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**The Decade for Health Workforce Strengthening in the SEA Region 2015–2024:
Second review of progress, challenges, capacities and opportunities**

In 2014, Member States of the WHO South-East Asia (SEA) Region agreed to the “Decade for Strengthening Human Resources for Health in SEA Region 2015–2024”. The WHO Regional Committee for South-East Asia endorsed resolution SEA/RC67/R6 on “Strengthening Health Workforce Education and Training in the Region” the same year. This requested the Regional Director to report on progress in health workforce development to the Regional Committee for South-East Asia every two years, starting in 2016, for a decade.

The second review of progress in 2018 involved (a) reporting by Member States on 14 indicators, and (b) a regional meeting to review progress, challenges and opportunities. The High-Level Preparatory Meeting (HLP) held in the WHO Regional Office in New Delhi from 30 July–2 August 2018 reviewed the attached Working Paper and strongly supported its conclusions. It gave additional emphasis to some of the conclusions, and made the following recommendations.

Actions by Member States

- Continue efforts to improve rural retention and transformative education, and document and share experiences of the impact of such efforts on health worker performance and access to care.
- Improve the collection and analysis of data on HRH with a focus on frontline health workers.
- Improve the coordination of HRH functions between different departments within the ministries of health as well as in other ministries.

Actions by WHO

- Support the evaluation of best practices in the SEA Region in key areas such as improving rural retention and providing transformative education.
- Help build the capacity of policy-makers in the SEA Region in HRH policy analysis, strategy development and other aspects of HRH governance, through the development of regional training courses, strengthening of HRH units, intercountry exchanges of experience, and other relevant approaches.

- Support countries of the Region in strengthening the collection and analysis of HRH data with special emphasis on frontline health workers.

This Working Paper and the HLP Meeting recommendations are submitted to the Seventy-first Session of the WHO Regional Committee for South-East Asia for its consideration and decision.

Introduction

1. The WHO South-East Asia (SEA) Region has some well-known health workforce challenges. These include shortages, unequal distribution of health workers, difficulty in retention, adapting health workers' education to fit rapidly changing needs and improving health worker performance. Other issues include rapid urbanization, and the preference of doctors for specialization. It is critical that these challenges are met effectively by Member States, because health services cannot be delivered without health workers, which limits progress on universal health coverage (UHC) and the Sustainable Development Goals (SDGs).

2. Recognizing these challenges, in 2014 all Member States committed to a "Decade for Strengthening Human Resources for Health in the South-East Asia Region 2015–2024". The same year, resolution SEA/RC67/R6 on "Strengthening Health Workforce Education and Training in the Region" requested WHO to report on the progress in health workforce development every two years for the next decade. There is a particular focus on transformative education and rural retention.

3. This second review covers the period 2016–2018. The first review of progress in 2016 found that more progress was under way in the Region than had previously been realized. However, it also noted the difficulty in systematically monitoring progress due to the lack of standard, measurable indicators and weak national data on human resources for health (HRH). The first review also highlighted some key messages: the importance of linking HRH strategies to plans to improve service delivery, including UHC; the need for more focused policy attention to health workers who provide frontline health services; the significant role of the private sector in health workers' education and employment in some Member States; a recognition that there is no one magic bullet but a need for a "bundle" of interventions when addressing health workforce problems; the urgent need for indicators and better data, and the need for stronger linkages in and beyond the health sector for significant and sustained change, i.e. growing attention to HRH governance.

4. Since 2016, there has been action and progress in four main areas: transformative education; rural retention; improving health workforce data and health workforce governance.

2018: current situation, response and challenges

5. The second review of progress on the Decade for Strengthening Human Resources for Health in the South-East Asia Region has again been informed by a self-reported survey by Member States. The survey has 14 standard indicators, drawn from the National Health Workforce Accounts indicators (WHO, 2017),¹ and indicators in the Global HRH Strategy: health workforce 2030. The 14 indicators were agreed to by Member States during a regional workshop, "Improving the generation and use of HRH data in the SEA Region" held in 2017. Five categories of health professionals – doctors, dentists, nurses, midwives and pharmacists – are covered by the indicators. The indicators are listed in Fig. 1.

