



PRINCE MAHIDOL AWARD CONFERENCE



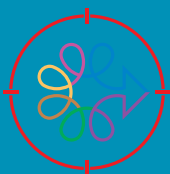
World Health
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Report on the Prince Mahidol Award Conference 2011 2nd Global Forum on Human Resources for Health

25-29 January 2011
Bangkok, Thailand



Second Global Forum on
Human Resources for Health
25 - 29 January 2011
Bangkok, Thailand

**Empower health workers
for health outcomes**

Table of Contents

Background of the Prince Mahidol Award	1
Prince Mahidol Award 2010	3
Message from Chairs of the International Organizing Committee	9
Conference Program in Brief	12
2 nd Global Forum on Human Resources for Health/ Prince Mahidol Award Conference 2011	17
Conference Sessions in Relation to the KD/AGA Strategies	20
Keynote Session - Community Health Workers: Key Agents for Reducing Child Mortality	22
AGA1 : Building coherent national and global leadership for health workforce solutions	31
AGA1 : Achievements	31
AGA1 : Challenges	33
AGA1 : Recommendations	35
AGA2 : Ensuring capacity for an informed response based on evidence and joint learning	39
AGA2 : Achievements	40
AGA2 : Challenges	41
AGA2 : Recommendations	43
AGA2 : Key Messages	45
AGA3 : Scaling up health worker education and training	46
AGA3 : Challenges	46
AGA3 : Recommendations	49
AGA4 : Retaining an effective, responsive and equitably distributed health workforce	54
AGA4 : Achievements	54



AGA4 : Challenges	55
AGA4 : Recommendations	58
AGA5 : Managing the pressures of the international health workforce market and its impact on migration	61
AGA5 : Key messages	62
AGA5 : Challenges	63
AGA5 : Recommendations	64
AGA6 : Securing additional and more productive investment in the health workforce	68
AGA6 : Challenges	68
AGA6 : Recommendations	69
Key Messages from 2nd Global Forum on Human Resources for Health	72
Conclusions : A long-rough-winding road to reach our HRH vision	76
Outcome Statement of the Second Global Forum on Human Resources for Health	78
ANNEX I Conference Organizing Committee Members	83
ANNEX II Conference Speakers/Panelists, Chairs/Moderators and Rapporteurs	89
ANNEX III List of Side meetings and Workshops	95
ANNEX IV List of Marketplace Posters and Awards Winners	98

Background of the Prince Mahidol Award

The Prince Mahidol Award was established in 1992 to commemorate the 100th birthday anniversary of Prince of Mahidol of Songkla, who is recognized by the Thais as 'The Father of Modern Medicine and Public Health of Thailand'.

His Royal Highness Prince Mahidol of Songkla was born on 1 January 1892, a royal son of Their Majesties King Rama V and Queen Savang Vadhana of Siam. He received his education in England and Germany and earned a commission as a lieutenant in the Imperial German Navy in 1912. In that same year, His Majesty King Rama VI also commissioned him as a lieutenant in the Royal Thai Navy.

Prince Mahidol of Songkla had noted, while serving in the Royal Thai Navy, the serious need for improvement in the standards of medical practitioners and public health in Thailand. In undertaking such mission, he decided to study public health at M.I.T. and medicine at Harvard University, U.S.A. Prince Mahidol set in motion a whole range of activities in accordance with his conviction that human resources development at the national level was of utmost importance and his belief that improvement of public health constituted an essential factor in national development. During the first period of his residence at Harvard, Prince Mahidol negotiated and concluded, on behalf of the Royal Thai Government, an agreement with the Rockefeller Foundation on assistance for medical and nursing education in Thailand. One of his primary tasks was to lay a solid foundation for teaching basic sciences which Prince Mahidol pursued through all necessary measures. These included the provision of a considerable sum of his own money as scholarships for talented students to study abroad.

After he returned home with his well-earned M.D. and C.P.H. in 1928, Prince Mahidol taught preventive and social medicine to final year medical students at Siriraj Medical School. He also worked as a resident doctor at McCormick Hospital in Chiang Mai and performed operations alongside Dr. E.C. Cord, Director of the hospital. As ever, Prince Mahidol did much more than was required in attending his



patients, taking care of needy patients at all hours of the day and night, and even, according to records, donating his own blood for them.

Prince Mahidol's initiatives and efforts produced a most remarkable and lasting impact on the advancement of modern medicine and public health in Thailand such that he was subsequently honoured with the title of "Father of Modern Medicine and Public Health in Thailand".

In commemoration of the Centenary of the Birthday of His Royal Highness Prince Mahidol of Songkla on 1 January 1992, the Prince Mahidol Award Foundation was established under the Royal Patronage of His Majesty King Bhumibol Adulyadej to bestow international awards upon individuals or institutions that have made outstanding and exemplary contributions to the advancement of medical, and public health and human services in the world.

The Prince Mahidol Award will be conferred on an annual basis with prizes worth a total of approximately USD 100,000. A Committee, consisting of world-renowned scientists and public health experts, will recommend selection of awardees whose nominations should be submitted to the Secretary-General of the Foundation before 31 May of each year. The committee will also decide on the number of prizes to be awarded annually, which shall not exceed two in anyone year. The prizes will be given to outstanding performance and/or research in the field of medicine for the benefit of mankind and for outstanding contribution in the field of health for the sake of the well-being of the people. These two categories were established in commemoration of His Royal Highness Mahidol's graduation with Doctor of Medicine (Cum Laude) and Certificate of Public Health and in respect to his speech that:

“True success is not in the learning, but in its application to the benefit of mankind.”

The Prince Mahidol Award ceremony will be held in Bangkok in January each year and presided over by His Majesty the King of Thailand.

Prince Mahidol Award

On 11 November 2010, the Prince Mahidol Award Foundation under the Royal Patronage held a press conference to announce the Prince Mahidol Award for 2010 at the Prince Mahidol Museum, Syamindra Building, Faculty of Medicine Siriraj Hospital. The press conference was participated by Clinical Professor Teerawat Kulthanan (Dean of Faculty of Medicine Siriraj Hospital, Mahidol University, in the capacity of Vice President of the Prince Mahidol Award Foundation), Clinical Professor Vicharn Panich (Chairman of the International Award Committee of the Prince Mahidol Award Foundation), Clinical Professor Supat Vanichakarn (Secretary-General of the Prince Mahidol Award Foundation) and Mr. Thani Thongphakdi (Deputy Director-General, Acting Director-General of Department of Information, Ministry of Foreign Affairs, Chairman of the Sub-Committee on Public Relations of the Prince Mahidol Award Foundation). Present at the press conference were also Mr. Kenneth Foster (Counsellor for public affairs, the Embassy of the United States of America) and Mr. Bradly Jones (Director of UK Trade and Investment, the British Embassy).

The Board of Trustees of the Prince Mahidol Award Foundation, chaired by Her Royal Highness Princess Maha Chakri Sirindhorn, was convened on 1 November 2010 to review the list nominations for the Prince Mahidol Award 2010, comprising of 72 nominees from 31 countries. In this connection, the Board of Trustees decided to confer this year's Prince Mahidol Award in the field of medicine to Professor Nicholas J. White, Chairman of Wellcome-Trust South East Asian Tropical Medicine Research Units, Professor of Clinical Tropical Medicine, Mahidol University and Professor of Tropical Medicine, University of Oxford and Professor Kevin Marsh, Director of Wellcome-KEMRI Research Programme, Kenya and Professor of Tropical Medicine, University of Oxford. In the field of public health, the Prince Mahidol Award is conferred to Professor Ananda S. Prasad, Distinguished Professor of Medicine, Wayne State University School of Medicine, Professor Kenneth H. Brown, Professor of Nutrition, University of California at Davis and Professor Robert E. Black, Professor and Chairman, Department of International Health, Bloomberg School of Public Health, the Johns Hopkins University. Details as follows:



Prince Mahidol Award Laureates for the Year 2010

Awards in Medicine



Professor Nicholas J. White
United Kingdom

Professor Nicholas J. White is world leader on the treatment of malaria especially on the use of artemisinin-based combination therapies. He and his team carefully conducted a series of clinical studies that clearly demonstrated the effectiveness of artemisinin for treatment of previously drug-resistant malaria, first in Southeast Asia and subsequently elsewhere around the world. Professor White advocates the combination of artemisinin with other drugs in order to increase the effectiveness and to avoid further drug resistance. This approach is now widely accepted by the World Health Organization. Artemisinin-based combination therapy has now become the recommended treatment of malaria worldwide, both in uncomplicated and severe cases. The careful clinical and pharmacological studies conducted by Professor White and colleagues have made a major contribution to the establishment of current treatment protocols and policy. This approach saves millions of lives of the population in developing countries especially in Asia and Africa where drug-resistant malaria is endemic.



Professor Kevin Marsh
United Kingdom

Professor Kevin Marsh pioneered the studies of immune epidemiology of malaria. Based mainly in Africa, his earlier studies showed the importance of strain-specific immunity in malaria. His team examined life cycle of malaria parasites in human body and how the body responds to the infection. This led to the recognition of several classes of variants of specific malaria antigens that play a key role in the pathogenesis of the disease. He and his colleagues further carried out immunological and clinical studies on several aspects of malaria in young African children which led to current understanding of the disease process and the effects of treatment. These works provide the basis for the development of vaccines for malaria to cover various strain variations.



Awards in Public Health



Professor Ananda S. Prasad
United States

Professor Ananda S. Prasad described the first cases of human zinc deficiency syndrome in 1963 in young adults with delayed sexual development, short stature, anemia, enlargement of liver and spleen, and abnormalities of bone maturation. Zinc supplementation resulted in significant increase in height, weight, bone development and sexual maturation. This pioneering work highlighted the importance of zinc in the health of humans and brought the attention of the scientific and public health communities to further study this important trace element. This discovery forms the basis that led to zinc supplementation to improve the health condition of populations around the world. Twenty percent of the world population are at risk from zinc deficiency. Professor Prasad continues to work on elucidating the biochemical and immunological mechanisms of zinc at the cellular level. The study led to the understanding how zinc deficiency affects human white blood cells and lowers the host defence system.



Professor Kenneth H. Brown
United States

Professor Kenneth H. Brown had devoted most of his career generating information and developing programs to improve nutritional and health status, especially in controlling and preventing zinc deficiency. He and his team conducted a series of community-based clinical trials of the effect of zinc supplementation on child growth and development as well as risk of infection. The studies showed that additional zinc supplementation helps to decrease the incidence and severity of diarrhoea and pneumonia especially in children living in developing countries. Children born to mothers who receive zinc supplementation during pregnancy have lower incidence of diarrhoea. He and colleagues further examined and evaluated various zinc fortification and supplementation strategies. Professor Brown is instrumental in the International Zinc Nutrition Consultative Group that advocates zinc supplementation, and it is now widely accepted as an important public health measure to prevent zinc deficiency as it is a major contributor to childhood morbidity and mortality.





Professor Robert E. Black
United States

Professor Robert E. Black's long-standing work on the importance of childhood nutrition significantly contribute to the wide application of zinc supplementation. His earlier studies in Bangladesh and India demonstrated that daily zinc supplementation during diarrheal episodes significantly reduced the severity of diarrhea. A similar situation occurs in pneumonia cases. He also described the diarrhea-nutrition cycle in which episodes of diarrhea lead to malnutrition and deficiency of trace elements, and in turn further augment the incidence and severity of diarrhea. The World Health Organization and UNICEF currently recommend that all childhood diarrhea cases should be treated with zinc supplement as well as oral rehydration. The program has been implemented in more than 40 countries around the world.

