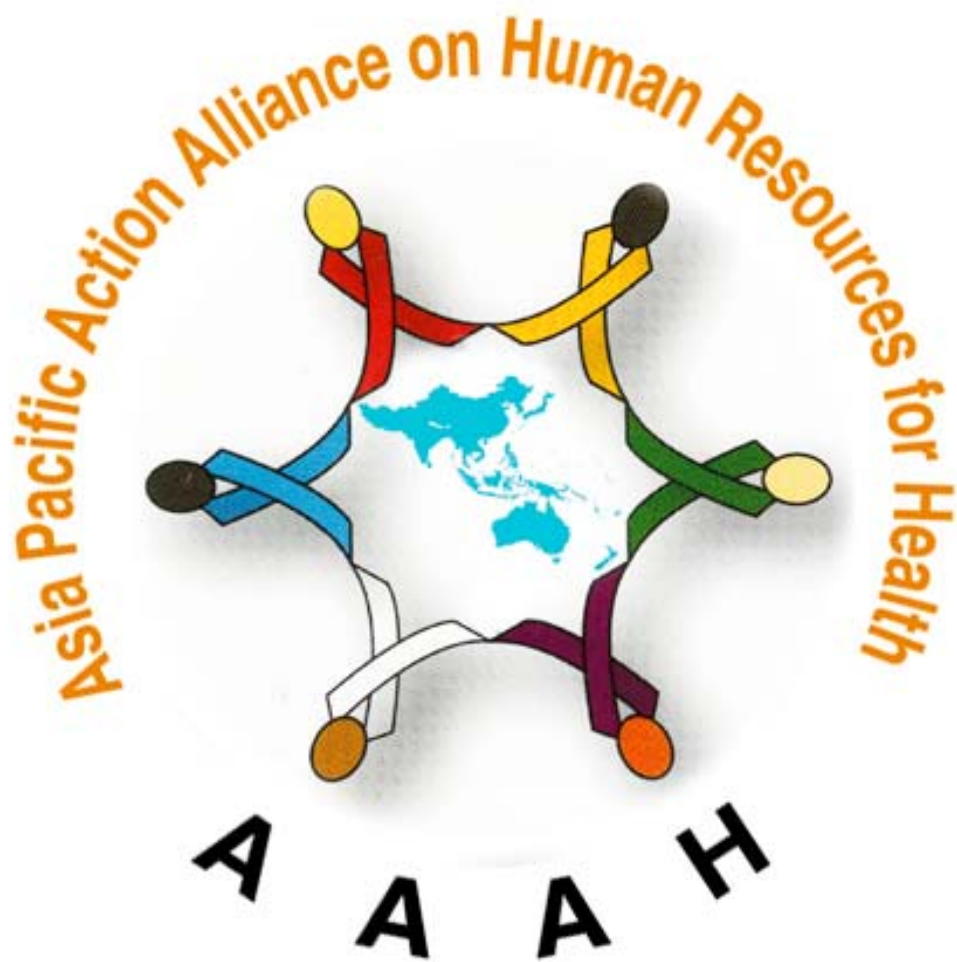
Proceedings of the  
First Asia-Pacific Action Alliance  
on Human Resources for Health Conference

28-31 October 2006  
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## 1. Introduction

The *Asia-Pacific Action Alliance on Human Resources for Health (AAAH)* is a regional partnership mechanism established in response to the international recognition of the immediate need for global and regional actions *to strengthen country capacity for health workforce planning and management*. It was initiated in August 2005 during a conference on health workforce in Bangkok with 10 founding member countries namely *Bangladesh, Cambodia, China, Indonesia, Lao PDR, Philippines, Myanmar, Sri Lanka, Vietnam and Thailand*. Strengthening country capacity in the management and development of national health workforce strategic plan and better sharing of HRH knowledge and tools to tackle specific high priority health workforce problems are identified as the top priorities from that conference.

With supports from the European Commission, the Rockefeller Foundation and the World Health Organization, the first AAAH Conference was held on 28-31 October 2006 at the Krungsri River Hotel, in Ayuthaya, Thailand. It was held back to back with the Thai National Health Assembly which allowed a good opportunity for participants to observe the development of the national health workforce strategic plan in Thailand.

The opening of the conference on 28 October 2006 was presided over by Dr. Mongkol Na Songkhla, Minister of Public Health, Thailand together with Dr. Samlee Plianbangchang, Regional Director of the WHO South-east Asia Regional Office.

The *goal* of the conference was to create a platform for regional members and global partners to work towards short and long term development actions for better health workforce system in all countries in the region, to ensure that health systems are capable of responding effectively to the challenges of HIV/AIDS, TB, and malaria, to accelerate progress towards the health MDGs and responding to current and emerging threats like SARS and pandemic flu. This can be translated into *five main objectives* of the Conference:

1. to identify how HRH constraints within the region are acting as a barrier to effective implementation of strategies for HIV/AIDS, TB and malaria control and to national strategies to achieve the health MDGs.
2. to follow up on HRH activities in member countries in the region
3. to share experience on national HRH strategic plan development as well as certain other priority HRH problems
4. to share experience on the development of the Global Health Workforce Alliance and other Regional Platform/Alliance
5. to develop and agree on a specific workplan for the next two years of the AAAH

To achieve these objectives, participants engaged in active discussion and activities in 12 sessions over 4-day period. In addition to the 10 founding member countries, additional members from *India, Nepal*, and 3 Pacific countries namely *Papua New Guinea (PNG), Fiji, and Samoa* were invited to attend. Representatives from the World Health Organization (HQ, SEARO and WPRO), global and regional development partners, the Global Health Workforce Alliance (GHWA), and other regional health workforce alliance/platform in Africa and the Americas were also invited.

The First Conference of the AAAH was organized by the International Health Policy Program (IHPP) – Thailand, under the supervision of the regional organizing committee

comprising of representatives from four AAAH members (Bangladesh, China, Philippines, Thailand), WHO/HQ/SEARO/WPRO, the GHWA, the European Commission and the Rockefeller Foundation.

This proceedings report summarized key activities and outputs from the Conference. It is organized in relation to the flow of the Conference sessions which can be grouped into 3 main sections. The first section is related to national and regional health workforce strategies development. It is then followed by priority health workforce issues. The last section is on the development of the AAAH Workplan. Information on the Conference participants, agenda, questionnaires and their results are shown in the Annexes.

## **2. National and Regional Health Workforce Strategies**

### **2.1 Towards National and Regional Health Workforce Strategies**

The first conference of the Asia-Pacific Action Alliance on Human Resources for Health (AAAH) started with an observation of the final process for the development of Thai Health Workforce Strategic Plan. This process was held as a part of the 3-day **National Health Assembly 2006** at the Impact Arena, Nonthaburi. The draft National HRH Strategic Plan was presented for a public hearing. There were active contributions from session participants from various sectors including public health workers, private sector and NGOs, academia, local administrative representatives, and Ministry of Public Health staff.

After observing the Thai case in the morning, participants had a chance to discuss and share their experience on national health workforce strategy development. Brief presentations were given by panelists from Thailand, Philippines and Bangladesh. Dr. Viroj Tangcharoensathien moderated this session.

- ◆ **Dr. Nonglak Pagaiya** from Thailand gave a brief historic background on the process in developing the national HRH strategic plan in Thailand. Thailand is facing with some shortage and severe mal-distribution of HRH.
- ◆ **Dr. Khaled Islam** from Bangladesh mentioned about the Bangladesh HRH strategic plan which has been in place since 1982 under the collaboration with the World Health Organisation and has been improved and modified to cover wide range of HRH problems in the country. The long term plan has been approved by the minister.
- ◆ **Dr. Kenneth Ronquillo** from the Philippines briefly outlined the development of the HRH master plan which was prepared, by multi-sectoral consultation, in 2005. The plan comprises of both short-term (5 years) and long-term (25 years) plans. Several tools and techniques have been utilized in the planning process.

Then, representatives from WHO SEARO, **Dr. Myint Htwe**, and WPRO, **Dr. Ezekiel Nukuro**, briefly talked about the regional HRH plans. The WPRO Regional HRH Strategic Plan covers a period of 5 years with 3 expected result areas, namely:

1. Health workforce response to population health needs (demand);
2. Health workforce development, deployment and retention (supply);
3. Sound stewardship, good governance and effective health workforce management.

WHO/SEARO has also developed the HRH strategic plan with similar objectives to the WPRO's. Moreover, on 22 August 2006 Health Ministers in the Region adopted the Ministerial Declaration on HRH or the "*Dhaka Declaration*". The strategic plan will be further discussed and finalized in December 2006 in Bali, Indonesia.

In addition, participants from other countries briefly talked about the existence of the national HRH strategic plan and the experience in development of HRH strategic plan in their countries. Since a number of countries have not developed the national strategic plans, they mainly shared the situation on health workforce in their countries.