¹ National health workforce accounts: a handbook. Geneva: World Health Organization; 2017.

Fig 1: The 14 health workforce indicators used for the second review of progress

Health Workforce indicator	NHWA*
Health worker density and distribution	
1 Health worker density	1-01
2 Health worker density at subnational level	1-02
3 Health worker distribution by age group	1-03
4 Female health workforce	1-04
Health professional education	
5 Graduation rate from education and training programmes	2-07
6 Accreditation mechanisms for education and training institutions and their programmes	3-02
7 Continuing professional development	3-08
Retention of health workers	
8 Vacancy rate	5-07
9 Share of foreign-born health workers	1-07
10 Share of foreign-trained health workers	1-08
HRH Governance	
11 Mechanisms to coordinate and intersectoral health workforce agenda	9-01
12 Central health workforce unit	9-02
13 Health workforce planning processes	9-03
HRH information systems	
14 HRHIS for reporting on outputs from education and training institutions	10-04
HRHIS for tracking the number of entrants to the labour market	10-05
HRHIS for tracking the number of active stock on the labour market	10-06
HRHIS for tracking the number of exits from the labour market	10-07
HRHIS for producing the geocoded location of health facilities	10-08

* refers to NHWA handbook

6. In addition to the survey, a more detailed review of progress in each Member State was carried out during the regional workshop for the second review of progress on the Decade for Strengthening Human Resources for Health in New Delhi, 23–25 April 2018.

7. The first and most important finding of the second review is that almost all Member States have improved the overall availability of health workers, albeit from different baselines. Eight Member States are now above the first WHO HRH threshold of 22.8 doctors, nurses and midwives per 10 000 population set in 2006² compared with six Member States in 2014. However, more remains to be done, as only two Member States have reached the current WHO threshold of 44.5 health workers per 10 000 population, derived as the basic health worker density needed to achieve the SDGs³ (Fig. 2). Global HRH thresholds provide a guide to need, but there are examples of individual countries achieving health targets despite reportedly low workforce densities. Each Member State should therefore take account of its own context and achievements when planning HRH needs.

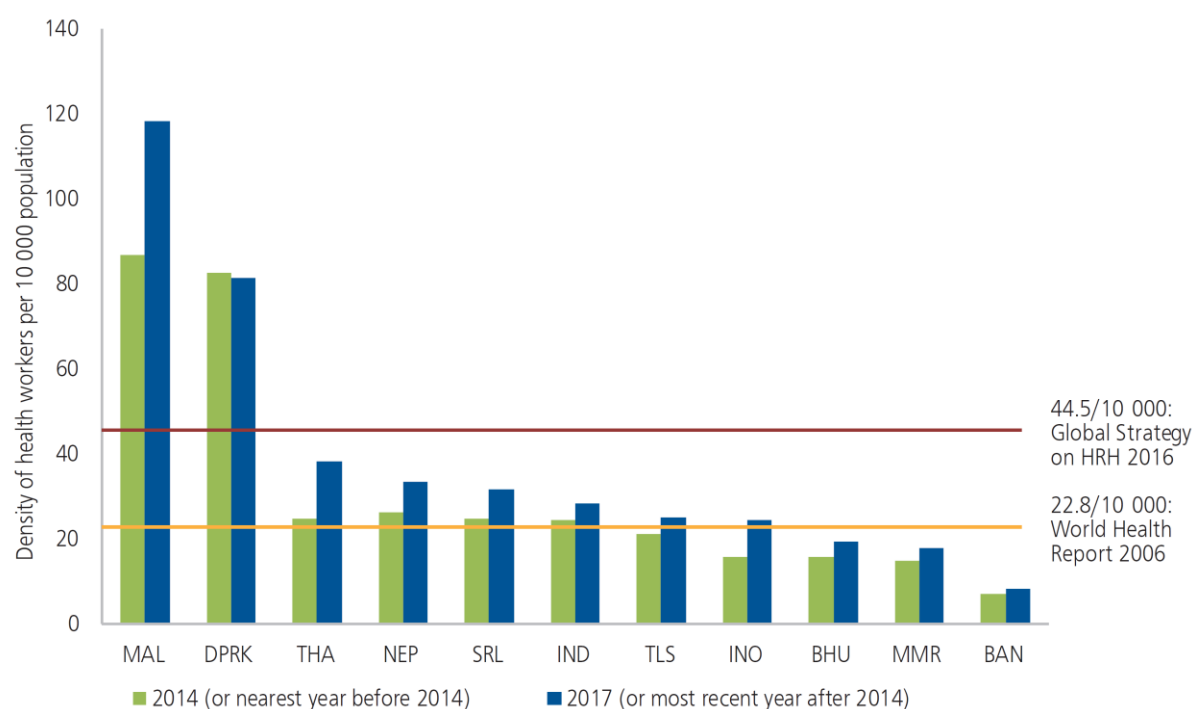
8. Second, there is a maturing body of regional experience with both transformative education and rural retention. There are some unique innovations in different Member States, which hold real promise of progress, and which require evaluation. These are highlighted in the following paragraphs. Judging the results and impact of HRH interventions requires more than estimates of health worker density, as these do not reflect performance.