Message from Chairs of the International Organizing Committee



Vicharn Panich



Francisco Campos



Carissa Etienne



Kiyoshi Kodera

A strong health workforce is the backbone of a robust health system. Access by everyone to a skilled, motivated and supported health worker is an essential step on the road to achieve the health-related Millennium Development Goals (MDGs) and, ultimately, universal health coverage. The link between adequate health worker availability and access to essential health services is firmly established: the higher the density and the more equitable the distribution, the better the health of the population.

Almost three years ago, at the 1st Global Forum on Human Resources for Health in Kampala, Uganda, participants including health workforce experts and advocates endorsed the Kampala Declaration and Agenda for Global Action (KD/AGA), a historic roadmap laying out key actions required at international, regional, national and local levels to improve human resources for health over the next ten years.

The Global Health Workforce Alliance, the Prince Mahidol Award Conference, the Japan International Cooperation Agency, and the World Health Organization, convened the 2nd Global Forum /Prince Mahidol Award Conference on Human Resources for Health, in Bangkok, Thailand.

As participants of this important Forum, we are all tasked with the responsibility to make a difference for the one billion people in the world who face a daily struggle to get basic health care from a skilled worker. Now is the time for all stakeholders to come together to renew commitments and take sustainable actions to make access to health services a reality for all.



As Chairs of the International Organizing Committee, we are very pleased to welcome you to Thailand's capital city, joining more than a thousand fellow champions, with a shared mission. We hope you will use this unique opportunity to share your successes and challenges, strengthen your networks and build new alliances and, above all, strengthen your determination to undertake new actions to deliver on our promises by 2015.

Over the next few days, you will hear first-hand how actions on the ground in a number of countries experiencing most severe health workforce issues are starting to make a difference. You will also hear about outstanding challenges in implementing the Kampala Declaration and Agenda for Global Action particularly with regards to the implementation of national health workforce plans, provision of quality training for all health workers, retention of rural health workers, implementation of the WHO Code and needed resources to fill the critical funding gap.

We have prepared a rich and full agenda with four plenary and 20 parallel sessions during the main conference programme which explore the range of health workforce issues and solutions. We urge you to take advantage of the varied range of 41 side meetings organized by partners. Please also take the opportunity to visit the Marketplace exhibition area where you will find poster displays showcasing case success stories as well as profiles of individual health workers which have been short-listed for awards to be given out during the Forum's closing ceremony. You are also invited to take part in one of the site visits, which will offer you a taste of Thailand's own efforts to strengthen and engage the health workforce.

We would like to thank the many committed individuals and organizations that have worked together to prepare and execute the plan for this Forum, in particular the international partners, the Prince Mahidol Award Foundation and the Royal Thai Government. We would also like to extend a special welcome to the many individual frontline health workers, whose wealth of experience, knowledge and dedication we will all have the opportunity to benefit from this week.

The importance of the health workforce is increasingly visible on global and national agendas and we believe that more progress is possible. We look forward to joining you in renewing commitments over the next few days and in carrying out sustainable actions, beyond the Forum so that, together, we empower all health workers to deliver better health outcomes for all people.

Vicharn Panich *Francisco Campos* *Carissa Etienne* *Mr. Kiyoshi Kodera*

Vicharn Panich Chair Prince Mahidol Award Conference	Francisco Campos Co-Chair Global Health Workforce Alliance	Carissa Etienne Co-Chair World Health Organization	Mr. Kiyoshi Kodera Co-Chair Japan International Cooperation Agency
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Conference Program in Brief: Prince Mahidol Award Conference 2011

Tuesday 25 January 2011

09:00-18:00 Side meetings and workshops

18:30-20:00 Welcome Reception and Launch of the first Progress Report on the Kampala Declaration and Agenda for Global Action

Wednesday 26 January 2011

07:00-18:00 Field visits

Thursday 27 January 2011

09:00-10:30 Opening Session & Keynote Address

11:00-12:30 **Plenary session 1:** From Kampala to Bangkok: Marking progress, forging solutions

14:00-15:00 **Plenary session 2:** Have leaders made a difference?: how leadership can show the way towards the MDGs?"

15:30-17:30 **Parallel Session 1:** Leading towards health workforce development at country level: What will it take?

Parallel Session 2: Serving in the frontlines: Personal experiences and country strategies for retention of HRH in rural areas

Parallel Session 3: Will the WHO Global Code stop the brain drain? What will it take to succeed?

Parallel Session 4: Do GHIs contribute to equity in access to HRH?

Parallel Session 6: Overcoming HRH crisis in conflict and post-conflict situations

Parallel Session 7: High level roundtable: Working together for health workers (by invitation)

Friday 28 January 2011

09:00-10:00 **Plenary session 3:** Professional leadership and education for 21st century

10:30-12:30 **Parallel Session 8:** Building capacity to translate HRH evidence into action to sustain HRH policy, decisions and system strengthening

Parallel Session 9: Innovative solutions for strengthening HRH information systems

Parallel Session 10: Scaling up HRH towards equity

Parallel Session 11: Seeking the stamp of good quality? Imperatives of HRH regulation and accreditation

Parallel Session 12: Financing health worker education and training

Parallel Session 13: Dedicated spirit: The charm and charisma of HRH

Parallel Session 14: The UN Secretary General Global Strategy for Women's and Children's Health: What will be done about the workforce?

14:00-15:00 **Plenary session 4:** Making HRH innovation work for strengthening health systems

15:30-17:30 **Parallel Session 5:** Economic fluctuations, universal health coverage and the health workforce

Parallel Session 15: Building capacity to generate evidence in HRH action oriented research

Parallel Session 16: Innovative education and training in HRH

Parallel Session 17: HRH situation and trends in developed countries and their potential implications for developing countries

Parallel Session 18: Trade in health services and impact on HRH

Parallel Session 19: Self reliance to health and well being through local resources and knowledge

Parallel Session 20: Skills mix to achieve universal access to essential health care

Saturday 29 January 2011

09:00-10:30 Synthesis: Summary conclusion & next steps

11:00-12:30 Closing session of the 2nd Global Forum



Summary in Brief

Program

Tuesday 24 – Saturday 29 January 2011

Forty-one side meetings and workshops. List of side meetings and workshops is shown in ANNEX III

Marketplace: Showcase of posters of the 36 successful case stories and 12 outstanding health workers. List of case stories and individual health workers as well as the final winners for Special Recognition Awards (for health workers) and Awards for Excellence (for case stories) are shown in ANNEX IV

Wednesday 26 January 2011

Seven optional field visits

- **Wat Pra Baht Nam Phu:** The Buddhist Temple that Cares for Full-Blown AIDS Patients
- **Pra Nang Klao Hospital:** Humanized Health Care Volunteers
- **Phnomsarakam Community Hospital:** Pay for Performance to Increase Job Satisfaction and Retention
- **Ban Paew Hospital:** The First and Only Public Autonomous Hospital in Thailand
- **Uthong Hospital:** Combination of Conventional and Alternative Medicines
- **Taladjinda Health Center and Sampran Hospital:** Community Participation
- **Siriraj Hospital:** The Role of Medical School in Human Resource Development for Health

Thursday 27 – Friday 28 January 2011

- Keynote address
- Four plenary sessions
- Twenty parallel sessions

Participants

1,015 participants from 105 countries

Afghanistan, Argentina, Australia, Bahrain, Bangladesh, Belgium, Benin, Bhutan, Botswana, Brazil, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Chad, Chile, China, Colombia, Comoros, Congo, Cote D'Ivoire, Democratic Republic of Congo, Denmark, Djibouti, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, France, Germany, Ghana, Guinea, Guyana, Hong Kong, Hungary, India, Indonesia, Iraq, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kenya, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Lebanon, Lesotho, Liberia, Madagascar, Malawi, Malaysia, Mali, Mauritania, Mauritius, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nepal, Netherlands, New Zealand, Niger, Nigeria, Norway, Pakistan, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Romania, Rwanda, Senegal, Sierra Leone, Singapore, South Africa, Spain, Sri Lanka, Sudan, Suriname, Swaziland, Sweden, Switzerland, Taiwan, Tajikistan, Tanzania, Thailand, Togo, Tunisia, Uganda, United Kingdom, United States, Uruguay, Vietnam, Yemen, Zambia, Zimbabwe



Forum Co-hosts

Prince Mahidol Award Conference, Global Health Workforce Alliance, World Health Organization, Japan International Cooperation Agency

Forum Sponsors

China Medical Board, Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH, European Commission, Ministry of Foreign and European Affairs of France, Ministry of Health and Ministry of External Relations of Brazil, Norwegian Agency for Development Cooperation, The Rockefeller Foundation, United State Agency for International Development, World Health Organization Regional Office for South-East Asia

The Forum Co-Hosts further acknowledge the contributions of

Averting Maternal Death and Disability Program of Columbia University, UK Department for International Development, Partnership of Maternal Newborn and Child Health, Thai Health Promotion Foundation, The Global Fund to Fight AIDS, Tuberculosis and Malaria, The World Bank, United Nations Population Fund.

Prince Mahidol Award Conference 2011 2nd Global Forum on Human Resources for Health

Background

The first ever Global Forum on Human Resources for Health was held in Kampala, Uganda in March 2008. The Kampala Declaration and Agenda for Global Action (KD/AGA) that emerged from this meeting committed participants to an ambitious agenda to invest in and improve human resources for health (HRH), particularly in countries facing critical health workforce challenges. The KD/AGA is built around six fundamental and interconnected strategies, based on previous actions and commitments. It is a synthesis that specifically highlights challenges and the need for change which reflects the essential continuum of planning, training, deployment and retention. The purpose of the KD/AGA is to translate political will, commitments, leadership and partnership into effective actions. The Alliance was given the mandate to track progress in implementing the strategies adopted, with a focus on achieving access for all to skilled, motivated and supported health workers.

The six interconnected the KD/AGA Strategies are:

1. Building coherent national and global leadership for health workforce solutions
2. Ensuring capacity for an informed response based on evidence and joint learning
3. Scaling up health worker education and training
4. Retaining an effective, responsive and equitably distributed health workforce
5. Managing the pressures of the international health workforce market and its impact on migration
6. Securing additional and more productive investment in the health workforce



Almost three years of implementation of policy and strategies have passed since the first Global Forum on Human Resources for Health in Kampala. In addition, there have been a number of World Health Assembly Resolutions and WHO Regional Committee Resolutions which call for immediate action to solve this global crisis.

The 2nd Global Forum on Human Resources for Health was held between on 25-29 January 2011, in Bangkok, Thailand, in collaboration with the 2011 Prince Mahidol Award Conference. The overall objective was to accelerate the global movement on HRH towards achieving the Millennium Development Goals (MDGs) and universal access to essential health care. In addition, it was agreed at the joint planning workshop among the co-hosts of the Forum on 3-4 December 2009, that the Global Forum would be a combination of technical and policy elements while also focusing on evidence-based actions, existing gaps and how to overcome them. It was the intention of the conference to be crafted along the line of the KD and six strategies of the AGA. It was envisioned that the deliberations would review the development and progress made, and identify challenges met in mitigating global health workforce crisis. It was organized to best support global movements towards better HRH to achieve universal coverage. Countries are the indispensable players in solving the health workforce crisis, thus, priority was given to engage speakers and participants from countries to share experiences and lessons learned. Speakers from international development partners also played a role in terms of sharing policies and strategies at the international and global levels which have an impact on implementation at the country level. The ratio of country to international partner speakers proposed was 3:1.