- In *Cambodia*, the country is facing with shortage of HRH and the distribution problems.
- In *China*, there are more and more medical and nursing graduates but the public sector does not have capacity to absorb all the graduates, and most of them prefer to work in cities. The Government is thus trying to develop policy that can accommodate this problem.
- In *Indonesia*, decentralization causes major impact on the imbalance capacity. Besides, globalization, disaster and disease outbreak also have impacts on human resources for health. However, the country wants to participate in the global market of the health workforce due to high availability of certain health workforce cadres, particularly nurses.
- In *Nepal* the focus is more on doctors but not other categories of health professionals. The country is also affected by problems of internal and external brain drain resulted from globalization and privatization.
- *Sri Lanka* is also facing with problems of shortage, mal-distribution, and lack of appropriate planning for production.
- *Vietnam* has set up the national strategy for 2010 and 2020 with the priority on mal-distribution and shortage of health workforce. The policy is to place doctors to work in rural areas.
- *India* is setting up the institute of public health to be in charge of improving the standard of curriculum and training as a measure to solve problem of health workforce migration.
- *Fiji* has high number of nurses but the government has no vacant positions to employ all of them, so the country has created partnerships with other island countries to share the nurses.
- *Laos* has similar problems with other neighboring countries such as rural placement.
- *PNG* is facing with 2 decade of shortage of health workforce while the population is increasing. The 10 year national health plan has been approved.
- *Samoa* has several HRH problems. The country has the Strategy for Development of Samoa which includes strategy for health development covers workforce strategy.
- *Myanmar* is also facing with the shortage and maldistribution of the HRH. The country has drafted the national health workforce strategic plan with 3 priority areas in the plan.

## 2.2 The HRH Framework and Tools

This session was moderated by **Dr. Manuel Dayri**, Director of Department on Human Resources for Health Development of the World Health Organization/HQ. The session started with a presentation by members of the steering group on the HRH Action Framework, **Dr. Mario Dal Poz** (WHO) and **Mr. Jim McCaffery** (the Capacity Project).

With support by the WHO and USAID, the development of the HRH Action Framework began with a technical consultation among multilateral and bilateral agencies, donors, partner countries, NGOs and members of the academic community held in Washington DC on 14-15 December 2005. The framework has 6 components on planning and managing the health workforce, including health workforce management, policy, finance, education, partnerships and leadership. It aims to support policy makers and HRH experts for the development of an effective and sustainable countries' health workforce.

This framework will be helpful in the assessment and development of a comprehensive country strategy. It facilitates the development of these strategies into an organised and systematic implementation plan with participation from all sectors. It can also be used as a 'filter' to refine current HRH strategies.

Dr. Dal Poz also mentioned a number of important factors for the success in implementation of the HRH action framework, which can be grouped into *process related factors and content related factors*.

- ◆ For the process related factors, the implementation of the action Framework will be successful only if it is a *country-led participatory process* rather than being led by external partners. In addition, the top policy level commitments are essential for the success.
- ◆ For the content related factors, he mentioned that the health workforce strategies should aim at achieving measurable results and be *harmonised with relevant component of the health system development*. The decision should be based on available evidences, and monitoring and evaluation should be applied from the beginning in order to effectively collect the lessons learnt, to improve future actions.

The framework is expected to be finalised by the end of January 2007.

Afterward, **Professor Roy Pargas** and **Dr. James Witte** from Clemson University introduced the *Software Tool for Policy Diagnosis and Dialogue or SoftPoDD* which is a web-based interactive tool to help guide the HRH policy development. The programme serves as a user-friendly portal to the powerful HRH Framework tools. It will be available on the web.

The pilot project for the programme is expected to complete on 15 December 2006 and the *SoftPoDD* version will be delivered. The AAAH Participants were invited to try the programme during the Conference period. Feedbacks from the AAAH will be utilised in improving the software.

### **3. Priority Health Workforces Issues: experience sharing and discussion for further collective actions**

#### **3.1 Health Financing and Health Workforce**

This session explored how countries can effectively set their health financing policies to strengthen health workforce system. **Dr. Viroj Tangcharoensathien**, Director of International Health Policy Programme-Thailand and **Dr. Tim Evans**, Assistant Director-General of the WHO, as the members of the Health Financing Taskforce - an independent entity aiming to accelerate the achievement of full, fair and effective financing for health in developing countries - gave the presentations.

**Dr. Tim Evans** talked about cost and financial needs for human resources for health. He emphasised on the investment in health workforce including the costs for training and recruitment of health workforce. There are several transnational issues on workforce cost and financing such as the aversion to investing in health workers amongst donors / development banks; the focus of MDGs that is missing the systemic aspects of financing workforce, under-counting real cost of training; proportion of the budget to be used for training; compensation and reciprocity for migrant health workforces; and valuation of remittance of migrant health workforce.

He mentioned that a study has shown that investment in health workforce is cost effective, giving a sample of the study by the Touch Foundation which suggested that investing \$100 million in skilled HRH training in Tanzania will have a greater impact upon disease burden than investing \$100 million in any other aspects.

**Dr. Viroj Tangcharoensathien** mentioned that countries in Asia Pacific region share common HR problems particularly on shortage and mal-distribution (public-private, urban-rural), and skill mix (low performance, non-responsive, and high absenteeism). The root causes of these problems are inadequate national policy and strategies, globalisation, privatisation, and limited fiscal spaces due to reliance on out of pocket payment system in several countries. All of which have become major factors contributing to international migration of health workforce.

He then proposed the following recommendations for improvement of health financing and health workforce.

1. Promoting constitution rights for people with equal access to healthcare, education, employment opportunity through legislative amendments
2. Investing more in health and education of the population through increase of budget to GDP ratio and ensuring better allocation to health, education and other social sectors. At the same time, external resources maybe mobilised
3. Ensuring equity by introducing health protection to the poor and strong government determinations towards gradual extension to achieve universality through pro-poor budget allocation and risk equalisation mechanisms, including minimising the proportion of out-of pocket payment
4. Better health gains from the limited health resources available through ensuring allocative efficiency through the application of cost effective intervention; more

investment in public health functions of health systems, especially diseases surveillance and primary prevention of major risk factors of the population; establishing / reforming the provider payment methods that send strong signal towards efficiency, rational use of health resources and long-term cost containment.

5. Functioning and responsive primary health care services through evidence based HRH policy and interventions to address specific pushing and pulling forces; regulatory framework and effective relationship of the private provider sector; and careful implementation of decentralisation to safeguard the PHC and public health functions
6. Evidence base for agenda setting, policy formulation, implementation, and monitoring and evaluation by institutionalisation of national capacity to generate, analyse and translate evidence into policy, and publicising these evidences to the public and policy stakeholders, and civil society.

After the presentations, participants discussed this issue.

*Dr. Lepani Waqatakirewa* from *Fiji* mentioned that shortage of HRH result in more training but finally they are lost to other countries and he is in doubt whether host countries realise the problem of shortage in country of origin. He suggested that this issue should be included in the workplan of the AAAH. *Prof. Sudhir Anand* proposed that the cost of producing the HRH should be borne by the host country not the country producing the HRH. He also suggested a study of HRH cost effectiveness in term of BOD, as it allows much better budget allocation. *Dr. Jayawickramarajah*, WR to Thailand said that the World Health Report 2006 provides important information on HRH trend and related data. *Dr. Rosalia Sciortino* from the Rockefeller Foundation mentioned about making more effective use of resources and providing incentive to retain health workforce in rural area; and the value of health service activities should be highly regarded no matter of duty difference between doctors or nurse. Finally, *Dr. Lincoln Chen*, Chair of the GHWA Board, raised a question whether public financing is always good and private is always bad. The answer is not a clear yes or no but it probably depends on how system should be performing and based on the principle of fairness, and what the realistic compensation expectations of health workforce are.

### **3.2 Non-financial incentives to support HRH retention, productivity and equitable distribution**

In addition to financial incentives, non-financial incentives play important roles in workforce recruitment, training, and retention. This session was facilitated by **Dr. Myint Htwe**, WHO/SEARO with discussants from Sri Lanka, Pacific Island countries, and Nepal sharing their country experience. Further contribution from Dr. Francisco Campos was on the experience from Brazil. This session promoted better understanding of the norms of non-financial incentives which can be included in the AAAH workplan.

In his presentation, **Dr. Francisco Campos** emphasised that HRH in Brazil is linked to the concept of national health. He then gave brief outline of Brazil national health system. Family health strategy is the main health policy and being implemented in 84% of municipalities throughout the country. The main challenges for this policy are that in urban

areas, despite positive difference of salaries, professionals are reluctant to join FHP, due to lack of prestige. For rural areas, previous programme that encouraged professionals not to leave for inner cities has failed. Professional alleged lack of support as the main reason for leaving. However, since then, there has been an improvement of self-confidence and prestige of the family health practitioners. The Ministry of Health also supports multi-professional and medical residence in primary health care, increase incentives to research and promotes doctoral-level thesis studies in primary health care management. The synergic parallel track is now implemented. And there are a number of additional measures implemented to address specific challenges in rural and remote areas, such as the TeleHealth programme.

**Professor Lalitha Mendis** from Sri Lanka presented the use of non-financial incentives in Sri Lanka, starting with the current situation of the HRH in the country that Sri Lanka is facing with insufficient numbers of HRH in some categories, mal-distribution, international and in-country migration, and the lack of clear health policy, proper information system and modern management system. She mentioned that non-financial incentives to encourage health care workers to work in provinces include improved living conditions of housing and accommodation, good schooling for children of those health workers (army has this arrangement), provision of car loans and housing loans, supporting good working conditions that satisfy the professional conscious and good job satisfaction, and giving recognition or credit and rewarding system for difficult work in different areas.

**Dr. Lepani Waqatakirewa** from Fiji represented the Pacific Island Countries gave a presentation on non-financial incentives in the pacific island countries. The country is facing with migration of HRH due to the need of higher education and training abroad and most of them do not return after the training.

