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

In 2014, Member States of the WHO South-East Asia Region agreed to the “Decade for Strengthening Human Resources for Health in SEA Region 2015–2024”. The same year, the WHO Regional Committee for South-East Asia endorsed resolution SEA-RC67-R6 on “Strengthening Health Workforce Education and Training in the Region”. The resolution requested the Regional Director to support Member States in the implementation of the Regional Strategy on Health Workforce Education and Training in the SEA Region 2014–2019; and to report on progress with health workforce development to the Regional Committee for South-East Asia every two years, starting 2016, for a decade. This is the first review.

To review progress in implementation of the Decade for Strengthening Human Resources for Health in SEA Region, a self-report survey was conducted by SEAR Member States during March and April 2016. The High-Level Preparatory Meeting held in the WHO Regional Office in New Delhi from 11–14 July 2106 reviewed the attached Working Paper and made the following recommendations.

Actions by Member States

1. Consider the implications of the new Global HRH Strategy: Workforce 2030 when developing national HRH strategies and plans, and link these to service delivery needs.

2. By end 2016, agree on feasible priority actions for HRH strengthening for 2017–2018, with a focus on HRH governance, rural retention and transformative education, in consultation with relevant stakeholders as needed.

3. Use regional events to help advance the national HRH agenda and share best practice and experience: for example, meetings of the Asia-Pacific Action Alliance on Human Resources for Health (AAAHRH) network; South-East Asia Regional Medical Education (SEARAME) network and the Measurement and Accountability for Results workshop, in late 2016.
**Actions by WHO**

1. Provide technical assistance to Member States, including for strengthening governance and supporting HRH units to fulfil their functions.

2. Develop indicators for monitoring progress on HRH, especially on retention and transformative education, in alignment with the Global HRH Strategy: Workforce 2030, and to harmonize reporting on HRH.

3. Support production, synthesis and dissemination of regional evidence on rural retention and transformative education through case studies and briefing notes on crucial topics.


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

1. Human resources for health (HRH) continue to pose a critical challenge for SEAR. According to most recent data, five countries (Bangladesh, Bhutan, Myanmar, Nepal, Timor-Leste) still have a density of skilled workforce lower than the WHO-recommended threshold of 22.8 per 10,000 population. In addition, health workforce competency issues and distribution problems still persist.

2. A “Decade for Strengthening Human Resources for Health in SEA Region 2015–2024” was agreed by Member States of the Region in 2014. Resolution SEA-RC67-R6 on Strengthening Health Workforce Education and Training in the Region requested WHO to report on progress in health workforce development every two years for the next decade, commencing 2016. At a regional workshop in Bhutan in late 2014, existing WHO guidance was used to guide deliberations on interventions. Two-year national action plans were developed focusing on the rural retention of, and transformative education for, health professionals, with an initial focus on doctors and nurses.

3. A regional workshop to review progress was held in Bangkok on 20–22 April 2016 following a national self-report survey exercise. Eight Member States have completed the survey, and two have partly completed it. The workshop covered HRH trends and distribution; developments in HRH governance and leadership; actions on rural retention and transformative education; and HRH information and research. The “cross-walk” with the new Global HRH Strategy, and the WHO Global Code of Practice for International Recruitment of Health Personnel were also discussed.

Current situation, strategic issues and progress

HRH governance and leadership

4. Most SEA Region countries have national HRH strategic plans, with time frames ranging from 5 to 15 years. The responsible unit for developing these plans is normally in the public sector, such as HRH units within ministries of health. Indonesia is establishing a new board, the Directorate of Organization Development for Coordinating HRH Functions, which remains a government body.

5. Overall, it seems most countries do not involve the private sector when developing HRH strategic plans, despite the major role the private sector now plays in the production and employment of health workers. Bangladesh and Thailand have multi-stakeholder boards to establish a strategic plan. In Thailand, the National HRH Commission involves both public and private sectors in HRH planning and management. However, these do not have the power to ensure implementation.