² The world health report 2006: working together for health. Geneva: World Health Organization; 2006.

³ Global strategy on human resources for health: workforce 2030. Geneva: World Health Organization; 2016.

9. Third, there is a definite improvement in the completeness of HRH data reported by Member States. This improvement must be maintained. More effort is needed to capture other important cadres of frontline health workers if progress on the main objectives of national HRH strategies during the Decade is to be tracked and sustained.⁴

Fig 2: Trends in availability of health workers in Member States of the SEA Region, 2014–2017
(Density of doctors, nurses and midwives per 10 000 population)



Source: Country data reported to WHO (main sources MoH & professional councils)

Health workforce governance: strategic direction, coordination and partnership

10. Ten Member States report having HRH strategies, of which five have been updated in the past two years (Table 1). These strategies include actions on the education of health professionals, retention and performance of health workers, and HRH data. There also appears to be growing attention to linking HRH strategies more explicitly with service delivery changes, which is needed for optimum progress.

⁴ Decade for strengthening human resources for health in the South-East Asia Region: second review of progress, 2018. New Delhi: World Health Organization, Regional Office for South-East Asia; 2018.

Table 1: National health workforce strategies in the WHO SEA Region

Country	Name of the document	Period
Bangladesh	Bangladesh health workforce strategy 2015	2016–2021
Bhutan	Health human resource master plan	2011–2023
DPR Korea	Strategic plan for development of human resources for health	2011–2015
India	No HRH strategy. Contained in National Health Policy 2017	2017–2025
Indonesia	Action plan for the development of HRH	2015–2019
Maldives	National health workforce strategic plan	2014–2018
Myanmar	Myanmar human resources for health strategy	2018–2021
Nepal	Human resources for health: strategic roadmap 2030	2018–2030 (draft)
Sri Lanka	Human resources for health strategic plan	2009–2018
Thailand	Health workforce plan	2016–2026
Timor-Leste	Timor-Leste human resources for health master plan	2017–2021 (draft)

11. One topic that has become more prominent because of the rise in NCDs and renewed efforts to improve access more generally has been the potential of mid-level health workers to improve access to care. Because of the importance of mid-level workers, the Regional Office has produced a technical brief on the topic.⁵ Evidence suggests that mid-level health workers can safely deliver most essential health interventions, provided they are properly trained and supported. Some Member States of the Region are also exploring the introduction of family practitioners in frontline services; in some cases, as part of family practice teams.