After the presentation, the participants discussed the issue further. *Mr Tim Martineau* said that there should be a distinction between incentives for workforce retention and incentives for good performance. *Dr. Tim Evans* from WHO said we could improve conceptual framework on incentive, with greater clarity on what non-financial incentive, prestige such as low-cost non financial incentive or value to the workforce performance can have cultural transformation for longer term dividend. *Dr. Nonglak Pagaiya* from Thailand raised that non-financial incentive may need more financial investment than the financial incentive. *Prof. Wichit Srisuphun* mentioned that there is a pilot project on local recruitment for local placement for nurses in Thailand which is a good sample of non-financial incentive. *Dr. Manuel Dayrit* also raised that those HRH love their jobs and job satisfaction is the most important incentive.

### **3.3 HRH knowledge generation, management, and sharing**

This session examined effective ways to increase production of relevant knowledge for health workforce planning, management, and development and to promote knowledge sharing both within and between countries. Experience at the global level was shared by Dr. Jim McCaffery on the development of the HRH Global Resource Center and by Mr. Tim Martineau on compilation of the HRH Tools Compendium. In addition, representatives from China and Cambodia discussed country needs and gaps from their perspectives. The session was facilitated by Dr. Eric Friedman.

**Dr. Zhang Junhua** from China mentioned in his presentation that the total health workforce in China was 6.35 million, of which 1.94 million and 1.35 millions are licensed physicians and nurses, respectively. Most of them are working in urban areas. China is facing with low qualification of HRH as the majority of them (74 percent) are trained with associate degree or vocational education while 12.3 percent did not have formal health professional training. Only small portion continued with higher education. Regional imbalance is another problem. There are more number of health workforce in the eastern provinces than in western provinces. At the same time there is a big gap of distribution between urban and rural area as 47 percent of population in urban area occupy 67 percent of the total HRH while in rural areas there are 300,000 employees who did not have formal health professional training working in healthcare settings. Notably, there is an inversion of the doctor to nurse ratio, i.e. 1: 0.97 in hospitals and 1 : 0.40 in township health station.

In Cambodia, **Dr. Porn Sam Song** pointed out that the main HRH problems that the country is facing are the immigration of clandestine HRH from other countries such as Vietnam and China, different nursing curriculum and training, the lack of regulation and national standard for HRH development for both public and private institutions, and long-term problem of lacking financial and non-financial incentives. To solve the problems, the government is in the process of formulating the sub-decree on the criteria for health sciences training institutions. The system for national qualification examination was also developed. Besides, the HRH Board has been established, and the HRH strategy and policy (2006-2010) has been developed based on the National Health Plan. However, to further improve the situation, the country still needs to train more midwives among students selected from rural areas and 4 month intensive midwifery skills course for nurses working rural areas; strengthen motivation of HRH such as providing acceptable basic salary and promotion; enforce compulsory service at the public sector for a certain period of time; provide incentive to encourage HRH to work and retain in rural or unattractive areas; and set up the registration and licensing system for HRH.

After the country presentations, **Dr. Jim McCaffery** from the Capacity Project shared the experience of information management by the HRH Global Resource Centre. The *HRH Global Resource Center* is a digital library with over 800 documents devoted to human resources for health. It provides information and resources to help address the critical health workforce challenges, particularly in developing countries. The Resource Center team also offers professional librarian support and welcomes contributions from users.

In addition to the extensive online collection of HRH resource documents, the Resource Center has three types of content on the homepage: HRH Leaders in Action Series, News, and Resource Spotlights. Users are welcome to nominate leaders for the interview series, to identify resources they have found useful for a Resource Spotlight, and to volunteer to review resources. The website can be accessed at <http://www.hrhresourcecenter.org/>

Then **Mr. Tim Martineau** from University of Liverpool introduced the HRH Tool Compendium. Since there has been a heightened increase in the interest of the planning, managing and development of human resources in health, the Compendium will assist in finding HR tools appropriate for such development and work. The tools and resource documents included in the Compendium have been reviewed by two or more people with HR expertise. Nearly all the tools are available in electronic form and are free of

charge. The review and compilation of the tools are supported financially by the WHO. The main target group of users is HR practitioners, consultants and academics working in health systems in mid and low income countries.

At present, the Compendium consists of various tools for broad diagnostic/appraisal, HR functions/ organisations, planning/ costing, performance, employee relations/ change management. All these tools can be accessed at <http://www.hrhcompendium.com>.

### **3.4 HRD in response to AIDS, TB, Malaria, MDGs, and Pandemic Flu**

This session explored the implications on health workforce system of AIDS, TB, Malaria, MDGs, and pandemic flu. Participants from Indonesia, Myanmar, and Vietnam shared their experience on current roles and limitations of health workforce development in addressing these challenges. The session was moderated by **Dr. Neil Squires** from the European Commission.

**Dr. Tin Min** from Myanmar pointed out that Myanmar has been threatening with the emerging infectious diseases particularly HIV/AIDS, tuberculosis and malaria as well as avian influenza. These have become big challenges for development of HRH to overcome the problems while the HRH situation itself remains a problem particularly with lacking of explicit HRH policy, mal-distribution, and lack of good HRH management.

As HIV/AIDS has become a national concern, the government has developed, in coordination with all partners, the National Strategic Plan for HIV/AIDS 2006-2010. However, there are several challenges in term of HRH development to address the HIV/AIDS problems, including limited resources for training, supplies and equipment to practice; lacking of quality assurance; and the lack of incentive to retain staff to work with the national HIV programme. For tuberculosis, staffing and infrastructure at all levels within the national tuberculosis programme (NTP) are overstretched. Nearly a quarter of posts at various levels are vacant. The country has developed the National Strategic Plan (2006-2011) that includes scaling up activities and HRH requirements. Myanmar is also facing similar HRH challenges for malaria and avian influenza such as management skills, field and rapid response skills. The country has a plan to develop a comprehensive HRH policy in general and well planned rotation/transfer policy, to develop comprehensive HRH Database system, to strengthen coordination between all stakeholders, to develop feasible financial and non-financial incentive system, to improve networking for HRH, to improve the skill mix balance, to initiate research for HRH to improve planning, production and management of HRH, and to review recruitment policies, job profiles, work load, and accountability.

Similar to Myanmar, HIV/AIDS, tuberculosis and malaria are major health problems in Vietnam, as presented by **Ms. Nguyen Lan Huong**. The prevalence of HIV positive and tuberculosis cases are increasing. HRH for HIV/AIDS, TB and malaria are distributed in central and local levels, however, those at the local levels are less specialised and qualified. With increasing cases of HIV/AIDS and TB, but shortage of HRH, the workload has been increased. Also, the country is facing with other HRH problems such as mal-distribution of HRH due to internal brain drain from rural to urban area, outdated training model despite changing of disease pattern, and poor management of HRH and investment in health. The country has implemented several measures to overcome these problems in order to be well responding to the problems of emerging disease, for

examples reorganisation of the health care system, increasing capacity of health training institutions, upgrading technical capabilities of local health facilities and providing continuous training for health workers, providing training for local people according to their needs and requirement, providing incentives for health workers to serve in rural areas, and increasing investment in health.

In Indonesia, **Dr. Mary Siti Maryam** described that the country is facing with both re-emerging and new emerging diseases. Decentralisation has resulted in limited HRH mobility between districts after decentralisation. In addition, there is an insufficient number of skilled HRH to conduct surveillance, early diagnosis and prompt treatment when there is a disease threat. HRH is of low quality with insufficient quantity due to limited resources to support HRH development. The important strategies implemented in Indonesia to overcome HRH problem in response to threatening diseases are improvement of HRH distribution by provision of incentives for HRH working in remote, underserved and unattractive areas; refresher training of health personnel to response the need for the development of village preparedness programme from 12,000 villages in 2006 to 69,000 by the year 2009; development of national training models in all diseases including HIV/AIDS, TB, malaria, Avian Flu; improvement of surveillance, monitoring and HIS at all administrative levels; providing technical assistance and budget support to local government; and establishment of self-regulation mechanism of health professional body such as medical/dental council. International collaboration is also sought for technical and financial supports to overcome the problems. Besides, the development of HRH institutions in eastern part of the country is also carried out.

### **3.5 Globalisation / International Trade and implications on HRH: Supply, Demand and Migration**

This session explored the implications of globalisation and international trade on health workforce system in member countries. Presenters from the Philippines, Thailand and India described their countries' situation and the countering policies and actions. The session was moderated by **Dr. Suwit Wibulprasert**, Ministry of Public Health, Thailand.

**Professor Marilyn Lorenzo** from the Philippines gave an overview of four modes of services under the General Agreement on Trade in Services (GATS), including cross-border supply (Mode 1), consumption abroad (Mode 2), commercial presence (Mode 3) and movement of natural person (Mode 4) with push and pull factors and important players for each mode. For examples, the major drivers for movement of patients under Mode 2 are increase number of aging population that need more health services, shortage of health professionals in the country so patients need to seek health services elsewhere, high cost of services or poor health facilities as well as long waiting for treatment in home country. Thailand, India, Malaysia and Singapore are the major exporters of health services. For Mode 4, Philippines is a major exporter of health professionals while the country allows entry of foreign medical professionals only under certain intra-company arrangement or contracts but not allow them to practice or establish commercial presence. Professor Lorenzo also described the situation of HRH in the Philippines that due to low salaries of medical professionals, lack of opportunities for medical professionals in the country, and low budget on health expenditures, there have been emigration of doctors and nurses accompanied by declining in enrollment in medicine (from 9,106 in SY 2002-03 to 6,551 in SY 2003-04) but rapid increase in enrollment in nursing (from 8,600 in

1998-99 to 34,277 in SY 2003-04). At the same time, the quality of nursing education has declined. During 2000-2005 the passing rates for nursing license examination were about 45-52%. About 58% of 269 nursing schools in 2005 were categorised as low and very low performance.