The theme of this conference thus follows the KD/AGA: Reviewing progress, renewing commitments to health workers towards MDGs and beyond. As such, this conference proceeding synthesizes, summarises and reports the presentations, issues, discussions, achievements, challenges, recommendations and outcomes of the 2nd Global Forum on Human Resources for Health under the KD/AGA Strategies headings above.

Theme of the Forum

Reviewing progress, renewing commitments to health workers towards MDGs and beyond

Structure of the Main Conference Program

The 2nd Global Forum on HRH / Prince Mahidol Award Conference 2011 hosted activities, including:

- Side meetings,
- Capacity building workshops,
- Field visits,
- Marketplace,
- Main conference program.

The main conference program consisted of the Plenary and Parallel sessions, in addition to the opening, closing and official dinner sessions. The content of the sessions were based on the structure and contents of the KD/AGA, as well as the results of the on-line survey carried out by the Global Health Workforce Alliance (the Alliance).

Our HRH Vision



“all people, everywhere, shall have access to a skilled, motivated and facilitated health worker within a robust health system”

*“The Painful Fact
Worldwide, one billion people never see a health worker all their lives.”*

Sigrun Mogedal

Conference Sessions in Relation to the KD/AGA Strategies

All the conference sessions, including keynote, plenary sessions and parallel sessions, were classified, as shown in the table below, according to the six Agenda for Global Actions. All of the six AGA contribute to the achievement of the goal of equitable access to a skilled, motivated and facilitated health worker in a robust health system (see Table 1).

Table 1 Conference sessions by six AGA and cross cutting issue

AGA strategies	AGA1: Coherent national global leadership	AGA2: Evidence based responses	AGA3: Scaling up education training	AGA4: Retaining effective, responsive health workforce	AGA5: Managing inter-national migration	AGA6: Securing additional, productive investment	Cross cutting
Keynote	●						
Plenary 1							●
Plenary 2	●						
Plenary 3			●				
Plenary 4			●				
Parallel 1	●					●	
Parallel 2				●			
Parallel 3					●		
Parallel 4	●						
Parallel 5							●
Parallel 6	●						
Parallel 7	●						
Parallel 8		●					
Parallel 9		●					
Parallel 10			●				

AGA strategies	AGA1: Coherent national global leadership	AGA2: Evidence based responses	AGA3: Scaling up education training	AGA4: Retaining effective, responsive health workforce	AGA5: Managing inter-national migration	AGA6: Securing additional, productive investment	Cross cutting
Parallel 11			●				
Parallel 12			●				
Parallel 13				●			
Parallel 14	●						
Parallel 15		●					
Parallel 16			●				
Parallel 17					●		
Parallel 18					●		
Parallel 19				●			
Parallel 20			●				
Total	7	3	7	3	3	1	2

GOALS

Equitable access to a skilled, motivated and facilitated health worker in a robust health system



Plenary 1 From Kampala to Bangkok and
Parallel 5 Economic fluctuation, UHC and HRH

AGA1 Coherent national, global leadership	AGA2 Evidence based responses	AGA3 Scaling up education /training	AGA4 Retaining effective, responsive health workforce	AGA5 Managing inter-national migration	AGA6 Securing additional productive investment
Keynote Plenary 2 Parallel 1, 4, 6, 7, 14	Parallel 8, 9, 15	Plenary 3, 4 Parallel 10, 11, 12, 16, 20	Parallel 2, 13, 19	Parallel 3, 17, 18	Parallel 1



2nd Global Forum on Human Resources for Health

Keynote Session - Community Health Workers: Key Agents for Reducing Child Mortality



Prof. Robert Black
Professor and Chairman,
Department of International Health,
Johns Hopkins School of Public Health,
United States

Recently there has been a renewed focus on Community Health Workers (CHWs). Their role as voluntary and minimally-paid workers was prominent in the 1978 Alma Ata Declaration. The reasons for renewed focus may be summarized as follows. CHWs are seen as critical for reaching the health related Millennium Development Goals by increasing access to and coverage of interventions. They have the potential to reach most remote and poorly-served populations, thereby improving equity. Furthermore, some interventions are more effectively delivered by CHWs rather than by facility-based health workers.

Interventions that can be delivered by CHWs include community mobilization, water and sanitation interventions e.g. promotion of hand washing, point of use water treatment and safe water storage and latrine construction, promotion of latrine use. CHWs can play a central role in nutrition through distribution of vitamin A, iron etc., breastfeeding promotion and counseling, counseling on weaning practices and treatment of severe malnutrition.

CHWs may also be involved in vector control through distribution and promotion of mosquito nets the environmental control of vectors, and in mass treatment, e.g. of trachoma and onchocerciasis. Their role in the management and treatment of HIV/AIDS includes voluntary counseling and testing, ensuring compliance with treatment and providing home-based care.

CHWs can play a key role in Community Case Management of serious childhood illnesses, particularly malaria, diarrhea, pneumonia and newborn sepsis, the cause of two-thirds of child deaths. Management of these serious infectious diseases is demonstrated through diagnosis of malaria by rapid diagnostic testing and treatment with Artemisinin Combination Therapy, diagnosis of diarrhea and treatment with oral rehydration salt (ORS) and zinc, diagnosis of pneumonia and treatment with antibiotics, and Integrated Community Case Management. There is significant evidence that community-based treatment of pneumonia decreases childhood pneumonia mortality (Sazawal and Black. *Lancet Infect Dis.* 2003 3(9):547-56).

CHWs are also critical for delivery of newborn care through antenatal home visits, birth preparedness and newborn care preparedness programs and by promotion of ANC attendance. Postpartum home visits are essential to provide newborn care, for identification and referral of sick newborns and the management of sepsis. The Projahnmo Trial^[1] evaluated effectiveness of a community-based maternal and newborn care intervention package in a rural Bangladesh setting where 9% of facility-based delivery and 47% of neonatal deaths were due to infections. The randomized trial had 24 clusters, each having an average population of 20,000; randomly allocated to home care, community clinic or a comparison arm. The home care arm reduced infant mortality rate from more 45 per 1000 live births to less than 30, a 30% improvement over the other two arms, over a period of 2 years. There is also considerable additional evidence of the positive impact of community-based interventions on neonatal mortality^[2].

[1] : Baqui et al. *Lancet* 2008 doi:10.1016/S0140-6736(08)60835-1

[2] : Lassi, Haider, Bhutta. *Cochrane* 2010, DOI: 10.1002/14651858.CD007754.pub2



In conclusion, CHWs can play many key roles in promotive, preventive and therapeutic health services within a health system. In areas with limited access to, or utilization of health facilities, community-based treatment of serious childhood illnesses can reduce mortality and improve health equity. Evidence is extensive that CHWs can safely and effectively treat pneumonia and newborn sepsis. Many countries would benefit from implementing and scaling up integrated community case management of malaria, diarrhea, pneumonia and newborn sepsis.

“Evidence is extensive that CHWs can safely and effectively treat pneumonia and newborn sepsis, and countries would benefit from implementing and scaling up integrated community case management of malaria, diarrhoea, pneumonia and newborn sepsis”

Robert E. Black, Prince Mahidol Award Laureate 2010



Dr. Pakdee Suebnukarn
Dansai Hospital, Thailand

**Finalist for Special Recognition
Award (for Health Worker)**

Health care in the past relied heavily on information and knowledge from outside, such as the Health Ministry and academia. With the top-down perspective nature, the details are usually overlooked. The idea is usually presented as an overview highlighting some issues as a result of analysis and decisions based on knowledge and theoretical frameworks. Once we are more **inside**, we learn more about people in the community, the culture and the land where they live. We see how they live and the occupations that rely on each other. We see the community and self care system that connects with the nature, beliefs and religious institutions. Only if we perceive and acknowledge the information profoundly as we are people inside the community, our heart will open for new perspectives and ideas to create health care services and systems that harmonize with the community's needs and lifestyle.

The Healthcare professional team at Dansai District Hospital including doctors, dentists, and pharmacists are all from outside Dansai. We encourage activities for learning and building relationships with the community. The camp for new staff aims to learn and work together with the primary care unit in order to understand the way of life, the community's culture and the social dimension of illness. Being an insider, our health care services together with the people in the community are more natural, flexible, and able to change according to the social context and surrounding diversity. Understanding and generosity are the essentials of humanized health care.

In the community, educational opportunities especially for pursuing medical and health care professionals are limited. We find people



from the community and provide an Educational Scholarship Fund for them to study in an appropriate institute, and recruit them back to the Hospital with sufficient salary. This can be a way to give back to the community and their loved ones. We sent two local men who work as clerks in the hospital to learn how to make prosthetic legs at the Prostheses Foundation of Her Royal Highness Princess Mother. They went back and established the Prosthetic Leg Center at Dansai Hospital to provide prostheses for disabled people in Dansai and the surrounding communities. They also joined the Prostheses Foundation as volunteers to provide prostheses to poor and underprivileged amputees in the remote rural areas.

At Dansai Hospital, we value our staff potential. We discover each person's dreams and desires. We envision their soul's growth and potential. We prepare space for learning, growing and pursuing their own dreams. Working at Dansai Hospital provides meaning for their life. We encourage various health related activities inside and outside the hospital, for example, a nature youth camp, the Bookstart Project, and Art Camp.

We embrace the **“Volunteer Spirit Culture—voluntarism”** which leads us to collaborative networking with other sectors both inside and outside the community. Our aim is to take care of our people as best as we can. One of the most outstanding activities of Dansai Hospital is cardiology services provided by a volunteer cardiologist from Chiang Mai University once a year. Working closely with our internist, we are able to identify patients who need further treatments from the Cardiology Center. We are able to reduce the number of visits the patients need to see the cardiologist 300 Kilometers from Dansai, and ultimately create a better quality of life for our patients. We also have cataract surgery services every 3 months by a volunteer ophthalmologist who works at a private hospital. Having done this service for 16 years, he and our team have performed eye surgery for 1,018 patients. We set up the Health and Rehabilitation Fund for Elderly which covers some expenses.

Creating inspiration and acknowledging the seeds of virtue for commitment to care in the organization are my duties as a leader. We value everyone in the organization. Each staff member is a seed of goodness. It's my duty to create a good working

environment and to eliminate obstacles and cultivate them to grow and bear flowers and fruits to benefit other people. My final lesson from working at Dansai Hospital for 21 years is to create a “Volunteer Spirit Culture,” which I believe is sustainable human resource management.

“Volunteer spirit is essential for any health worker, and having enough good colleagues is the ‘heart’ of the organization”

Dr. Pakdee Suebnukarn, a doctor from Dansai Hospital located in a remote area in the northeast of Thailand





P.D. Lalitha Padmini
Public Health Midwife, Sri Lanka

**Finalist for Special Recognition
Award (for Health Worker)**

Welcome— “Ayubowan” — Long Life.

Her Royal Highness Princess Maha Chakri Sirindhorn, Distinguished invitees. Arogya parama labha. Santhutti paramag dhanan “- Dhammapada. The Lord Buddha said, “Good health is the highest gain - Contentment is the greatest wealth”.