12. In addition to policy direction, HRH governance involves effective coordination of intersectoral action, which is vital for progress on transformative education and rural retention. The WHO Global HRH Strategy recommends HRH coordination units as a means to strengthen HRH governance. A WHO survey in 2017 found that eight Member States of the SEA Region had an HRH coordination unit within the Ministry of Health. These units cover a wide variety of functions and staffing levels, partly related to the mix of strategic versus administrative functions. While there is no “one size fits all” for what HRH units should do, there does appear to be scope for improving the capacity of these units to support policy analysis, strategy development, coordination and monitoring of HRH strategy implementation.

⁵ Mid-level health workers: a review of the evidence. UHC Technical brief. New Delhi: World Health Organization, Regional Office for South-East Asia; 2017 (http://apps.who.int/iris/bitstream/handle/10665/259878/UHC-health_workers.pdf?sequence=1&isAllowed=y, accessed 18 May 2018).

Transformative education

13. Transformative education is about enabling health professionals to better respond to people's health needs by changing how they are educated. It involves changes in both what students are taught and how they are taught, and both instructional reform and institutional reform. WHO developed guidance in 2013.⁶

14. Transformative education is still a relatively new concept, but there is more acceptance of the need for change in how health workers are trained compared with two years ago. All Member States of the Region report that they are doing something in this area, even if there is still some difficulty in explaining the term itself.

15. The 2016 review found that "overall, SEA Region countries are in early phases of implementation of transformative education". Implementation has continued in the past two years. In 2017, three Member States – Bangladesh, Sri Lanka and Thailand – had national meetings on transformative education, with the other Member States participating. There is progress on a range of approaches. The most frequent are: interprofessional education, which has now been initiated in more Member States than was the case two years ago, but is still in its early stages; use of information technologies in education, which is increasing; growing experience with accreditation of health professional training institutions, a workshop in early 2018⁷ found that Indonesia and Thailand have established accreditation systems, while other Member States are taking steps towards this; progress on continuing professional development and on faculty development is reported. Curriculum adaptation is something all Member States do regularly, but some have begun to put more focus on new teaching approaches.

16. One limitation to this progress is that there continues to be more attention to unidisciplinary education, and a greater focus on medical education rather than on education of other health professionals such as nurses and allied health professionals.

Rural retention

17. All Member States report experience with strategies to improve rural retention, and what was striking in this second review was a definite sense that progress is being made. However, many Member States still have issues of unequal distribution and rural retention of health workers. While evidence is still limited, some data on HRH distribution and vacancy rates have now been reported by some Member States and this can be used as a baseline for future tracking.

18. In terms of interventions used to improve retention in rural areas, compulsory service and targeted admission policies are the most commonly reported. The first review in 2016 noted that these approaches needed to be linked to other interventions such as career development, continuing professional development, transparency in posting, and personal and professional support, i.e. a bundle of interventions is needed. The 2018 review has reinforced that message,

⁶ Transforming and scaling up health professionals' education and training: World Health Organization guidelines 2013. Geneva: World Health Organization; 2013.

⁷ Experience with accreditation of health professionals' education in the South-East Asia region: expert workshop – summary report, 14–15 February 2018, Bangkok, Thailand. New Delhi: World Health Organization, Regional Office for South-East Asia; 2018. (http://www.searo.who.int/entity/health_situation_trends/summary_report_expert_workshop_on_accreditation.pdf?ua=1, accessed 18 May 2018).

but also refined it. First, the same retention strategy can have different effects on different target groups (younger versus older health workers; doctors versus nurses), and may have different effects on health systems at different levels of development. This makes it important to understand health workers' perspectives and needs before introducing a new retention strategy. A second message is that incentives for retention need to be applied fairly. Last, "costly" retention strategies such as financial incentives for remote areas and telemedicine have their place, but there may be other more cost-effective interventions that can be used to improve retention.

19. There are few studies documenting the impact of the many reported retention strategies in the Region. A clear recommendation to WHO during the 2018 workshop was to document experience in this area.

20. International outmigration of health workers continues to affect the availability of the domestic health workforce in some Member States. The upcoming reporting on implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel will provide an opportunity to update trends in mobility and policy responses. WHO will support reporting by the designated national authorities in Member States.