In order to improve the quality and retention of health professionals, the government has developed an HRH master plan with key strategies such as an increase health budget specially for HRH development, an improvement of retention / return scheme by brain circulation programme, and encouragement of life long learning among health professionals to build up their capacity and credentials. Finally, Prof. Lorenzo proposed the options for negotiation of professional movement under international trade system, such as conducting multi-stakeholder meetings to discuss Philippine position in the GATS framework, regional arrangements, and bilateral arrangements specifically for identifying the benefits and costs in relation to health objectives, implementation of exchange compensation schemes, open up activities with significant inflows of capital that would enhance local linkages, and identifying options for allowing foreign medical practitioners and foreign investors and mutual recognition of licenses and standards.

**Ms. Cha-aim Pachanee** Thailand, talked about international trade in health services in ASEAN and international trade in health services in Thailand. Within ASEAN, the ASEAN Framework Agreement on Services (AFAS) is the main agreement on international trade in health services among the member countries and covers all ASEAN members despite their membership status of the World Trade Organisation. She mentioned that the ASEAN members could be classified into 2 groups, by each mode of services, i.e. the importer and exporter. This is the main motivation for liberalisation of trade in health services in ASEAN. The important negotiation under AFAS is on the establishment of the Mutual Recognition Agreement (MRA) on nursing and medical professions. The MRA for nursing profession has been negotiated under several meetings of the Health Sectoral Working Group and the final draft has been approved and will be signed by the head of states, in December 2006, while the MRA for medical profession is under negotiation. She then pointed out that liberalisation of health related services under the AFAS can post both positive and negative implications. For Mode 2, although influx of foreign patients can increase revenue to the country, it can create a dual market structure and severe maldistribution of health resources due to internal brain drain of HRH from public / rural areas to urban private health facilities. For Mode 3, foreign investment in health service business can create a tiered healthcare system and increase inequality of services between urban and rural hospitals. For Mode 4, brain drain of HRH can constraint the development of the national healthcare system, at the same time immigration of HRH can create oversupply and competition with local professionals.

Later, Ms. Pachanee briefly talked about the implication of government policy in promoting export of health services to foreign patients while trying to provide universal coverage of health care to Thai people, or a so-called 'dual track health policies'. With over supply of private health services during the economic crisis in 1997, the government supports the export of health services to foreign patients to improve business of private health service providers. Due to good standard health services with impressive hospitality and reasonably price, the number of foreign patients seeking health service in Thailand increased sharply in the last few years, resulting in increasing demand for HRH particularly medical doctors. It is estimated that in 2015, the total additional doctors required by foreign patients will be 15-22% of those doctors in the private sector or 6-8 %

of those doctors required by the total health system if the number of foreign patients increase at 10-12% per year. The important implication from this phenomenon is internal brain drain of HRH from public to private sector. Thai government therefore has implemented both demand and supply side interventions to overcome possible negative implication.

After the two presentations, Dr. Kavita Sivaramakrishnan from India gave a brief outline of situation on HRH and globalisation in India.

## **4. Toward AAAH Strategies and Workplan**

### **4.1 Regional Alliance/platform on HRH**

During this session, Dr. Jennifer Nyoni of WHO/AFRO and Dr. Charles Godue of WHO/PAHO shared with participants the activities of regional health network or alliances in the 2 regions. Dr. Manuel Dayrit was the moderator of this session.

**Dr. Jennifer Nyoni** gave a presentation on Africa Health Workforce Platform and Observatory. She mentioned that Africa is in critical shortage of the health workforce. The health workforce has weak capacity at various levels. The statistics on HRH is also poor and there is weak evidence-based knowledge available and used on policy decisions.

Dr. Nyoni then explained more about the African platform and the African observatory. The concepts of African Health Workforce platform and Observatory were endorsed at the July 2005 stakeholder consultation. The proposed strategic focus of the African Platform is on an advocacy for common African position on key HW issues, high level policy dialogue, and resource mobilisation. The platform focuses on workforce performance improvement, the mid level and community based health workforce, and improving the workforce density by strengthening the capacity of training institutions for pre-service training. The Platform is expected to be launched in 2007.

For African Health Workforce Observatory, Dr. Nyoni said it is a cooperative initiative and partnership of several stakeholders to improve human resources development through promoting and facilitating evidence-based policy-making. The Observatory has 4 following objectives:

- to develop national capacity for evaluation and monitoring of HRH situation and trends
- to provide information and evidence for the formulation of HRH development policies, strategies and plans
- to provide a forum for partnership, sharing of experience and advocacy in HRH development
- to facilitate the use of HRH data for informed decision-making at all levels of the health system

The functions of the Africa Health Workforce Observatory are country monitoring and information; research and analysis; sharing and dissemination of good practices, lessons learnt, forum within and across countries; and promoting national and inter-country networking, capacity building for HRH. Dr. Nyoni also raised that to successfully develop the health workforce observatories at a country level, some critical success factors such

as having champions in the country, advocacy and political commitment, identifying stakeholders, having a good understanding of situation, and funding opportunity are needed.

**Dr. Charles Godue** from WHO/PAHO then gave a presentation on the network of observatories of human resources for health in the Americas Region. With the total population of 833,112,000 people living across 48 countries in the region, in 2000 over 63 million resided in areas where the human resources density was below the minimum target of 25 per 10,000. In these 15 countries where the health human resources density ratio is below 25 per 10,000, it would require approximately 128,000 additional doctors and nurses to reach that level.

The Observatories was initiated since 1995 when, during the Summit of the Americas, PAHO was given the responsibility to monitor health sector reforms in the Region. The initiative of the Observatory of Human Resources for Health was launched at the summit in Chile in 1999. The objectives of the observatories are to:

- raise awareness on the importance of human resources issues
- monitor the impact and implications of health sector reforms on human resources
- promote the production / utilisation of information and knowledge for analysing problems, define priorities and identify effective HRH interventions
- promote sharing of experiences and networking between countries on HRH policies

The observatories focus on priority issues and policies rather than issues of interests to stakeholders. The main strategies of the initiative are country-based i.e. build on existing country dynamics and actors; minimum of formality, high organisational flexibility to accommodate diversity, political contexts; empower, strengthen the capacity of HRH Units of the Ministries of Health; being responsive when technical assistance was required; and providing visibility to the countries' policy initiatives and a forum for discussion through the annual meeting of the Observatories. So far, the observatories have been launched in 9 countries in 1999 and in 2005 there were 23 countries involved in the initiative. The website of the observatories can be accessed at [www.observatoriorh.org](http://www.observatoriorh.org).

After the presentations, Dr. Suwit Wibulpolprasert raised a question whether there is a need for HRH observatories in the Asia-Pacific. He then urged the participants to discuss in the group works, whether these observatories should be encouraged by the AAAH.

#### **4.2 AAAH in relation to other related regional and global mechanisms**

Drs. Kathy Cahill, Neil Squires, and Kate Bond shared their inputs on the AAAH and its expected contribution to regional and global HRH development.

**Dr. Kathy Cahill** emphasised the complexity of health system and many players and actors that are involved. Addressing the health workforce problems therefore requires resolving issues on both the supply and demand sides in the context of a dynamic healthcare system. It thus involves several steps from supply side from training, regulation, utilisation, to retention and the elements of health workforce demand including health care need and access.

**Dr. Kate Bond** added to the discussion on the complexity of regional entities and the potential of AAAH in working with and learning from other regional and global mechanisms. There are many existing networks that are functioning in the region. Some are networks for specific functions such as education networks or for specific diseases such as HIV/AIDS, malaria. Dr. Bond also raised an example of regional human resources development network to support cross-border health. She suggested that AAAH should have a clear set of expectations and strong technical approaches that support country work in collaborative action. The process could be cohort development with continuity of engagement and progressive learning, development, and evolution with adequate safe space to disagree, debate, deliberate. The countries will also benefit from mentoring process.

**Dr. Neil Squires** proposed that the work of AAAH to be based on the HRH Action Framework. Several tools can be utilised for an effective and sustainable health workforce. In addition, implementation of the activities would be a critical success factor towards improved health workforce outcomes and better health services. Health workforce actions also need to be sensitive to specific country context including its labor market and the characteristics of other health system components.

#### **4.3 AAAH strategies and Work plan**

To develop AAAH strategies and work plan, participants were divided into 3 groups of their interest to work on the following issues:

*Group 1: Regional level activities*

*Group 2: Activities to support countries*

*Group 3: Governing structure and funding mechanism*

After group work, a representative from each group presented the outcome of group discussion to the participants. The results were discussed in two consecutive sessions.

The first session was on **AAAH work-plan for the next two years**, moderated by **Dr. Francis Omaswa** from the Global Health Workforce Alliance. During the session, presentations from group 1 and group 2 were shown to explain the choices of regional level activities that AAAH should pursue in response to the priority actions identified in the August 2005 meeting, and the list of activities by AAAH to support and strengthen all or selected group of its member countries.