At the peak of a civil war in the north and east of Sri Lanka, on the 1st of July 1998, after one and a half years of extensive training in public health and midwifery, I assumed duties as a Public Health Midwife in a remote village called Medagama in Dimbulagala in the Polonnaruwa District of Sri Lanka, with a thousand and one expectations. Although I was very young when I assumed duties, I became a very close friend, a mother and a close relative to those poor people who made a living through agriculture and were living in fear due to the war.

Soon, I realized that the poverty, malnutrition, abuse of alcohol, and teenage marriages were some of the important problems facing my poor people who lived under trying conditions. At the outset, I also realized that these are the greatest challenges confronting my professional career. In order to serve them better, I organized a group of volunteers selected from the village itself. I traversed the whole village in search of all, be it young or old. There is no house in the village that I have not visited.

I identified their health needs along with their social problems. They helped me to develop the infrastructure to improve their health care. I used the opportunities to creatively educate them. After not very

long, I was able to ensure that there were no teenage pregnancies, although they got married at a young age and the malnutrition status gradually started to improve. No infant cried due to loss of the mother, no mother cried due to the loss of her infant and all infants are breastfed during their first six months.

Although we had a war in our country, the government ensured that all segments of the population had access to health care. Although we frequently heard the firing of guns, and were subjected to terrorist attacks, I continued to serve these innocent people without abandoning them for 13 long years.

I am proud to be a Family Health Worker in Sri Lanka. We have a health care delivery system well recognized throughout the world. Its foundation was the Health Unit System that started way back in 1926. We take care of the young people even before they get married. Since then the pregnant mothers, the infants, children, young and old are all cared throughout their life. Since long ago, our country provides free healthcare to every citizen with the life-course approach.

At this juncture, I must emphasize another important point. There are many health workers like me, silently serving the communities throughout the world, without coming into the limelight. If one can recognize these silent heroes and give them opportunities like this, we could harness their talents and motivate them to serve better. Then our whole world will become a better and a healthy place to live.

I am grateful to my senior officials in the health sector. Their guidance very much helped me in reaching great heights. Today, I am very happy to share this little bit of my experiences from my professional career. I wish to extend my grateful thanks to the Global Health Workforce Alliance, Prince Mahidol Award Committee, the AAAH and all of you for recognizing me and giving me this opportunity to address you.



Finally, I commit myself to serve my motherland as well as the global community to the best of my ability with more vigor.

Thank you! May you all live longer! **“Ayubowan”**.

“There is no house in the village that I have not visited.” “There are many health workers like me, silently serving the communities... if one recognizes these silent heroes, give them opportunities, one could harness their talents and motivate them to serve better...our world will become a better and a healthy place to live.”

P.D. Lalitha Padmini, Public Health Midwife, Sri Lanka

AGA1:

Building coherent national and global leadership for health workforce solutions

The challenges that most countries face with respect to their health workforce require health leadership at national and global levels to articulate problems and implement solutions. At the national level, it is imperative that MOH takes the lead in developing the strategic HRH plan, in close consultation with the other ministries and actors such as those of education, finance, labour, and the civil service, as well as ensuring their successful implementation. This is often hampered by the fragmentation of efforts, unrealistic time frames and the lack of involvement of relevant stakeholders, particularly those from other sectors. ^[3]

AGA1: Achievements

AGA1 achievements to date may be viewed on three levels:

Globally

HRH is now high up in the global political agenda following a number of high profile events:

- 2005 Paris Declaration and 2008 Accra Agenda for Action (AAA), fostering alignments on health system strengthening (HSS) and HRH

[3] : O'Neil, 2008 Human resource leadership: the key to improved results in health. Human Resources for Health, 6:10doi:10.1186/1478-4491-6-10



- 2006: WHO World Health Report 2006 was launched; it was referred to, cited and made recommendations to be applied by different stakeholders
- 2006: Advent of the Global Health Workforce Alliance (the Alliance)
- 2008: Kampala Declaration and Agenda for Global Action adopted at the 1st Global Forum on HRH in Kampala
- 2008-10: a number of national HRH strategies, regional HRH strategies were developed, implemented, monitored and evaluated
- 2008: Toyako G8 Summit 2008 focusing on health information system (HIS), HRH and health financing.
- 2008-10: A number of WHA resolutions, including the 2010 WHO Global Code of Practice on International Recruitment of Health Personnel, two EB128 resolutions, international development partners' policy and works in support of HRH
- 2010 WHO Global Policy recommendations on rural retention, ongoing work on scaling up transformative professional education, training

Nationally

Despite global advocates, there have been some patchy developments, mainly in building HRH capacity. There are examples of capacity to use evidence through HRH Observatories, a mechanism for strengthening HRH leadership and evidence based policy decisions, for example the National HRH Observatory (NHRHO) in Sudan. Capacity to develop HRH plans has increased, although quality and implementations have yet to be improved; only 23% of plans have been costed among the health workforce critical shortage countries. Capacity to mobilize domestic and official development assistance (ODA) resources has improved, although it is still fragmented. Finally, the capacity to align donor and Global Health Initiatives (GHI) in line with national priorities is improving; the Global Fund in some countries has demonstrated desperate need for positive outcomes.

Locally

There has been very limited involvement by either local leadership or learning from communities. Involvement of civil society and local governments to ensure good governance and effective policy implementation are exemplified by leadership and decentralization changing the lines of accountability in Indonesia, and by decentralization and its implications on HRH, and involvement of civil society in good governance policy implementation in Rwanda. Learning from communities encompasses health workers understanding local people, their lives, needs and beliefs, and the voluntarism spirit strengthening the bonds between health workers, the people and the communities. Also CHWs are increasingly playing a critical role and contribution in achieving MDGs in many settings. There is a need for clear policy and legal framework to support the function of CHWs.

AGA1: Challenges

The challenges for building coherent national and global leadership for a health workforce are many. Despite the high level of global commitment, slow progress has been observed in translating policy into actions. One of the main bottlenecks is lack of country institutional capacity on HRH governance and adequate national investment in HRH production, reform of education, deployment of graduates, incentives and effective retention strategies. There is lack of recognition by all stakeholders of the centrality of HRH to health systems, and that health system strengthening is the quest to achieve the health-related MDGs and the wider objective of universal health coverage.

There is limited institutional capacity in most HRH units at Ministries of Health to develop strategies, coordinate intersectoral actions (public-private production, deployment, retention and migration), and to translate strategies into good planning that can mobilize adequate resources for implementation, monitoring and evaluation. This is most challenging in decentralized systems.



Lack of adherence to the Paris Declaration, particularly donor harmonization, is confounding these challenges. There are significant negative consequences of GHI when they are not well coordinated. Additionally the available resources are not invested strategically; a common trend emerged that in-service training gets the largest share, and donors are almost absent in employing current labour forces and investing in pre-service training. Mostly donor funding is not predictable and sustainable long-term, while resource poor settings desperately need donor funding support. Lastly, there are also concerns about countries capacities to influence and manage aid flows and HRH.

Overcoming HRH crises in conflict and post-conflict situations



Health workforce development is a vital component of any health system, however building the health system in countries during an acute and chronic critical shortage or in the post conflict phase of recovery is complex and poses specific challenges. Health and other personnel need to be on the scene as quickly as possible with the necessary skills and equipment to allow them to function effectively. This comprises a combination of those already in the area recruited and those arriving from outside contexts. Local and international health workers need to be deployed in a way that maximizes their respective skills, experiences, and resources.

Training of mid-level health cadres and others (such as CHWs, sanitary officials and technical nurses) is needed for severe country crises in order to replace the losses and re-establish the demolished health infrastructure. Political conflict can affect access to qualified health facilities of people (e.g. in the case of the occupied Palestinian territory). In severe crises, particularly from natural disasters, although there is a lot of international help, there are still many challenges such as inadequate sanitary conditions. In many cases there is no disaster protocol to guide effective response. Armed conflicts create migration and internal and international displacement of people, and security is the main reason for this. Many opportunities are missed to update the skills and knowledge of health workers in the country from international experts. The result is a weakening of capacity within the health system as a result of recruitment of national staff out of public and private facilities into international agencies.

Global Health Initiatives (GHI) have the ability to mobilize huge amounts of financial resources which can contribute constructively and positively to national HRH plans. Shortages of HRH are a bottleneck to scaling-up service delivery and a hurdle to effective implementation of GHI supported programs. Some anecdotal studies show that GHI-supported programs cause internal mobility of health workforce, from rural to urban, from poorly funded public service providers to better funded NGO programs etc. There has been increasing focus on retention strategies through training and improvement of working and living conditions of health workers in rural areas.

AGA1: Recommendations

In the case of Malawi, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) experience was perceived to be positive because the design of various HRH interventions related to ART implementation was engaged and owned by the country. However, GHIs lead some other countries to be dependent on external donor assistance and some of them tend to create inequitable distribution of projects and funds (GHIs tend to spend money where it is convenient, rather than where it is needed). The panel discussants presented their suggestions and how to improve the mobilization and better utilization of financial resources from GHIs.



For the Global Fund, the importance and opportunities of shaping national HRH plans have been emphasized. PEPFAR highlighted the initiative to increase sustainability and ownership of interventions and to focus on moving toward a sustainable response to address broader public health needs. Though perceived that they positively and negatively contribute to equity in access to HRH, the performance of GHI largely depends on the clear government policies and accountability of the government as well as their institutional capacities in harmonizing different donors and GHI in line with the country health systems priorities. The following recommendations were made:

- While sustaining global commitment and HSS momentum, country governments have to take real action
 - Declare health workforce crisis as a national agenda, and integrate into the national health development strategy and plan.
 - Strengthening institutional capacity HRH governance
- Call upon development partners adhering to the Paris Declaration
 - Increase country ownership, sustainable HRH response in light of GHI
 - Mutual accountability-donors and countries are held equally accountable for development results
 - Reciprocal commitment by both countries and development partners e.g. the African country commitment to the Abuja Declaration that 15% of budgets are allocated to health, and developed nations' commitment of 0.7% GDP for ODA
- Foster international efforts to reconstruct health services and build up HRH in particularly fragile states. These states comprise 26% of the world's population, 1/3 of the poverty, their average citizen lives on less than \$1.25 per day, and they represent half of the world's under five deaths and one third of maternal deaths. Most are neglected and little or no progress has been observed.

GHI need to focus on moving toward a sustainable response to address broader public health needs. Improvement in the mobilization and utilization of financial resources from GHI is needed for scaling up of health workers in terms of numbers through transformative approaches such as pre-service training programs,

and addressing the retention of not only doctors, nurses and midwives but also community health workers, social services providers, management staff, and laboratory staff.

Strengthening of HRH strategic planning at the national level is required to tackle training, recruitment, employment retention and deployment. Medical and nursing education partnerships can improve capacity of health care providers if done through partner agencies and country governments. Lastly, the profile of HRH needs to be raised through key advocacy events such as the G8 and UN MDG summits.

Coherent policy between traditional medicines and western medicines should be fostered, through well-planned TM/CM/AM HRH strategy, as well as strengthened communication between traditional medicine and conventional providers, formulating national policies, regulations and standards for traditional medicine, and integrating traditional medicine into national health systems, especially in the context of primary health care.