Improving health workforce data

21. During the regional HRH data workshop in 2017, Member States agreed that it is critical to have a better understanding of the questions to which policy-makers seek answers before embarking on a major exercise to strengthen HRH information systems. There is an increasing momentum to improve HRH data and HRH information systems in the Region. Eight Member States reported the steps taken to improve health workforce data in the past two years, building on their existing HRH information systems and using the new WHO guidance on National Health Workforce Accounts (NHWA) and information technologies.

22. Despite this progress, well-recognized challenges in HRH data persist: data are often highly fragmented and of poor quality; there are reported difficulties in getting HRH data on frontline health workers and from the private sector, and issues of data security must be considered. Key messages from the 2018 workshop were: improving data is a political as well as a technical exercise, and strengthening HRH information systems requires the involvement of stakeholders beyond ministries of health, and going beyond a technical focus on introducing new hardware and software. Systems develop gradually, and from the start should be designed in a way that allows progressive expansion beyond ministries of health alone. Better coordination among stakeholders within and outside ministries of health, regulation and innovative solutions to get the private sector to provide data are areas that need attention in the coming two years.

Conclusions from the second review of progress on the HRH situation in the SEA Region

23. In the past two years, the SDGs, UHC, WHO's Global Strategy on HRH; the UN High-Level Commission on Health Employment and Economic Growth, and the SEA Region's own Decade on Strengthening the Health Workforce have collectively helped to sustain a clear and compelling focus on the critical elements of the HRH agenda. Against this backdrop, the second

review has identified good, if variable, progress being made by Member States, with further relevant actions being planned.

24. The second review of progress provides evidence that the availability of health workers has improved, and that interventions related to transformative education and rural retention have advanced. HRH data seem to be improving, and the adoption of standard indicators to track progress in the Region has helped. However, more and better data on frontline health workers and the private sector should be captured. While there is a high level of commitment to a Decade of HRH in the SEA Region, and full agreement on its continued relevance, there is a continuing challenge in how to best demonstrate impact.

25. For full impact, HRH strategies and actions must be aligned with and support service delivery. To improve frontline services, the HRH debate needs to go beyond doctors and nurses to allied health professionals and other workers. This second review of progress highlights that this is an area that will require more attention.

26. The private sector has a major but variable role in HRH across the Region, as educator and/or employer. This second review highlights that there has been limited progress so far in engaging private training institutions and providers in national strategy development and governance for HRH. More work is needed in this area.

27. Intersectoral action remains challenging. It will be important to follow up on the recent HRH unit survey to generate further ideas on ways to strengthen national institutional capacity for HRH governance.

28. The second review of progress identified five areas for follow up by Member States. These covered: (i) maintenance of political leadership to accelerate progress on implementing HRH strategies that include actions to address transformative education and rural retention, and that reflect service delivery needs and advance UHC; (ii) continuing to explore accreditation as a useful contribution to creating a culture of quality in educational institutions and programmes for health professionals; (iii) ensuring that interventions used to improve rural retention take account of their different effects on different groups of health workers, and a health system's level of development; (iv) maintaining the improvements in HRH data and use it to track progress; and (v) strengthening HRH governance by reinforcing the capacity of existing HRH units.

29. The second review of progress identified six areas for follow up by WHO: (i) support improved documentation of the impact of interventions on rural retention and transformative education through case studies and technical briefs on key topics; (ii) facilitate exchange of experiences between Member States through existing regional networks, and other formal and informal means; (iii) explore ways to increase HRH policy and planning expertise in the Region by initiating discussions with universities and schools of public health on the possibility of developing HRH training courses and/or modules; (iv) provide technical assistance to Member States as requested, both on overall HRH policy and planning, and on more specific areas such as development of an HRH information system; (v) support reporting on the Global Code of Practice by designated national authorities in Member States; (vi) monitor and evaluate progress on the Decade of Strengthening HRH through progress reports in 2020, and alternate years thereafter.