The second session was on **AAAH governing bodies and the funding**, moderated by **Dr. Katherine Bond** from Rockefeller Foundation.

On the last day of the conference, **Dr. Piya Hanvoravongchai** and **Dr. Zhang Junhua** presented the final draft of the AAAH Work-plan and governing structure. The session was facilitated by Dr. Suwit Wibulpolprasert. (See Annex 1 for priority actions agreed by participants.)

## 5. Closing

On the final session of the conference, **Dr. Lincoln Chen**, President of the China Medical Board and Chair of the GHWA Board, invited participants to express their commitments on collaboration with the AAAH in improving HRH situation in the country and in the regions. Many of them expressed how much they have gained from the Conference and will share it back in their countries. Movement towards national strategic plan and health workforce strengthening will be done when they get back.

Since AAAH activities are country-based, communication and collaboration with key players in the countries will be carried out through AAAH country focal points. In this session, the focal points of 15 countries were then identified based on self-selection of the participating members from each country and introduced to the Conference.

Before ending, Dr. Chen thanked Dr. Viroj Tangcharoensathien, Dr. Suwit Wibulpolprasert and the secretariat from the International Health Policy Programme-Thailand for their great efforts in organising the conference and providing impressive secretariat support.

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## **Annexes**

# Annex 1

## AAAH priority actions agreed by the conference

The participants prioritized five key actions to be implemented as follows: 1) *Advocacy for HRH at regional and country levels*; 2) *Information monitoring and HRH information system strengthening*; 3) *Knowledge generation, management and sharing*; 4) *Capacity building in member countries*; and 5) *Technical support*. Within these 5 key actions selected priority action items were highlighted by the participants.

**Action 1:** To **advocate** for HRH at regional and country levels

- a) **Advocate importance of human resource issues to be on the national health agenda**
- b) **Leverage funding for HRH in the region and its member countries**
- c) Development of guidelines for HRH plan for countries to assess their level of progress in the area
- d) Promote and facilitate the regional HRH strategies developed by WHO SEARO & WPRO
- e) Accommodate sub-group platforms with similar HRH issues e.g. Pacific island group

**Action 2:** To work as information clearing house for regional HRH **monitoring** and to support HRH information system strengthening at country level

- a) **Support regular HRH assessment and situational analysis in member countries including monitoring of HRH plans**
- b) **Support an improvement of country HRH information system including data collection, analysis, and reporting of relevant indicators**
- c) Advocate for an inclusion of core HRH statistics into routine country's and regional health information systems, including recent initiatives such as the Health Metrics Network
- d) Formulate a common list of meaningful HRH indicators for the region and work with the global platform to help build global monitoring systems

**Action 3:** To coordinate **knowledge** generation, management and sharing:

- a) **Identify ongoing HRH knowledge management activities at national levels**
- b) **Collect case studies and lessons learned on HRH from member countries**
- c) Create mechanisms for sharing of information such as
- d) Organize workshops on specific HRH issues
- e) Develop and maintain a regional website for active information exchange
- f) Initiate a number of joint research projects on specific HRH issues. The choices may include:
  - Critical review of selection and recruitment policy for HRH in the region with a view to identify which policies yield committed Health workforce
  - HRH for priority health issues and problems,
  - HRH attrition and deployment patterns,
  - HRH analysis and needs assessment,
  - HRH optimum skill mix, and multiskilling of nurses
  - HRH distribution
  - HRH Information management,
  - Mapping of HRH and health care needs in member countries
  - Evaluation of effectiveness of existing HRH plan,
  - Methodology of good practice generation

**Action 4:** To coordinate and assist countries on **capacity building** for HRH management.

- a) **Create leadership development awareness (materials, resource persons)**
- b) **Conduct workshops and trainings on specific HRH areas as well as in support of the formulation and implementation of HRH Strategic Plan.**
- c) Facilitate electronic exchanges of best/good HRH management practices.
- d) Advocate for inclusion of HRH management courses in schools of public health and health professionals' curricula
- e) Facilitate bilateral mentorship between countries within the region
- f) Standardize core competences of health professionals and accreditation of courses

**Action 5:** Coordination of **technical support** as requested by member countries.

- a) **Provide technical support to the member countries in developing HRH plans.**
- b) **Network and cooperation between countries with similar issues**
- c) Identify different capabilities of member countries
- d) Support countries in the development of their proposals to the Global Fund and GAVI and for the formulation and implementation of the HRH strategic plan and policy as requested by the countries
- e) Create a list of regional expertise in the area of HRH

**AAAH Administration:**

- a) Formation of AAAH Steering Committee
- b) Establish formal Secretariat Office
- c) Identify country focal points
- d) Compile list of regional and country partners
- e) Communication with members and public

## **Annex 2**

### **AAAH Steering Committee**

#### **AAAH Steering Committee Members**

|                           |                           |        |
|---------------------------|---------------------------|--------|
| 1. Thailand               | Dr. Suwit Wibulpolprasert | Chair  |
| 2. Bangladesh             | Dr. Khaled Islam          | Member |
| 3. China                  | Dr. Zhang Junhua          | Member |
| 4. Fiji                   | Dr. Lepani Waqatakirewa   | Member |
| 5. India                  | Dr. Srinath Reddy         | Member |
| 6. Philippines            | Dr. Marilyn Lorenzo       | Member |
| 7. WHO/SEARO              | Dr. Myint Htwe            | Member |
| 8. WHO/WPRO               | Dr. Ezekiel Nukuro        | Member |
| 9. Rockefeller Foundation | Dr. Katherine Bond        | Member |
| 10. World Bank            | Dr. Fadia Saadah          | Member |

#### **AAAH Secretariat**

1. Dr. Piya Hanvoravongchai - Coordinator
2. Ms. Cha-aim Pachanee - Assistant Coordinator
3. Ms. Lalittanan Moolasart - Secretary

## Annex 3

### Conference agenda

| <b>Sat 28 October 2006 Towards National Health Workforce Strategies</b> |   |
|---|---|
| 9.45-12.00  | Observe Thailand National Health Assembly and the development of Thai Health Workforce Strategic plan   |
| 12.00   | <i>Lunch</i>  |
| 13.00-14.30   | Discussion on the experiences of the development of regional and national strategic plan.<br>Presenters: <i>WHO/WPRO/SEARO, Philippines, Bangladesh, Thailand</i><br>Moderator: <i>Viroj Tangcharoensathien</i>   |
| 14.30   | <i>Afternoon Break</i>  |
| 15.00-16.30   | The HRH Framework and Tools<br>Presenters: <i>Mario Dalpoz, Roy Pargas</i>  |
| 16.30-17.00   | AAAH Conference Opening Remarks by WHO SEAR-Regional Director, Thailand Minister of Public Health   |
| 17.00- 18.30  | Transport from <i>Impact Convention Center</i> to <i>Krung Sri River Hotel</i> .<br>Meeting logistics announcement on the bus: <i>Chawewan Yenjit</i>   |
| 18.30   | <i>Check-in at Krungsri River Hotel</i>   |
| 19.00- 21.30  | Welcome Dinner and Remarks:<br>-The AAAH: <i>Suwit Wibulpolprasert</i><br>-World Health Report 2006 and Its Recommendation: <i>Tim Evans</i><br>-HRD in response to the HIV/AIDS, TB and Malaria and the MDGs: <i>Neil Squires</i><br>-Global movement on HRH: <i>Sigrun Mogedal</i><br>-Global Health Workforce Alliance: <i>Lincoln Chen / Francis Omaswa</i> |

| <b>Sun 29 October 2006 Priority Health Workforces Issues: experience sharing and discussion for further collective actions</b> |  |
|--|--|
| 8.30-10.00   | Health Financing and Health Workforce<br>Panelists: <i>Viroj Tangcharoensathien, Tim Evans</i>   |
| 10.00  | <i>Morning break &amp; HRH Policy Clinic</i>   |
| 10.30-12.00  | Non-financial incentives to support HRH retention, productivity and equitable distribution<br>Discussants: <i>Sri Lanka, Pacific Island countries, Nepal, Francisco Campos</i><br>Moderator: <i>Myint Htwe</i> |
| 12.00  | <i>Lunch &amp; HRH Policy Clinic</i>   |
| 13.00-14.30  | HRH knowledge generation, management, and sharing<br>Panelists: <i>China, Cambodia, Jim McCaffery, Tim Martineau</i><br>Moderator: <i>Eric Friedman</i>  |
| 14.30-16.00  | HRD in respond to AIDS, TB, Malaria, MDGs, and Pandemic Flu<br>Panelists: <i>Indonesia, Myanmar, Vietnam</i><br>Moderator: <i>Neil Squires</i>   |

|             |   |
|-------------|---|
| 16.00       | <i>Afternoon break &amp; HRH Policy Clinic</i>  |
| 16.30-18.00 | Globalisation/International Trade and implications on HRH: Supply and demand and migration<br>Panelists: <i>Philippines, India, African Platform</i><br>Moderator: <i>Suwit Wibulpolprasert</i> |
| 1900        | <i>Dinner</i>   |