*“We know how to get it done,
it’s not complicated.”*

Carol Jenkins
Chair Elect, African Medical and
Research Foundation (AMREF), USA





AGA2:

Ensuring capacity for an informed response based on evidence and joint learning

The development of effective policies and plans that address the country specific constraints relating to health workers requires strong technical capacity to compile, analyze and use HRH data, as well as to draw upon best practice from other countries. Unfortunately in many low- and middle-income countries (LMICs) these capacities are weak and health workforce data are sometimes non-existent, and are often unreliable, fragmented and out-of-date, making the accurate monitoring of the workforce very difficult.

HRH is a complex issue and involves many different stakeholders. Policy dialogue is an effective tool to bring these different partners and stakeholders together, which is very important to formulate HRH policy and help translate it into action. The three most important competencies that help ensure the translation of HRH evidence into policy and action (apart from technical competency) are (i) communication and advocacy; (ii) social skills to bring different stakeholders together; and (iii) management skills.

With new technologies, including the internet, the evidence base is growing rapidly, making it much more challenging for policymakers to be on top of and to keep abreast of relevant strategic information and innovations. Thus, there is a need for intermediaries or mechanisms to sift, collate, synthesize, and prioritize research that will help policymakers to use the information in decision-making in a timely manner. Furthermore, policymakers should not rely solely on published



evidence; there is a need to take into account informal and non-published evidence.

Innovative solutions for strengthening HRH information systems are needed. There is a great demand on HRH information in support of appropriate HRH strategic planning and decision making. Many potential data sources are available related to HRH information including, census, labor force surveys, health facility surveys and administrative sources with different degrees for each key attribute in terms of completeness, level of disaggregation, periodicity, possible error, accessibility to micro-data, and relative cost.

The challenges of HRH information systems include technical issues such as data quality, coverage and comparability, capacities, harmonization, and data dissemination and use. There is a global movement in support of HRH information system strengthening through a group of experts providing standards and sharing knowledge to improve availability, quality and use of HRH data and statistics.

Countries may adopt alternative data sources managed by regulatory bodies or professional councils, such as professional registration systems. The experience on using this data source in Swaziland demonstrates the need of good partnership with related regulatory bodies. Information from professional registration systems can help identify unlicensed health professionals and track the practice of health professionals. The multi-sectoral partnership is also expressed in Tanzania through a HRH working group etc. in order to improve HRH data flow and data utilization in the country. The sustainability of HRH information systems in countries demands continuous maintenance, capacity building, commitment of stakeholders, financial support and partnership consideration.

AGA2: Achievements

AGA2 is where there is the least progress among all six AGA in health workforce critical shortage countries, with only 43% coverage, according to a survey conducted by the Alliance ^[4].

[4] : Baqui et al. Lancet 2008 doi:10.1016/S0140-6736(08)60835-1

...Fewer than half the respondents of health workforce critical shortage countries, (43%) reported having a mechanism to inform policy-making through data sharing. Countries reported having statistics for higher level cadres, but less so for community health workers. Around half the countries reported having updated their HRH statistics once or twice in the last two years. Data are mostly available on employment status and distribution, but not on migration patterns.

The strengthening of the evidence platform is as important as the application of evidence for policy decisions to make effective evidence based responses. Specific competencies, tools and mechanisms are still required. There have been some innovations in evidence based response, most notably the HRH Observatories, one of the innovative platforms in monitoring HRH dynamics. Sharing evidence across countries in a region is powerful, e.g. sharing international migration and professional cohort data can be very useful for understanding work-life and durability in professional life. The recently established Thai Nurse Cohort is one of the innovations for long term tracking of nursing personnel for which specific policy interventions can be devised.

AGA2: Challenges

There is a huge amount of evidence on HRH now available, making it more difficult to determine what pieces of evidence are most important and most relevant and what are not. Many policymakers are subjective and do not value and use evidence appropriately, and policy briefs for policymakers are often too long. The reliability and strength of evidence needs to be rechecked as some pieces of evidence are hard, solid data, while others are just subjective opinions or tales of experience of a few individuals and institutions, which may not be representative of the targeted population.

It often takes too long for new pieces of evidence to be available in the public domain due to long procedures associated with peer-reviewed journals. Furthermore, university systems and academic institutions place too much emphasis on publication in peer-reviewed journals as key performance indicators for



promotion/recruitment of academic staff, making research and research publications, paid for mainly by the taxpayers, less responsive to public and policy needs. Furthermore, differences between the academic language and policy makers' language make it more difficult for these two groups to understand each other and for their ideas to synchronize and maximize use of evidence for policy decisions.

Fundamental problems relate to the limitation of reliable data, institutional capacity, and lack of trust between relevant stakeholders leading to withholding of information (protectionism of data of data), and evidence gaps.

The issues of using 2.3 doctors, nurses and midwives per 1,000 population as a benchmark in defining countries in a critical health workforce status was discussed at lengths in the Forum. National averages do not reflect the real situation in rural areas where it is very common that the health workforce is inequitably distributed across urban and rural areas and geographical regions. People in less affluent areas are facing greater difficulties in having access to a health worker.

Data is particularly limited concerning HRH in the private sector e.g. production and employment of health workers. Data is also lacking in tracking migrations (domestic and international), on recruiters and their behavior, and time-series for long term projection. Data often doesn't reflect the inequity dimension, and even if available, is unreliable, conflicting and not up-to-date.

This is further confounded by lack of data comparability, definitions, standards and classifications. Institutional capacity is required to strengthen and harmonize HRH information systems to allow the use of data for policy decisions and effective monitoring and evaluation, to integrate HRH information systems into national HIS, to package messages and to effective interface processes between evidence and decision making.

The “**data hugging syndrome**” (see also the Proceedings of the Prince Mahidol Award Conference 2010 on Global Health Information Forum 27-30 January 2010)[⁵] comes from a lack of trust and lack of standard protocols on data sharing among institutions, and prevents maximizing the use of limited data. Such problems result in evidence gaps in HRH plan development and implementation of the plans. Data needs to be available to support decision making on curricula development responsive to local health and health systems needs, setting competencies and skill mix requirement, and implementing workforce migration and effective policy interventions. Lack of good data also affects the quality and performance of the health workforce, the performance of task shifting policies and the cost and financing of HRH production and deployment.

AGA2: Recommendations

- There is a need to inform policymakers of the value of evidence and to show policymakers the implications of not using evidence
- Efforts should be made to shorten the procedures of peer-reviewed journals
- University systems should make efforts to be more creative and diversify key performance indicators of academic staff, and not rely too much on publications in peer review journals as contributions to informed policy decisions and health systems development are equally important
- Efforts should be made to get the academics and policymakers closer together and understand each other better
- Universities should be more responsiveness to country demands, not only intellectual and theoretical discussions among themselves
- Competent facilitators to bring different stakeholders together are critical, and efforts should be made to build trust among stakeholders. Inclusion and engagement of all stakeholders is extremely important

[⁵] :http://www.pmaconference.mahidol.ac.th/index.php?option=com_content&view=article&id=209%3A2010-pmac-report&catid=966%3A2010-conference&Itemid=152[access 24



- The following recommendations were proposed by participants to strengthen HRH information systems and data platforms:
 - Fix administrative databases on HRH production, distribution and migration
 - Standardize data definitions, interoperability, harmonization and data sharing across stakeholders
 - Apply long term HRH situation monitoring e.g. professional cohort study
 - Data sharing on international migration - destination country plays a vital role
 - Improve datasets to facilitate inequity analysis
 - Use an equity-based approach to “link cost, coverage, impact and burden averted”
 - Improve skills needed to prioritize strategic information for policymakers.

Evidence based responses are needed to strengthen institutional capacity in translating data into evidence and decision making. Countries need to maximize the use of global evidence such as the WHO Policy Recommendation on rural retention for small scale piloting, assessing the outcome, adjusting the policy and scaling up accordingly.

Policy or technical briefs are often too long and too theoretical for policymakers to digest information effectively. It is important that policy briefs/research are translated and published in the language of the local audience, and countries may consider, where appropriate, to apply the concept of “1-3-25” templates suggested for policy briefs: 1 page as summary in bullet points, 3 pages as executive summary, and 25 pages maximum to present and practical methodology and findings.

The Know-Do gap should be minimized by improving effective interface between academia and policy makers, generating demand for quality data among policy makers for evidence based decisions. Qualitative research with appropriate methodology can be a powerful tool to convince policymakers, and cannot be neglected.

AGA2: Key Messages

A number of key messages were identified from the deliberations:

- The three most important competencies that help ensure the translation of HRH evidence into policy and action (apart from technical knowledge) are: (i) communication and advocacy; (ii) social skills; and (iii) management skills
- Policy dialogue is an effective tool to bring different partners together
- There is much evidence out there; hence, it is necessary to filter and prioritize information for policymakers
- Do not rely solely on published evidence; there is a need to take into account of informal and non-published evidence as well



AGA3:

Scaling up health worker education and training

The goals of AGA3 are ensuring the availability of the full range of health workers with the appropriate mix of skills, and require innovative approaches to training and education, and the implementation of coordinated and context-specific policies that address each country's human resource needs.

Seventy-five percent of priority countries under severe shortage of health workforce reported having programs increasing production of their health workforce. A number of major challenges to intensifying the scaling up of health worker education and training still exist, particularly the need for sustained financial and political commitment and inter-sectoral coordination. Some examples of the challenges commonly faced by countries struggling to increase their health workforce include: disparity between the scale-up plans and funding available for deployment of these trained health personnel; lack of country ownership and continuity of political commitment; lack of coordination across different players; lack of sufficient training.

AGA3: Challenges

We are currently facing a severe global health workforce crisis with critical shortages, imbalanced skill mix and uneven geographical distribution of health professionals, leaving millions without access

to health services. More professional health workers are needed - but not simply more of the same. Efforts to scale up medical, nursing, and midwifery education must increase the quantity, quality and relevance of the providers of the future if they are to meet population health needs.

Progress in scaling up training is uneven, and there is even slower progress for CHWs. Scale-up must increase quantity, quality, relevance of the providers, and must translate innovations into systematic reforms. Solutions need to be based on in-depth understanding of local context and challenges. There are no quick fixes to HRH education and training at country-level.

Reforms in education must be informed by community health needs, and evaluated with respect to how well they serve these needs. The traditional professional education creates knowledge brokers, improved medical technology, but a monopoly on knowledge, financial self-interests, over-specialization, urban preference, and health inequity. Stronger collaboration between the education and health sectors, other national authorities, and the private sector, will improve the match between health professional education and the realities of health service delivery. We need to transform and expand the education of health professionals to strengthen country health systems and meet population health needs.

However, faculties and training institutions often face similar challenges as HRH – recruitment, retention and quality. Medical education spending is generally only 1-3% of the total health budget. Even though we train about 1 million new health workers worldwide every year, this is not sufficient to reach health-related MDGs. The private sector is often a significant education provider but is poorly regulated and integrated into national strategies. In some countries private universities are providing medical and nursing education for export only in light of a critical health workforce crisis situation in the country. Their curriculum and training orientation are not responsive to national demand.

The World Health Report 2006 (WHO) highlighted that shortages in managers is more acute than clinical workers. Training plans and capacity building are also needed to replenish mid-level health cadres.





CHWs lack recognition by healthcare professionals due to perceived low quality of care delivered by them; also there is a lack of standardized training and certification as well as legal framework for CHWs to work appropriately in health systems. Many participants feel that there is little evaluation work on the roles and effectiveness of CHWs in the treatment of HIV/AIDS prevention and care, nutrition relief etc. However there was significant evidence presented that CHWs can play a key role in community case management of serious childhood illnesses, and they are also critical for delivery of newborn care through antenatal home visits, birth preparedness, newborn care preparedness programs and by promotion of ANC attendance (see also keynote speech by Prince Mahidol Awardee Professor Robert Black). There are also limitations of evidence as studies are in many cases small scale pilot projects with substantial external inputs and support for scaling up at a national scale is a problem.