6. For all SEA Region countries, besides engaging more with the private sector, there is a need to establish systems to monitor progress and assess achievements of national HRH strategic plans.
Health workforce education

7. Transformative education is not primarily about changing curriculum content. It is about changing how health workers are taught, to enable them to work across professions, recognize social responsibilities, and adapt to changing needs.

8. Countries defined their initial priorities during the 2014 consultation in Bhutan, drawing on WHO recommendations on transforming and scaling up health professionals’ education and training. The review in 2016 finds that most countries have maintained these priorities. Three countries – Bhutan, Myanmar and Sri Lanka – adjusted priorities following national consultations.

9. Overall, SEA Region countries are in early phases of implementation. There are many examples of curriculum content being updated, and some of innovative education approaches such as competency-based education, team-based training and interprofessional education. The scope of the regulations is expanding to include private sector education and allied health professionals.

10. Bangladesh has initiated the creation of a national accreditation council or body. Sri Lanka conducted a gap analysis and training needs assessment for faculty development and conducted a situation analysis of simulation methods. Overall, actions related to faculty development, curriculum development and continuing professional development (CPD) for health professionals are the main priorities of SEA Region countries.

11. Two areas of concern are how to better manage the regulation and accreditation of training institutions and curricula (public and private) to better meet the objectives of transformative education, and how to introduce and sustain continuing professional development.

12. More specific indicators and evaluation methods are needed to monitor progress.

Rural retention

13. All countries identify retention of health workers in rural areas as a major issue. All agreed that a “bouquet” or package of interventions is needed to obtain sustained improvements, and that many retention interventions are relatively cheap.

14. There is widespread support for targeted admission policies for students from rural areas, though with differences in the selection criteria. Targeted admission policies need to be linked to other interventions such as career development, compulsory service, transparency in posting, and personal and professional on-the-job support. Financial incentives and telemedicine have their place, but on their own are not magic bullets. Strategies that work for retaining health workers change as those workers move through their careers.

15. Data remain patchy. Recent evidence on the impact of these interventions does not yet exist. There is a need for more rigorous measurement of progress against a baseline.

Information systems on human resources for health

16. HRH data and HRH information systems have been rather neglected. However, there is now increasing attention being paid to these globally as well as in SEAR. New technologies provide an opportunity to improve data if used appropriately. More attention is needed to create demand for data and information, and to make it more accessible such as by timely and simple visualization.
17. Improving data is a political as well as technical exercise. Strengthening HRH information systems requires the involvement of stakeholders beyond ministries of health, and going beyond the introduction of new software. Systems develop gradually, and from the start should be designed in a way that allows progressive expansion beyond ministries of health alone.

18. The figure below shows trends in doctors, nurses and midwives in SEAR, based on data reported by countries to WHO SEARO in 2014, 2015 and 2016. It also reveals challenges in reporting on health workforce trends. Some countries appear to have big increases in only two years. These are for different reasons: For example, the Maldives has a small population, so a small increase in actual numbers shows up as a big increase in density. Nepal data that were reported in 2014 was derived from data available for a much earlier year.

![Aggregated Density of Physicians, Nurses and Midwives per 10,000 population in SEAR Countries, as reported in 2014 and 2016](image)

**Emerging messages**

19. The Sustainable Development Goals, and within that, universal health coverage, have clearly added momentum to the HRH agenda. So have other initiatives such as WHO’s new Global Strategy on HRH; the UN High-Level Commission on Health Employment and Economic Growth and the SEA Region’s own Decade on Strengthening HRH. It will be important to take advantage of these opportunities to advance a critical but complex agenda. The table below shows the crosswalk between the objectives of new Global HRH Strategy and the Decade on HRH Strengthening in SEAR.
20. HRH strategies and actions must be linked to service delivery, with a focus on reaching those being left behind. To improve frontline services, the HRH debate needs to go beyond doctors and nurses, and address allied health professionals.