### **Mon 30 October 2006 AAAH Strategies and Workplan**

|              |   |
|--------------|---|
| 8.30- 10.00  | Regional Alliance/platform/ observatories on HRH:<br>Presenters: <i>Eric Buch, Charles Godue, Jennifer Nyoni</i><br>Moderator: <i>Manuel Dayrit</i>                           |
| 10.00        | <i>Morning break &amp; HRH Policy Clinic</i>  |
| 10.30- 12.30 | Three group works on (1) regional level actions; (2) activities to support countries; and (3) governing structure, and funding mechanisms                                     |
| 12.30        | <i>Lunch &amp; HRH Policy Clinic</i>  |
| 13.30- 15.00 | Presentation and discussions 1: AAAH workplan for next two years<br>Moderator: <i>Francis Omaswa</i>  |
| 15.00        | <i>Afternoon break &amp; HRH Policy Clinic</i>  |
| 15.00- 16.30 | Presentation and discussion 2: AAAH governing bodies and the funding<br>Moderator: <i>Kate Bond</i>   |
| 16.30-18.00  | AAAH in relation to the other related regional and global mechanism<br>Discussants: <i>Kathy Cahill / Neil Squires / Kate Bond /SEARO/WPRO</i><br>Moderator: <i>Tim Evans</i> |
| 18.30        | <i>Dinner</i>   |

### **Tue 31 October 2006 AAAH Action Plan**

|              |   |
|--------------|---|
| 9.00 – 10.30 | Finalise AAAH Work-plan, governing structure and collaboration with GHWA and other partners<br>Presenter: <i>Piya Hanvoravongchai / Zhang Junhua</i><br>Moderator: <i>Suwit Wibulpolprasert</i> |
| 10.30        | <i>Morning break</i>  |
| 11.00 -12.30 | The way forward: General discussion<br>Moderator: <i>Lincoln Chen</i>   |
| 12.30        | Closing   |

## Annex 4

### List of participants of the ALN Workshop (August 2005) and First AAAH Conference (October 2006)

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**Note:**

|  |
|--|
| Attended ALN Meeting, August 2005                      |
| Attended 1 <sup>st</sup> AAAH Conference. October 2006 |
| Attended both ALN meeting and AAAH Conference          |

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# Annex 6

## Pre-Conference Questionnaire and Results



### We'd like to know you more

Your answer will help us improve our AAAH secretariat services. Please return this questionnaire to any AAAH Staff at the Conference **before the end of 28 October**.

- ❖ What is your role at this AAAH Conference?
- AAAH Member   
  Resource Person   
  GHWA Member   
  Others

- ❖ What is your affiliation?
- Health Ministry/Gov   
  University   
  Private / NGOs   
  Others

- ❖ Do you have knowledge/experience in ...
- |                 |                           |                          |                 |                           |                          |
|-----------------|---------------------------|--------------------------|-----------------|---------------------------|--------------------------|
| HRH Planning?   | <input type="radio"/> Yes | <input type="radio"/> No | HRH Management? | <input type="radio"/> Yes | <input type="radio"/> No |
| HRH Production? | <input type="radio"/> Yes | <input type="radio"/> No | Health Systems? | <input type="radio"/> Yes | <input type="radio"/> No |

- ❖ Have you read ...
- |                           |                           |                          |                    |                           |                          |
|---------------------------|---------------------------|--------------------------|--------------------|---------------------------|--------------------------|
| World Health Report 2006? | <input type="radio"/> Yes | <input type="radio"/> No | JLI Report on HRH? | <input type="radio"/> Yes | <input type="radio"/> No |
|---------------------------|---------------------------|--------------------------|--------------------|---------------------------|--------------------------|

- ❖ Have you visited the following website ...
- |                    |                           |                          |                  |                           |                          |
|--------------------|---------------------------|--------------------------|------------------|---------------------------|--------------------------|
| AAAH (aaahrh.org)? | <input type="radio"/> Yes | <input type="radio"/> No | GHWA (ghwa.org)? | <input type="radio"/> Yes | <input type="radio"/> No |
|--------------------|---------------------------|--------------------------|------------------|---------------------------|--------------------------|

- ❖ Would you be willing to work with the AAAH secretariat in the future? If yes, in which area/capacity?
- \_\_\_\_\_

### Your opinion on the AAAH

Your inputs are very valuable to us. The information from this section will be used for group discussion on the AAAH Work Plan & Governance on 30 October.

- ❖ With budget constraint, which of these priority actions should the AAAH focus on? (check one)
- review and advocate for HRH support at regional and country levels
  - support member countries developing their national HRH strategy
  - develop regional guidelines and best practices on HRH planning & management
  - coordinate technical support to countries
  - organize workshops/trainings on specific HRH areas
  - others (specify) \_\_\_\_\_
- ❖ How should AAAH work with a country? (check one)
- through a focal point identified in this Conference
  - through the Ministry of Health
  - through WHO country office
  - others (specify) \_\_\_\_\_
- ❖ Should AAAH have a Governing Board?
- Yes     No
- ❖ If yes, who should be on the Governing Board? (check all that apply)
- country representatives
    - all countries: one from each member
    - specify: \_\_\_\_\_ countries
  - WHO (SEARO & WPRO)
  - WHO (Head Quarters)
  - GHWA representative
  - funding agencies e.g. Rockefeller, EC
  - invited experts/scholars
  - others (specify) \_\_\_\_\_
- ❖ Should AAAH secretariat rotate among its members?
- Yes     No

## Pre-Conference Questionnaire Results



### FROM THE AAAH QUESTIONNAIRE

\*OPINION ON AAAH\*

| <i>Priority Activites for AAAH</i>                                 | AAAH |     | ALL |     |
|--|------|-----|-----|-----|
|  | No.  | %   | No. | %   |
| Review and advocate for HRH support at regional and country levels | 1    | 7%  | 10  | 27% |
| <b>Support member countries developing national HRH strategy</b>   | 7    | 50% | 13  | 35% |
| Develop regional guidelines & best practices on HRH planning       | 4    | 29% | 8   | 22% |
| Coordinate technical support to countries                          | 2    | 14% | 5   | 14% |
| Organize workshops & trainings on specific HRH areas               | 3    | 21% | 8   | 22% |
| <b>Total</b>   |      |     | 44  |     |

| <i>How to work with countries</i>                   | AAAH |     | ALL |     |
|---|------|-----|-----|-----|
|   | No.  | %   | No. | %   |
| through a focal point identified at this Conference | 6    | 43% | 15  | 41% |
| through the Ministry of Health                      | 7    | 50% | 21  | 57% |
| through WHO country office                          | 2    | 14% | 9   | 24% |
| Other (specify)                                     |      |     | 1   | 3%  |
| <b>Total</b>  | 15   |     | 46  |     |

| <i>AAAH Governance</i> | AAAH |      | ALL |     |
|------------------------|------|------|-----|-----|
|                        | No.  | %    | No. | %   |
| Have Governing Board?  | 14   | 100% | 34  | 97% |

| <i>Who should be on the AAAH Governing Board</i> | AAAH |     | ALL  |     |
|--|------|-----|------|-----|
|  | No.  | %   | No.  | %   |
| All countries: one from each                     | 13   | 93% | 27   | 75% |
| if not all, specify number of countries          | 5.00 | 1   | 6.25 | 4   |
| WHO (SEARO & WPRO)                               | 12   | 86% | 24   | 65% |
| WHO (Head Quarters)                              | 10   | 71% | 18   | 49% |
| GHWA representative                              | 9    | 64% | 20   | 54% |
| Funding agencies                                 | 11   | 79% | 20   | 54% |
| Invited experts/scholars                         | 5    | 36% | 15   | 41% |
| Other (specify)                                  | 1    | 7%  | 4    | 11% |

| <i>Secretariat</i>   | AAAH |     | ALL  |     |
|--|------|-----|------|-----|
|  | No.  | %   | No.  | %   |
| Secretariat be rotated among members                             | 6    | 43% | 21   | 60% |
| Frequency of rotation every .... years (if rotating secretariat) | 2.33 | 6   | 2.64 | 22  |
| Having membership fees   | 4    | 29% | 10   | 31% |
| Willingness to work with AAAH Secretariat                        | 1    | 7%  | 1    | 0   |
| *Quality of this conference's preparation                        | 4.15 | 13  | 4.20 | 35  |

\*RESPONDENT INFO\*

| <i>Respondent's role at the Conference</i> | AAAH |   | ALL |     |
|--|------|---|-----|-----|
|  | No.  | % | No. | %   |
| AAAH member                                |      |   | 14  | 37% |
| Resource person                            |      |   | 7   | 18% |
| GHWA                                       |      |   | 4   | 11% |
| Others                                     |      |   | 11  | 29% |
| No answer                                  |      |   | 2   | 5%  |
| <b>Total</b>                               |      |   | 38  |     |

| <i>Respondent's Affiliation</i> | AAAH |      | ALL |      |
|---------------------------------|------|------|-----|------|
|                                 | No.  | %    | No. | %    |
| Minister                        | 11   | 79%  | 19  | 50%  |
| Univ                            | 2    | 14%  | 8   | 21%  |
| Private                         | 1    | 7%   | 5   | 13%  |
| Others                          |      |      | 5   | 13%  |
| No answer                       |      |      | 1   | 3%   |
| <b>Total</b>                    | 14   | 100% | 38  | 100% |

| <i>Respondent's work areas</i> | AAAH |     | ALL |     |
|--------------------------------|------|-----|-----|-----|
|                                | No.  | %   | No. | %   |
| HRH Policy and Planning        | 10   | 71% | 23  | 61% |
| HRH Management                 | 5    | 36% | 14  | 37% |
| Education / Training           | 8    | 57% | 24  | 63% |
| Funding / Financing            | 0    | 0%  | 5   | 13% |
| HRH Research                   | 8    | 57% | 18  | 47% |
| Specific/Priority Diseases     | 1    | 7%  | 4   | 11% |
| H System Development           | 3    | 21% | 12  | 32% |
| Other (specify)                | 0    | 0%  | 4   | 11% |

| <i>Have read . . . ?</i> | AAAH |     | ALL |     |
|--------------------------|------|-----|-----|-----|
|                          | No.  | %   | No. | %   |
| WHR2006                  | 13   | 93% | 29  | 76% |
| JLI Report               | 4    | 33% | 15  | 48% |

| <i>Have visited website?</i> | AAAH |     | ALL |     |
|------------------------------|------|-----|-----|-----|
|                              | No.  | %   | No. | %   |
| AAHRH.org                    | 8    | 62% | 19  | 51% |
| GHWA.org                     | 2    | 20% | 8   | 25% |