“Sometimes we have to build the plane while we are flying it”

Vinicius Oliveira, Coordinator,
Open University of the National Health System, Brazil



“We need to increase the supply side and then we need to retain these workers”

Berhanu Feyisa Tilla, Director,
Federal Ministry of Health, Ethiopia

In light of the existence of Traditional Medicine/Complimentary Medicine/Alternative Medicine (TM/CM/AM), HRH needs to be acknowledged, as it represents a great usage by the global population. The current referral systems between TM/CM/AMs and bio-medical health care systems need addressing. TM/CM/AM integration into the health care system should be considered, particularly into the primary health care system. Upgrading the TM/CM/AM health workforce through education and training could institutionalize the conventionally informal training, by appropriate licensing and certification. At present there are few mechanisms for TM/CM/AM knowledge and information sharing, inadequate research, and issues of reliability of information. Regardless of this, the promotion of healthy life-styles through TM/CM/AM including mental health would benefit all countries and cultures.

AGA3: Recommendations

At the root of today’s crisis lies the gulf that exists between professional health education and health service delivery. Educational institutions must implement reforms that allow them to recruit students from the communities they serve, teach to the local disease burden and community health needs, and educate students to practice within the care delivery models that are likely to best serve the local populations’ health needs. When graduated, they need to be deployed to work in health systems with which they are familiar, preferably placement in their home towns. Support for continued professional in-service training and education requires strong inter-ministerial collaboration with universities, the Ministry of Health and professional associations or councils.



Driven and informed by population's health needs, transformative scaling up of education and training are desperately required.^[6] A transformation that associates academic excellence with the delivery of improvements in population health outcome is needed. The training needs of managers and administrators, and health researchers must also be addressed.

There are strong suggestions for professional educational reform involving a move from traditional scientific-based curriculum towards a system and competency-based model to achieve a new professionalism towards equity in health. A change from "task shifting" to "task sharing" across professional boundaries and team-working with the community (resistance from professionals) is also strongly supported.

Innovation needs to be a way of life and not an exception. Education, research and health service delivery need to work in synergy and only broad and inclusive multi-sectoral planning at the national level will allow the coordination necessary to effectively scale up numbers and align professional education with country health needs. The role of the faith based community is also central in many contexts and their engagement in HRH development must be promoted. In low-income countries, donor financing should help finance scale-up of medical education.

Lower-level cadres, in particular CHWs should be emphasized. If CHWs are equipped with proper skills and adequate training to meet the needs of specific communities, and if interventions are chosen properly, low

“Innovation needs to be a way of life and not an exception”

Leana Uys, Chief Executive Officer,
Fundisa, South Africa



[6] : Transformative scale-up means delivering educational reforms that address increases in not only quantity, but also the quality, skill and competencies that are relevance to the health care providers they intend to serve, in order to strengthen health systems and improve the health of the population.

qualifications should not lead to low quality of services. Participation from health care professionals and policymakers is required to improve the quality and competence of CHWs. They must be linked to the formal health care delivery system, properly guided and supervised by health care professionals. CHWs are not the solution to inadequate health care services in many countries, but they are a part of the solution. Other mid-level professional are equally important and should be reflected in the policy agendas.

Governments need to consider how they shape public policy for HW education. Countries face different institutional history and there are always many institutions involved e.g. Ministry of Health, Ministry of Finance, Ministry of Education, and so forth. There are mixed training institutions: private and public. The approach needs to reflect these realities. It is also important to consider the epidemiological context, demand, technological availability, and the ability to absorb technology with the resources that the country has.

“Educational institutions must implement reforms that allow them to recruit from the communities they serve, teach to the local disease burden, and educate students to practice within the care delivery models that are likely to best serve the local population health needs”



Reflection point,
Parallel Session 10
Scaling Up HRH
Towards Equity



“Task shifting is very important to implement to meet population demands.... must reconsider a legal system that supports task shifting”

Hideomi Wantanabe,
Dean, Gunma University, Japan

“Now is the time to move from talk to action to increase access to health workers in rural/remote areas”

Ebele Omeke Michael,
District Health Officer in a hospital in Moroto,
a remote district in North Eastern Uganda



AGA4:

Retaining an effective, responsive and equitably distributed health workforce

Policy-makers around the world are faced with the complex challenge of ensuring that there are sufficient numbers of skilled, motivated, and supported health workers in the right place at the right time, in particular in rural remote areas of the country. Since an entirely free labour market will never lead to an equitable distribution of health workforce, governments need to intervene in the healthcare market by influencing and ensuring equitable distribution of these health workers through appropriate and effective regulation and financial and non-financial incentives.

AGA4: Achievements

The WHO Global Code of Practice on International Recruitment of Health Personnel (the Code) has opened opportunities to tackle the challenges of international migration along with its contribution of tools and guidelines (e.g. on retention of health workers in rural areas). The Alliance is also playing a key convening role behind the HRH response. The contribution of the International Health Partnership (IHP+) in collaboration with others such as the Health Metric Network, Pay for Health, the Alliance, and the Catalytic Initiative to Save a Million Lives (CI) is improving alignment and coordination, and this has resulted in some progress in intersectoral collaboration.

WHO has recently launched a global recommendation on increasing access to health workers in remote and rural areas through improved retention.^[7] The 16 recommendations in this guideline have yet to be piloted, evaluated and scaled up by countries, however the WHO is providing technical support to a number of countries that want to implement these guidelines, and is working with several partners to expand this process, including the World Bank and Capacity Plus.

AGA4: Challenges

Only 63% of health workforce critical shortage countries have implemented retention policies (online The Alliance survey) and the impacts have not been evaluated. Retention strategies are being implemented piecemeal, rather than as a package of retention strategies, so often they have little impact. There is a growing consensus that the approach needs to be community-oriented and based, working with and for the community. Where there are pilots on retention, often these pilots were not evaluated in a scientific way for their effectiveness for scaling up the effective intervention or mix of interventions.

Recruitment is as equally important as retention. Recruitment needs to target selecting the right students (from rural areas, ensuring quotas for rural students into medical schools etc.). Rural students may sometime have lower level of knowledge compared with students from urban centers and capital cities, so they require special support and tutorials, such as bridging programmes, for successful completion of nursing and medical education. Without these special efforts, successful outcomes are less likely.

The creation and implementation of specific post-graduate training programs responding to the rural health needs and working environment has been shown to be effective, but needs to ensure career promotion is possible without having to leave rural areas. However at present there is a disproportionate attention to specialty training compared to primary health care training resulting in inadequate education and training of health workforce for the rural health conditions.

[7] : <http://www.who.int/hrh/retention/home/en/index.html>



Curricula and mechanisms for re-training of rural health workers also need to be implemented.

The organization of professional networks, including research networks, among rural health care workers can help to address shared issues or challenges. Rural health workers face poor social environments and fewer opportunities for families, children and spouses, and these problems will only be solved through social development in these rural areas.

Community participation, working with and for the community, is considered to be the key to rural retention of health workforce. For example in Japan, villagers manage, and they are the employers of health workers. In Mali, young rural doctors employed through private-public partnerships, are paid by their communities, in a context of decentralization.

Poor infrastructure and workplaces and problems with medical supplies remain a challenge. This needs to be overcome by effectively engaging other ministries, but personal innovation and creativity can help. As one delegate commented about Melinda Gates' "What can we learn from Coca Cola?; how is that Coca-Cola can be found in most remote rural communities where there are no health care services, no condoms, sanitation, vaccinations"? This statement clearly reflects the market for profit motives of private enterprises, and governments should learn from these enterprises how to be responsive to the health needs of population, as well as effective public private partnership in favor of the rural retention. It was also discussed that a positive practice environment has proven to be one of effective interventions for retaining health workers in rural and underserved areas.

“Rural life is much better than urban: you breath cleaner air, you walk to your clinic, you have your family and friends close to you, creativity is stimulated”

Dr Awujobi, Consultant Rural Surgeon,
Awojobi Clinic Eruwa, Nigeria

Sustained political commitment is important, with support from international organizations. After the WHO evaluation in 2008, the government of Mali is now pursuing more and stronger policies, including the re-introduction of the two-year rural internship, with associated incentives for rural doctors to make them stay. Decentralization is an important success factor for retention as suggested by the Mali study where the rural physicians have contracts with the community and are accountable to them.

However context counts and each country has its own characteristics and specific situations require appropriate country specific strategies. At the bottom of their hearts, many health workers go into the professions to “make a difference and to save lives” – we need to keep this spirit alive and strengthen it.

“Long term thinking requires a long term set up”

Barbara McPake, Director,
Institute for International Health Development, UK

“We should not forget that health workers are people and individuals and not mere statistics”

Dr Grace Allen Young, Pharmacist, Former Permanent
Secretary, MOH, Jamaica



“People are the most important resource that countries have. Before countries and governments focus on infrastructure and supplies, they need to improve and support their human resources.”



Dr. Saidou Ekoye,
Secretary General, Ministry of Health, Niger

AGA4: Recommendations

The WHO global recommendation on increasing access to health workers in remote and rural areas through improved retention could serve as a stepping stone for countries to pilot and test the effectiveness of different combinations of rural retention packages including education, regulation, financial incentives, and professional and personal support. Pilots should be evaluated, and packages readjusted and scaled up in a systematic manner.

Other interesting measures worth exploring for their feasibility for piloting are for example, deploying mobile medical teams, ensuring security of health professionals and institutions as well as on other potential mechanisms not yet fully explored in the sixteen recommendations of WHO, such as performance based pay, role of the private sector, contractual arrangements in the fragile settings, and making basic public services available, e.g. schools for children.

Non-financial incentives such as social recognition and internal drive from the moral satisfaction of working with the underserved people are powerful in a number of professionals serving long years in rural remote areas, and they should be further supported by appropriate financial incentives and professional and personal support.



During the 2nd Forum, a global recognition was bestowed upon two dedicated health workers through the submission of names from countries in different regions, and an objective and transparent selection process was applied. This global award for the most outstanding health worker was given to a dedicated doctor from Mali and a midwife from Myanmar, whose efforts have resulted in a

major repercussion to regional and national level actions. The Asia Pacific Action Alliance on Human Resource for Health (AAAH) also awarded a number of dedicated health workers at its fifth annual conference in Bali, Indonesia and will continue to do so in the following annual conference. A number of countries have started providing such recognitions to health workers who contributed untiringly to rural health services.

International collaboration and international organizations have a role to support knowledge and experience sharing and training of health workers.

External and internal migration of health workers (that is, out of the country or within the country, from rural to urban or from public to private) may have similar causes, but governments and international partners have different mechanisms to address it.



One is the Code, which aims at mitigating the effects of external migration. This is complementary to other national policies and strategies, such as the ones proposed by the WHO rural retention guidelines, to address the internal migration. .

“There are many health workers that are committed and find happiness in the community. There is a need to show the world who they are and what they do and what motivates them to do what they do.”

PD Lalitha Padmini, Public Health Midwife in Medagama,
a remote village in Polonnaruwa District,
North Central Province of Sri Lanka

“I was born into medicine”

Dr Seydou Konate, a young rural doctor in Mali, who is the only doctor for 40,000 people, in a village 800 km from the capital, with no electricity - he only has a generator, and rudimentary equipment. His parents were health workers, and he learned to admire medicine from his family.