21. The commitment to a Decade of HRH in the SEA Region is unusual and valuable. It gives time to align short-term actions with a long-term vision. The two-year reporting cycle will help maintain attention, and gradually improve information on, change.

22. In many SEAR countries, the private sector’s role in HRH is too big to be ignored. It is a major producer and employer of health workers, and attracts health workers from the public sector.

Crosswalk between objectives of Global HRH Strategy and SEAR Decade of HRH Strengthening

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<tr>
<th>Global HRH strategic objectives</th>
<th>Global HRH targets</th>
<th>SEAR Decade of HWF strengthening</th>
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<tr>
<td>1. Optimize performance, quality and impact of the current health workforce.</td>
<td>By 2030, ALL countries have halved urban-rural health workforce disparities and made progress towards improving the course completion rates in health professionals training institutions.</td>
<td>Rural retention and health professional education reforms a major focus in SEAR.</td>
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<td>2. Align investments in HRH with current and future needs of the population, the health system and taking account of health labour market dynamics.</td>
<td>By 2030, ALL countries have made progress towards halving dependency of foreign-trained health professionals, by implementing the Global Code. By 2030, global progress on access to care by working to create, fill and sustain 10 million additional jobs in the health and social care sectors.</td>
<td>1. SEAR to review recommendations from UN Commission on health employment and economic growth 2. SEAR to maintain effort on the Code: 6 countries reported on implementation in round 2 3. SEAR response on jobs target needs to be discussed</td>
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<td>3. Build national capacities for effective leadership and governance of HRH actions.</td>
<td>By 2020, ALL countries have institutions to steer inter-sectoral HWF agenda.</td>
<td>HRM Unit/cells and national HWF strategies in SEAR to be more intensively supported.</td>
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<td>4. Ensure reliable, harmonized, up-to-date HRH data.</td>
<td>By 2020, ALL countries established national HWF accounts, annual report core indicators to WHO Secretariat.</td>
<td>Improved HRH data to be a priority in SEAR, linked to SDG monitoring.</td>
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23. Strong linkages within the health sector and beyond the health sector are essential for significant and sustained change. Mechanisms for engagement do exist, but they are not easy to adopt.

24. So far, no country has reported any systematic assessment of impact. Demonstrating impact takes time, and active monitoring of progress is essential to show paymasters that change is happening, and to adapt policies as needed. Some simple “tracer indicators” would be useful.

25. Countries agreed to confirm domestic HRH priorities and actions for 2017–2018 by end-2016. National HRH consultations are planned in India, Nepal, Sri Lanka, or have just taken place (Bhutan).
26. The South-East Asia Regional Office can take the following actions to advance the HRH agenda:

- Governance: documentation of national HRH units and their functions; development of indicators (with WHO HQ);
- Knowledge and evidence: case studies of progress and briefing notes on topics such as regulation, accreditation and continuous professional development; use of regional networks and events such as AAAH, and the annual Measurement and Accountability for Results workshops.
- Scale up a systematic approach to technical support.

**Conclusions**

27. HRH remains a major issue. All SEAR countries are taking action. The Decade of Strengthening Human Resources for Health in SEAR, with its focus on retention and transformative education, is valuable. It is important to link HRH developments to service delivery needs and UHC. Global developments including the SDGs, the new global HRH Strategy, the WHO Global Code on International Recruitment, and the UN High Level Commission on Health Employment and Economic Growth can help reinforce the attention needed on HRH in the Region.

28. Attention to numbers of health workers is important but not enough: so are quality and skill-mix. Country HRH needs depend on many factors, including population density. More attention to frontline health workers beyond doctors and nurses is needed, including the possible development of new cadres, standardized training quality, and attention to the demand-side for care.

29. Effective HRH governance and regulation is critical but also difficult. There are often disconnects between the multiple players involved in health workforce planning, recruitment and management. The private sector is now a major player in HRH production and employment. Brain drain is rising.

30. Better HRH data are essential, as is more exchange of experience on progress and results.