## Annex 7

### Post-Conference Questionnaire and Results

#### What do you think about the 1<sup>st</sup> AAAH Conference?

| Conference Objectives  | Strongly Disagree  | Disagree | Neutral | Agree | Strongly Agree   |
|--|--------------------|----------|---------|-------|------------------|
| This Conference helped identify how HRH constraints within the region are acting as a barrier to effective implementation of strategies for HIV/AIDS, TB, malaria, and the MDGs. |                    |          |         |       |                  |
| There was adequate follow up on HRH activities in member countries in the region   |                    |          |         |       |                  |
| Experience on national HRH strategic plan development as well as priority HRH problems was adequately shared   |                    |          |         |       |                  |
| Participants were clearly informed about latest development of the GHWA and other Regional Platform/Alliance(s)  |                    |          |         |       |                  |
| Conference Sessions  | 1<br>Disappointing | 2        | 3       | 4     | 5<br>Exceptional |
| Observing Thai National HRH Strategy Development   |                    |          |         |       |                  |
| National and Regional HRH Strategies   |                    |          |         |       |                  |
| HRH Framework and Tools  |                    |          |         |       |                  |
| Opening Remarks  |                    |          |         |       |                  |
| Welcome Remarks at Dinner  |                    |          |         |       |                  |
| Health Financing and Health Workforce  |                    |          |         |       |                  |
| Non-Financial Incentives for HRH Management  |                    |          |         |       |                  |
| Knowledge Generation, Management, Dissemination  |                    |          |         |       |                  |
| HRH in response to HIV/AIDS, TB, Malaria, MDGs   |                    |          |         |       |                  |
| Globalization, Trade Agreements, and HRH   |                    |          |         |       |                  |
| Regional Alliances and Platforms on HRH  |                    |          |         |       |                  |
| Group Work to develop AAAH Workplan & Governance   |                    |          |         |       |                  |
| AAAH in relation to other regional & global partners   |                    |          |         |       |                  |
| Conference Extras (if you attended)  | 1<br>Disappointing | 2        | 3       | 4     | 5<br>Exceptional |
| HRH Policy Clinics   |                    |          |         |       |                  |
| HRH Tools Demonstration  |                    |          |         |       |                  |
| HRH Framework Workshop   |                    |          |         |       |                  |
| Secretariat Services   | 1<br>Disappointing | 2        | 3       | 4     | 5<br>Exceptional |
| Airport Pickup   |                    |          |         |       |                  |
| Meeting Support  |                    |          |         |       |                  |
| Accommodation  |                    |          |         |       |                  |
| Food   |                    |          |         |       |                  |
| Communications   |                    |          |         |       |                  |
| OVERALL EXPERIENCE   | 1<br>Disappointing | 2        | 3       | 4     | 5<br>Exceptional |

## Post-Conference Questionnaire Results

| Achieving Conference Objectives   | Average Score | Standard Deviation | Median Score | Number of responses |
|---|---------------|--------------------|--------------|---------------------|
|   | <b>4.0</b>    |                    |              |                     |
| Identify HRH Constraints for HIV/AIDS, TB, malaria, & MDGs.             | 4.0           | 0.6                | 4.0          | 32                  |
| Follow up HRH activities in member countries                            | 3.5           | 0.9                | 3.5          | 32                  |
| Share experience on National HRH Strategic Plan & Priority HRH Problems | 4.1           | 0.5                | 4.0          | 32                  |
| Update on GHWA and other Regional Platform/Alliance(s)                  | 4.4           | 0.6                | 4.0          | 31                  |
| <b>Conference Sessions</b>  | <b>3.8</b>    |                    |              |                     |
| Observing Thai Strategy Development                                     | 3.8           | 0.8                | 4.0          | 32                  |
| National and Regional HRH Strategies                                    | 3.8           | 0.6                | 4.0          | 32                  |
| HRH Framework and Tools   | 3.9           | 0.6                | 4.0          | 32                  |
| Openning Remarks  | 3.6           | 0.9                | 4.0          | 32                  |
| Welcome Remarks at Dinner   | 3.8           | 0.8                | 4.0          | 32                  |
| Health Financing & Workforce  | 3.9           | 0.6                | 4.0          | 31                  |
| Non-Financial Incentives  | 3.8           | 0.8                | 4.0          | 32                  |
| Knowledge Generation, Management  | 3.8           | 0.8                | 4.0          | 32                  |
| HRH and HIV/AIDS, TB, Malaria, MDGs                                     | 3.6           | 0.7                | 4.0          | 31                  |
| Globalization & Trade Agreements  | 3.9           | 0.8                | 4.0          | 32                  |
| Regional Alliances and Platforms  | 4.1           | 0.7                | 4.0          | 32                  |
| Group Work on Workplan & Governance                                     | 4.1           | 0.8                | 4.0          | 31                  |
| AAAH and other partners   | 4.0           | 0.6                | 4.0          | 32                  |
| <b>Conference Extras (if you attended)</b>                              | <b>4.0</b>    |                    |              |                     |
| HRH Policy Clinics  | 3.9           | 0.7                | 4.0          | 19                  |
| HRH Tools Demonstration   | 4.1           | 0.8                | 4.0          | 19                  |
| HRH Framework Workshop  | 4.1           | 0.6                | 4.0          | 17                  |
| <b>Secretariat Services</b>   | <b>4.4</b>    |                    |              |                     |
| Airport Pickup  | 4.5           | 0.7                | 5.0          | 31                  |
| Meeting Support   | 4.6           | 0.5                | 5.0          | 32                  |
| Accommodation   | 4.2           | 0.7                | 4.0          | 32                  |
| Food  | 4.3           | 0.7                | 4.0          | 32                  |
| Communications  | 4.4           | 0.7                | 5.0          | 32                  |
| <b>OVERALL EXPERIENCE</b>   | <b>4.2</b>    | <b>0.6</b>         | <b>4.0</b>   | <b>14</b>           |

## **Annex 8**

### **Opening remarks**

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#### **Remarks**

**By Dr. Viroj Tangcharoensathien, Director, IHPP-Thailand**

**First Asia-Pacific Action Alliance on Human Resources for Health Conference**

**28 October 2006, Thailand**

HE Dr. Mongkol Na Songkhla, Minister of Public Health, Thailand

Dr. Samlee Plianbangchang, Regional Director, WHO South-east Asia Regional Office

Dr. Tim Evans, Assistant Director General of the World Health Organization,

Dr. Lincoln Chen, Chair of the Global Health Workforce Alliance,

Distinguished participants, ladies and gentlemen,

As the Chair of the Organising Committee, I would like to welcome all of you to Thailand, to the first Conference of the Asia-Pacific Action Alliance on Human Resources for Health.

The AAAH is a response to the international recognition of the immediate need for global and regional actions to strengthen country capacity for health workforce planning and management. It was initiated in August last year during a conference on health workforce in Bangkok.

With financial support from the European Commission, the Rockefeller Foundation and the World Health Organization, *this first AAAH Conference is held from today until 31 October 2006 at Impact Convention Center and in Ayuthaya*. Participants from the ministries of health, academic and research organizations, and non-governmental sectors from 15 countries in South-East Asia and Western Pacific regions. The conference is also joined by resource persons from several organizations, and development partners including the Board members of the Global Health Workforce Alliance.

This morning and afternoon, the Conference participants had an opportunity to share their experience on national HRH strategic plan development and to learn about regional strategies and health workforce framework & tools.

In the next two days, we aim to identify how health workforce constraints are acting as a barrier to effective implementation of strategies for HIV/AIDS, TB and malaria control and the health MDGs. We will learn from other regions about their regional HRH networks/alliances and related activities with the aim that at the end we will have a clear Work Plan for the next two years of the AAAH.

Ladies and Gentlemen,

This afternoon we have an honour from H.E. Dr. Mongkol Na Songkhla, the Minister of Public Health, and Dr. Samlee Plianbangchang, Regional Director of the WHO South-east Asia Regional Office, to preside over the opening of this AAAH conference.

On this special occasion may I invite Dr. Samlee Plianbangchang, Regional Director, WHO South-east Asia Regional Office and Dr. Mongkol Na Songkhla, Minister of Public Health, Thailand and to give an opening remarks to the Conference.