AGA5:

Managing the pressures of the international health workforce market and its impact on migration

Health workers, like workers in many other sectors, tend to migrate to areas or countries where working conditions and payments are better. The international labour market for health workers is such that developed countries with strong purchasing power can outbid poorer countries. Such dynamics lead to a breakdown of public health systems in poorer countries that have already used their meager resources to train health workers. Policy-makers in both source and destination countries are thus faced with the dilemma of needing to balance two fundamental rights, namely the right of an individual to migrate and seek employment for betterment, and the right of the people and community to health.

Not only are rights of concern, but there is a need for policy makers in destination countries to strike a balance between rights and moral obligations among health personnel to their home countries, in particular when education and training is fully financed or heavily subsidized by the public resources.

Migration is not just due to trade liberalization, as the African and Asian cases reveal the push factors include internal inequalities, poor conditions of workplace, health workers' safety from political and domestic conflicts, economic instability and hardships. There is also the pull factor of demand for health workers in high income countries. Thus management of the migration depends on number of factors including the nature of specific trade agreements, various push and pull factors



influencing individual health care workers, and the relative costs and benefits facing countries.

AGA5: Key messages

The Code is an important voluntary tool in the face of growing needs from developed countries and increased tension in developing countries in particular with respect to the health workforce crisis. Although dissemination and promotion of the Code is critical, the Code will not stop migration, but can help improve the situation, significantly depending on the commitment to implement the Code by governments across the world. Implementation of the Code requires engagement with multi-stakeholders and civil society organisations at country level, as well as the collective efforts among WHO member states despite the voluntary nature of the Code.

Getting agreement and finalization of the Code by the World Health Assembly Resolution in 2010 was a challenge, and a compromise, but implementation of the Code will be an even bigger challenge. However the Code of Practice may not have a sufficiently strong effect as it is nonbinding under international law compared to trade agreements; the active voluntary implementation of the Code by all Member States is essential for a successful implementation of the Code.

The recognition of the rights of people to move has been restated in parallel with the recognition of the link to broader issues of health worker production, retention, improved working conditions, financial and non-financial incentives in source countries as well as increased production and self-sufficiency in terms of human resources for health among the developing countries. Circular migration can also bring mutual benefits to both developed and developing countries.

Developed and developing countries often share similar HRH challenges, even similar policy decisions and lessons can be learnt from one other. The impact of the economic recession on developed countries has already been noted and some reactions, such as introducing freeze on salaries, and strict visa issuing has occurred.

There have been positive movements in some developed countries, for example Norway and the USA. Norway has introduced a new immigration policy of restricted quotas of skilled personnel to enter the labour market from outside EU/EEA. As nearly all hospitals are state owned in Norway, the MOH is able to put pressure on hospitals as employers and give advice regarding recruiting from abroad. The USA succeeded in significantly increasing nurse output in the last decade; in 2001 production was approximately 70,000 per year, but it is now closer to 140,000 per year. We are also seeing a decline in numbers of foreign nurses taking the US licensing exam.

Various ways to improve health workforce sustainability and retention in developing countries, such as improving working environments, twinning of facilities and knowledge sharing have shown to be effective in improving health workforce satisfaction.

AGA5: Challenges

The legal and regulation systems within countries need to implement the Code, harmonizing it with the existing rules and regulations. Coordinating stakeholders in the country and assessing the impact of the Code needs to be part of this process. High level commitment to support monitoring and evaluation must go hand in hand with transparency in implementation and assessment of impact.

More emphasis needs to be placed upon ensuring that a sound evidence base is utilized when developing HRH strategies, plans and agendas in both developed countries as well as developing countries. Effective incentives and conditions to retain HW in developing countries will mitigate HW migration and the effect of economic recession. Some action needs to be taken to prevent 'brain waste' when migrant health workers qualifications are not recognized, and to set appropriate and effective compensation types back to source countries e.g. return of income tax paid by the health workers back to the country of origin was discussed in the deliberations.



AGA5: Recommendations

Countries should ensure policy coherence between trade and health across multiple ministries at a national level before making interventions at an international level. There should be trade people working in the health sector, and vice versa, health people working in the trade sector to assist in developing policy coherence as policy people are more strategic than health people. Policy coherence is a well informed decision, after constructive dialogue and extensive deliberations based on evidence across stakeholders on the impacts of trade on health, and vice versa health on trade, on what is the optimum policy stance on trade interests versus health interests. Foreign policy and global health diplomacy should be considered in tandem. A country should formulate its national global health policy and plan how to push that policy.

The WHO, WTO and the World Bank can work together to generate the most benefit for HRH from international trade in health services. Countries that have made commitments under the GATS can utilize the flexible approach of the GATS to scheduling commitments by choosing the modes and sub-sectors of health services in which they can make multilateral commitments based on their own potential benefit resulting from an individual national assessment. For example, conditioning the establishment of commercial presence for the recruitment of a certain number of local staff, or sending their doctors to rural areas for a number of hours every month can be envisaged.



Development of domestic policy regulatory frameworks (trade, FDI, Aid etc) is crucial to address the problem of resource outflows. To retain health personnel, governments must invest in the public health system so that there is a decent package of health care or primary health care available to people. New facilities, particularly in rural areas, should be invested in and well remunerated health professionals should be provided. Transparency in the recruitment of the health workforce can ensure retention and quality.

There are various ways to improve health workforce sustainability and retention in developed countries, but recent research demonstrates that improving working environments has proven particularly successful, and recent studies have shown working environments are also important for burnout rates, mortality and adverse patient outcomes. Magnet hospital models and twinning of facilities have also shown to be effective in improving health workforce satisfaction and knowledge sharing.

One potential solution to be explored is the role to be played by nursing staff in future years. In many developed countries, nurses are educated to a high standard and are often under-utilized, so there is scope to support them in more advanced roles. We are not getting real **“value for money”** if we are under-utilizing these high qualified human resources.





'the [WHO Global] Code [of Practice] is more than recruitment but a number of issues underlining migration'

Manuel Dayrit, Director, Dept. of Human Resources for Health, WHO

All countries

- Although the Code, acknowledges the freedom of movement, it emphasizes the legal obligations that health workers have under specific rules and regulations to serve the country health systems, in particular when professional education and training were heavily subsidized by public resources
- Sign bilateral agreements between countries to manage the flow of workers in an appropriate way, while protecting rights and benefits of migrated health workers as stipulated in the Code
- Actively implement the voluntary Code and monitor the progress of the implementation; while establishing and maintaining a reliable human resource information system.
- Transformative scaling up of health professionals, addressing the push factors that are required to prevent the out-migration and the adverse effect on health systems

Destination countries:

- Analyze the future needs and gaps, and plan how to meet these gaps by domestic production
- Opt for legal approaches, regulating the recruitment agencies
- Potential role of taxing migrating workers and transferring this revenue back to source countries to compensate for the education/training costs
- Scale up training, extend retirement age and improve retention

Source countries:

- Scale up of education and training institutes and improve working conditions for health workers
- Governments should not only rely on donors' support but should invest more in the health of the population
- Strengthen ministerial or inter-sectoral cooperation
- Maintain better records on the inflow and outflow of migrations
- It is crucial that the developing countries should use the WTO platform. It is the leveling ground for developing countries in trade negotiation while bilateral free trade negotiations and agreements may give more benefit to powerful economies.



AGA6:

Securing additional and more productive investment in the health workforce

In the 57 countries facing a critical shortage of health workforce, securing adequate funding for HRH is one of the most difficult challenges. It requires real commitments and the concerted effort of a number of players if effective and long-term solutions are to be found. Investment in the health workforce needs to be prioritized among competing demands for national level resources, and new solutions must be found to overcome the restrictions imposed in relation to the civil service wage bill (e.g. wage ceilings and civil service downsizing through the banner of “public sector reform”). The Paris Declaration on Aid Effectiveness commits multilateral and bilateral donors to aligning their financial support with national priorities. This presents an opportunity for countries with a health workforce crisis to stand firm in fostering their commitment to addressing this challenge by prioritizing it in their national and sectoral plans.

AGA6: Challenges

There has been some progress in implementing the Kampala Declaration, though with many challenges. Most HRH plans have not been evaluated for content, and only 25% have been costed. Only 63% of countries have implemented retention policies but impact has not been evaluated. There has been mixed progress in improving domestic career opportunities. Most countries report an increase in domestic resources as well as ODA,

but it is fragmented. It is noted by conference partners that the six AGA strategies are inter-dependent, and important for global human security, equity and justice beyond the 57 health workforce critical shortage countries.

In securing productive investment in the health workforce, leadership matters as in the example of Malawi, which achieved a 50% increase in health workers and a 40% increase in graduates since 2004. Recognition of the health sector crisis in national growth and development strategies and political commitment led to the "health emergency plan," with significant budget allocation, and zero tolerance of corruption.

AGA6: Recommendations

For securing investment, coordination is essential for more effective use of financial resources invested by donors. For making the case to policymakers, we need to learn from innovators in other areas, e.g. Coca Cola and its delivery and market method based on real time data, local entrepreneurship and marketing. Health and empowerment of the health workforce is essential for human security, for example managing global threats such as pandemic influenza A H1N1. HRH is also important in addressing growing inequalities in access to health and prevailing social injustices. National governments should be committed to financing the health sector adequately by adhering to regional and international covenants. This would guarantee adequate finances for the health sector to meet HRH needs.

In developing countries, only around 1-3% of total health expenditure is spent on medical education. The estimate is similar in OECD countries. Traditionally, the charity sector has also played an important role, however government now finances a larger share of medical education. Private household financing is also important and willingness to pay for medical education is often high.

There are multiple sources of financing for health worker education and the impacts of different financing sources need to be evaluated for quality and quantity. Different financing modalities have



important implications for equity. There are large disparities in the health workforce in many countries, with underrepresentation of women, rural backgrounds or ethnic minorities, etc. This is the case in both public and private education and training sectors. There is a need to develop policies and programs that harness private financing while also ensuring access to opportunities by all segments of the population.

There are powerful ways to increase participation by poor households including targeted subsidies or scholarships and similar approaches. Government financing of medical education needs to deal with the urban-rural aspect. Public policy should focus on ensuring adequate investment (by public and private sectors) in the rural areas. This is likely to be one of the most effective means to promote rural deployment and retention.

Health worker education and training programs in the private schools are diverse and under-regulated leading to a large variation in quality. Supporting the private sector requires solid regulation to avoid low cost, low quality seeking of the private schools.

There are two stages in financing medical education: rapid expansion of numbers in the short to medium term (catching up); and a lower steady state in the longer term. Countries may consider seeking donor funding for the catching up phase. Donor assistance to medical education has declined over time. New models should be considered. This could include charging a levy for donors and NGOs that want to work in a particular country. This levy could be used to support medical education in source countries. There is a need to also focus on strengthening faculty. For instance, Ghana saw a doubling of students between 2003 and 2007, but faculty only increased by 9%, so clearly there are doubts over quality and clinical competency of graduates.

Training of doctors can be 10-20 times as costly as training a CHW. This makes investment in low-level workers a sensible approach given resource limitations in low income countries. Thailand, Iran, and Ethiopia are good examples of producing low cost cadres of health workers. It is not only a cost-effective approach to increase availability of services overall, but also ensures expansion of services provided in rural and underserved areas.