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**Remarks by**  
**Dr Samlee Plianbangchang**  
**Regional Director, WHO South-East Asia**

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Your Excellency, Dr Mongkol Na Songkhla, Minister of Public Health, The Royal Thai Government;  
Distinguished participants and guests;

Ladies and gentlemen;

- At the outset, let me thank the Organizers of the Conference for inviting me to attend this function. I am pleased that the Asia Pacific Action Alliance on Human Resources for Health (AAAH) is convening this Conference. The Conference is very important indeed, as far as health development in general is concerned.

Ladies and gentlemen;

- Human resources are the core of health systems. Efficient and effective functioning of these systems depends on the motivated and dedicated health staff. There is ample evidence to show that the availability of competent health workers can contribute significantly to the overall improvement of health of population. Issues relating to health workforce had always been the key concern in the development and management of health services.
- World Health Assembly resolved in 1977, urging the Member States to work towards the attainment of health for all by the year 2000;
- It was realized in that context that no country in the world would be able to produce adequate health manpower to ensure the attainment of that goal. The goal that required all people in the world to lead a socially and economically productive life. As an important component of the global strategy for health for all by the year 2000, WHO programme on human resources for health was initiated. It was intended to develop human resources that could promote, among others, the involvement of people of all walks of life in health development. And this involvement must be at all levels; individual, family, community, sub-national and national.
- This strategy needs development and intervention through the educational process that can empower all those people to be able to lead a socially and economically productive life.
- To be successful in this endeavour, a competent health workforce is indispensable indeed.

Distinguished participants;

- The World Health Assembly resolution on health for all had very much expanded our perspective in health development. The development that needs efforts much beyond health sector. Now, six years after the target date of this global social goal. We are yet to realize health for all. Nonetheless, the concept of health for all still remains our “ultimate target” towards which all countries in the world should continue to stride forward. Since the adoption of HFA resolution, health has been universally accepted to be at the center of overall development in any country. While forging forward towards health for all goal, we have witnessed a lot of changes around us.
- The world has changed rapidly in many ways during the past two decades. These changes have profoundly affected the development process in socio-economic, and thereby health sectors. The liberalization of international trade, for example, is affecting goods and services in health in a big way. People today are better educated; and today the world has become a global village, more and more.

- These changes have led to the consumers' demand for more and improved health care and services. The patients demand from the service providers and the government for more protection of their rights. Advancement in sciences and technology has changed the way health care and services are perceived and practised.
- All in all, however, one cannot neglect the changes in socio-cultural dimension.
- Due to several factors, people's lifestyles have kept changing. There is significant increase in health risk behaviours, especially in the urban settings. This trend contributes to the increase in morbidity and mortality due to chronic non-communicable diseases.
- Furthermore, it is still a long way to go in ensuring equity and social justice in health care. The unreached are yet to be uniformly reached. Health consumers are yet to be treated with equal dignity. Effective measures are yet to be in place to ensure equitable distribution of health resources.

Distinguished participants;

- As universally accepted, health is at the centre of development, and health can contribute significantly to poverty reduction. This vision will be realized only when much more attention is paid to the means and ways to keep people always in good health. More attention has to be paid to the reduction of morbidity; in addition to the intervention to prevent death and limit disability. More attention needs to be paid to health determinants and risks in the development and implementation of health programmes.
- In such a process, there is a need to move towards positive, rather than negative health. Today, there are more ways to prolong healthy life. The current health development efforts should be geared towards healthy longevity, rather than simply a long life.
- Today demographic change has resulted in more aged population. There is an urgent need to look at the aging process, and apply appropriate interventions at various stages of growth and development to ensure healthy aging. We should not wait for the people to get old, and try to limit disability and prevent death at that point.
- However, the aged population is already here with us, we have to take the best care of it. It is important now to ensure "life cycle care". The efforts of health systems must be geared towards:
  - the optimal human growth and development from the conception onward;
  - the maintenance of good health throughout;
  - delaying the pathological process during life-time; and
  - limiting disability and dependency as much as possible, especially during the later years of life.

Ladies and gentlemen;

- These are some among many other issues that need to be tackled by health workforce in their efforts towards good health for all. While maintaining specializations in health professions, health staff in future will need to be versatile and broad in their visions. The visions that can help them see through a healthy life of people; and be able to ensure healthy longevity of the life. In addition to technical competence and skills, there is a need for health workforce to possess a high degree of ethical and moral value. We need the workforce with multidisciplinary and multisectoral perspective; The workforce that can really mobilise all stakeholders for effective health development at all levels. And, more important, we need the workforce with a strong sense of social responsibility and commitment.

- International agencies and institutions should join hands to support countries in their efforts to develop health workforce that suits development work in the 21<sup>st</sup> century. Consideration in the development of health workforce must take into account the required health actions at all levels, from the grassroots up to national. There is an urgent need to pay equal particular attention to those who work in community to serve the entire population. We need the staff members who can reach the unreached; to serve the poor, underprivileged, marginalized and vulnerable.
- The staff members who can effectively provide promotive and preventive health care in community. This is in addition to alleviating the suffering of people and curing disease and illness. There is an urgent need for the workforce who can get involved fully and effectively in the development and implementation of public health programmes.
- The programmes that deal primarily with health promotion and disease prevention. The programmes that aim at prevention and control of HIV/AIDS, malaria, tuberculosis, dengue, encephalitis, and many other diseases.
- The programmes that can ensure clean water, good hygiene, sound sanitation, and other aspects of healthy environment.
- The programmes that can reduce maternal and child mortality, and promote healthy population in the remote rural villages.
- At the same time, there is a need to strengthen the capacity of professionals and experts in the related institutions and facilities; So that they are able to effectively support the efforts of those who work in the fields, in the community, in the rural settings. These institutions and facilities have to play their key role in the development and training of community-based health workforce, grassroot health workers.

Colleagues;

- This development and training is one of the most important entry points for strengthening country capacity in health. Competent and dedicated health workforce can ensure sustainable health development. And can ensure the attainment of long-term health goals in countries. Development of human resources for health has always been the key priority of WHO. WHO is always ready to fully collaborate with member states and stakeholders / partners in this critically important areas. Last but not least, I would like to underline the importance of networking among concerned institutions and agencies, at both national and international levels. This networking will certainly optimize the impacts of their contributions to the success in ensuring competent and relevant health workforce. The impact on the overall development of human resources for health, especially in developing countries.
- In this connection, I would like to place on record my appreciation of the creation of the Asia Pacific Action Alliance on Human Resources for Health (AAAH). I also deeply appreciate its efforts in organizing this first Conference. The conference will be another important platform for the concerned international community to share knowledge, exchange information and tools in the area of human resources for health. I am sure that the outcome of this Conference will bring us a long way forward, towards working closely together to ensure availability of the required health workforce for health development in the 21<sup>st</sup> centuries.
- Finally, I wish the Conference all success;
- And I wish all participants an enjoyable stay in Thailand.

Thank you.

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**Opening Remark**  
**Dr. Mongkol Na Songkhla, Minister of Public Health, Thailand**  
**First Asia-Pacific Action Alliance on Human Resources for Health Conference**  
**28 October 2006, Thailand**

Dr. Samlee Plianbangchang, Regional Director, WHO South-east Asia Regional Office  
Dr. Tim Evans, Assistant Director General of the World Health Organization,  
Dr. Lincoln Chen, Chair of the Global Health Workforce Alliance,  
Distinguished participants, ladies and gentlemen,

It is my great pleasure to be here today among all dedicated people who are fully determined to work for the development and improvement of human resources for health.

I am very happy to learn about the active movement of this Asia-Pacific Action Alliance on Human Resources for Health (AAAH), which involves active participation of several countries both in the South-East Asian Region and the Western Pacific Region.

I am also very impressed to learn that this conference is not only represented by people from the ministry of health but also from the supply side of the human resources for health and the research sector, as well as resource persons from several organizations, and the development partners. This shows harmony in working together on a basis of multi-sectoral approach, which is an important factor to achieve goals of the AAAH, and the Millennium Development Goals.

We all know why human resources for health are important, and we are all aware of the global crisis in human resources for health, which restrains access to effective health services for many people worldwide, and it also restrains the progress towards the Millennium Development Goals, as well as in addressing the threats from HIV/AIDS, tuberculosis and malaria.

This morning, all of you observed the process of the national health workforce strategic plan development in Thailand and I learnt that this afternoon you also shared your country experience in developing the national HRH strategic plan in your countries. Each country may have different processes and strategies depending on its own situation and involvements of concerned stakeholders. However, the national strategic plan will be a framework for the achievement of priority HRH issues within the country.

Ladies and gentlemen,

I would like to take this opportunity to sincerely thank the International Health Policy Programme –Thailand for hosting this event.

I would like to thank the European Commission for its kind financial support to this conference, thank to the Rockefeller Foundation for its continued support in the area of human resource for health development. I also would like to thank the World Health Organization for its commitment in working with country on human resources for health issue.

I am confident that the deliberations and discussions in the next three days will be fruitful and provide important inputs for the joint workplan that can be implemented for the improvement of human resources for health. This benefit will not be only for our regions but will expand wider.

At the global level, we see the Global Health Workforce Alliance playing important role. At the regional level, we see the movements of the African Platform and other regional mechanisms. In a near future, we will see contributions from the AAAH which will yield impressive results in human resources for health development. This will be attributable to great efforts from all of you.

It is my pleasure to declare the first Asia-Pacific Action Alliance on Human Resources for Health Conference open.

I wish you all a successful workshop and a very pleasant stay in Thailand. I hope you will have time to visit historic spots while in Ayutthaya, the city that served as the longest capital in Thailand history. Thank you.