In creating partnerships between the public and private sectors, it is important to consider the actual and potential contribution of the private sector, and to consider the private sector in national strategies and planning. There are many interesting public-private partnership models (PPP) which have been tried in the developed countries; there is less experience in developing countries, partly because of the complexity of financial transactions, regulation, and so forth. The private sector can play an important role in expanding capacity in underserved areas through incentives and partnerships.



Key Messages from 2nd Global Forum on Human Resources for Health

AGA1 Coherent national and global leadership for health workforce solutions: there are strengths, weaknesses and great opportunities for countries and development partners in building coherent national and global policies, and harmonizing GHI programs in line with country priorities on human resources for health. Outcomes and contributions of GHI on HRH are mixed and uneven. The key success factor is the national ownership, mutual accountability and reciprocal commitments by donors and countries.

National policy coherence and intersectoral collaboration are required for the whole range of HRH streams: education and training, public and private recruitment, responses to and management of migration, employment retention and deployment, and financing. Effective and coherent policies and plans based on evidence are intimately linked with one another, and require comprehensive integrated approaches, with innovation and strong leadership based on country context.



AGA2 Ensuring capacity for evidence based informed

response: this is the most lagging achievement between the 1st Global Forum in Kampala and the 2nd Global Forum in Bangkok. Conference participants voiced concerns over (a) gaps between evidence generation and interface with HRH policy decisions, (b) sustaining capacity to generate local specific evidence to inform HRH policy, (c) knowledge management and harvesting existing evidence into policy and effective program implementation, monitoring and evaluation. Strengthening the capacity for evidence informed responses on HRH requires significant improvement and standardization of datasets and effective HRH information systems.

The reporting requirement by WHO member states on the implementation of the Code, though voluntary in nature, can be an entry point for improvement of HRH information systems. Countries are encouraged to maximize the full use of global evidence such as the WHO Policy Recommendation on rural retention for small scale piloting, assessing the outcomes, adjusting the policy and implementing accordingly. Systematic collection and assessment of lessons from country implementation can feed back into revising and strengthening global evidence.

AGA3 Scaling up health worker education and training:

there is an urgent need for countries and development partners to revisit and consider whether (a) the current pre-service educational and training institutions, and the trainees and graduates' clinical competencies, skills and attitude are responsive to the health needs of the population and health systems requirements, (b) the enrolment of students to training institutions are conducive for their contribution, upon graduation, to rural health services where the most needy population lives, (c) the in-service and continued education are supportive of their works, (d) the post-graduate training is relevant and supportive to contribute to the needy population. Upon such sincere assessment, countries may need to consider adopting/adapting transformative scale-up of the whole range of education and training as well as inter-professional training to be more responsive to health needs of the population.

A change from “task shifting” to “task sharing” across professional boundaries and team-working with the community (resistance from professionals) is strongly supported in the conference deliberations. Lower-level cadres, in particular CHWs, and their contributions to rural health needs are emphasized, though the middle-tier health personnel, particular middle-managers have been neglected.

AGA4 Retaining an effective, responsive and equitably distributed health workforce: it is recommended to fully use the WHO global recommendation on increasing access to health workers in remote and rural areas through improved retention to: (a) pilot and test the effectiveness of different combinations of rural retention packages including education, regulation, financial incentives, and professional and personal support; (b) evaluate these pilots; and (c) package and readjust according to the assessment, and scale up in a systematic manner. A proper mix of financial and non-financial incentives such as social recognition of the committed and motivated health workers in underserved areas are effective and sustainable solutions to mal-distribution of health workers.

It is strongly noted that policy intervention addressing HRH shortage and mal-distributions are inter-related across AGA3 and AGA4; this requires a coherent policy between education and training by recruiting rural students, and supporting them for successful completion and recruitment through hometown placement. This would ensure equitably distribution of committed and competent health workers.

AGA5 Managing the pressures of the international health workforce market and its impact on migration: The 2nd Global Forum applauds the World Health Assembly Resolution promulgating the Code. Having the Code has been a difficult global negotiation outcome; implementing the Code requires re-doubled efforts. Though of voluntary nature, the Code is an important and collective instrument in managing migration in a transparent and collective manner across WHO Member States. Various articles

of the Code support the improvements of HRH systems in both source and destination countries; proper interventions addressing “push and pull” factors are an important platform for successful management of international migration.

The reporting requirement by Member States, regional organizations and civil society organizations are the key instrument for the monitoring of the implementation of the Code, for which countries and development partners need to revisit and improve their HRH information systems, which are cross referred to in AGA2.

AGA6 Securing additional and more productive investment in the health workforce: increased investment on the health workforce by governments and donors was observed in the assessment of the KD/AGA. However, these investments need to be coherent with national interests in particular among the 57 priority countries with critical shortage of health workers. More investment on HRH production is inter-linked with AGA3 on scaling up of health workers education and training which must be responsive to local health needs and health systems structure, while addressing the inequitable distribution of these additional trained health workers in AGA4.

A mutual reciprocal commitment, not rhetoric, but real actions taken by international development partners and country governments to increase investment in health workforce production in line with health needs of the countries are fundamental for long term sustainable HRH development.



Conclusions: A long-rough-winding road to reach our HRH vision

- ▶ The KD/AGA set out a solid clear strategic vision for HRH development. The 2nd Global Forum confirms that the six points of the AGA are still valid and relevant; there is not need for revision as there are still gaps of implementation at country level. Yet, to accelerate the progress of the implementation of the KD/AGA, the 2nd Global Forum adopted its Outcome Statement.
- ▶ Progress in health workforce critical shortage countries has been slow and uneven, and these agendas are yet to be actively implemented faithfully by countries and international development partners.
- ▶ Evidence and recommendations are made available in particular the WHO global recommendation on increasing access to health workers in remote and rural areas through improved retention. This has yet to be rapidly adapted and translated into effective actions.
- ▶ Reality falls short of expectations and targets. The Alliance next review and assessment of health workforce critical shortage countries has yet to be more comprehensive, and reflect an in-depth understanding of the progress.
- ▶ The time to act is now; both political and financial commitment towards tangible results is required and not only rhetorical statements. Countries must take the driver's seat, as country ownership ensures sustainable HRH development.
- ▶ Solutions – there is no one size fits all; we need comprehensive approaches, innovation and strong leadership based on country context
- ▶ Though the 2nd Global Forum fostered the momentum of global collaborative efforts to mitigate the crisis situation of the health workforce, not much progress was observed between Kampala and Bangkok, not only because progress takes a long time, but also because there is a lack of a good baseline for measuring progress. Investment in evaluation and measuring progress is required for the next Forum.

- ▶ There is no consensus by the 2nd Forum when should the 3rd Forum be convened. One proposal is that the 3rd Global Forum on HRH should be convened when there is good progress to share and lessons to be learnt from. This is based on the evidence of slow progress observed between the Kampala and Bangkok Forums; therefore focus should be given to supporting countries for effective implementation. However, those who are in favour of convening the 3rd Forum regardless of progress of KD/AGA is justified by the need to move the global agenda forward and sustain the momentum. However, decision to convene the 3rd Forum rest within the decision of the governing body of the Alliance.



Photo credit WHO/Chris Black, Bull World Health Organ 2010;88:566-567 | doi:10.2471/BLT.10.020810



From Kampala to Bangkok: Reviewing Progress, Renewing Commitments

At the closing session of the 2nd Forum, the following outcome statement of the 2nd Forum was read out by representatives of co-host organizations: Dr. Siriwat Tiptaradol (Prince Mahidol Award Conference), Dr. Sigrun Mogedal (Global Health Workforce Alliance), Dr. Carissa Etienne (World Health Organization), and Mr. Kiyoshi Kodera (Japan International Cooperation Agency).



Outcome Statement of the Second Global Forum on Human Resources for Health

Bangkok, 27-29 January 2011

The Second Global Forum on Human Resources for Health (HRH) in Bangkok reviewed progress and renewed the commitment to strengthening the global health workforce, restating that a robust health workforce is a core element of health systems in all countries, and critical to achieving the Millennium Development Goals (MDGs) and Universal Health Coverage, with the vision that:

All people, everywhere, shall have access to a skilled, motivated and supported health worker within a robust health system.

Key advances in health workforce development have occurred over the past three years since the First Global Forum in Kampala. The adoption of the WHO Global Code of Practice in 2010 on the International Recruitment of Health Personnel (the Code) was a major achievement. The 2010 proceedings of the United Nations High Level Summit on the MDGs, the launch of the Global Strategy for Women's and Children's Health, the European Union Global Health Strategy, the African Union Summit, and other events have added momentum to health workforce development.

The Global Strategy for Women's and Children's Health states that an additional 2.6 to 3.5 million healthcare workers would contribute significantly to the lowest-income countries reaching MDGs 4 and 5. Requirements to achieve universal health coverage in a wider range of countries would be higher. The progress report on the Kampala Declaration and Agenda for Global Action demonstrates some advances, as well as challenges requiring increased attention, in the priority countries most affected by health workforce challenges. The upcoming UN General Assembly sessions on HIV/AIDS and on Non-Communicable Diseases will provide further opportunities to highlight the vital role of health workers.

The participants of the Second Global Forum reiterate the principles of the Kampala Declaration and the Code as instruments for alignment and accountability at global, regional, national and local levels, and call upon all stakeholders to accelerate implementation in a comprehensive manner.

Major gaps must be addressed

Supply of health workers In many countries, particularly in Africa and complex emergency settings around the world, education and training capacity has to increase to match the growing demand for health personnel. Although supply is not a constraint everywhere, countries with shortages are encouraged to exploit the full range of public policies, including inter-country collaboration, that influence supply of and demand for the labour force, enhance pre-service training through the adoption of emerging best practices, and ensure that poor and marginalized people get equitable access to quality services.

Reliable and updated information There is a need for strong national capacity in all countries to regularly collect, collate, analyze and share data to inform policymaking, planning, and management. New benchmarks, beyond the density of physicians, nurses and midwives, will be required. Attention should be paid to aspects such as geographic distribution, retention, gender balance, minimum standards, competency frameworks, and reflect the diverse composition of the health workforce.

More attention to prerequisites for success

Leadership Leadership by all state and non-state actors at global, regional, national and local levels is required to focus action on the health workforce. An “all of government” response is essential to ensure coherent policies across sectors. The capability to plan and manage the health workforce should be enhanced, as relevant to the local context.

Collaboration and mutual accountability National health workforce coordination mechanisms should be established to foster synergies among stakeholders. These mechanisms, such as the Country Coordination and Facilitation approach, should build on existing frameworks and processes, and foster inclusive communities of purpose where best practices are shared. It will be important that HRH plans and budgets are linked with national health strategies, policies and plans. At the same time there is need for mutual support and accountability between different stakeholders, and between policy makers, service providers and the people.

Distribution and retention Suitable policies and strategies should be adopted to attract and retain health workers with appropriate skills mix in rural and other under-served areas, including the deployment of community-based and mid-level health providers. As relevant to country context, strategies may include tailoring education to practice in rural areas, financial and non-financial incentives, regulation, personal and professional support, career development, improvements in rural infrastructure, and partnerships between the public and private sectors.

Performance and quality The quality of services should improve through accreditation and compliance with appropriate national standards for educational institutions and individual health workers, in both the public and private sector. Performance and productivity will also be enhanced through the establishment of cohesive interdisciplinary teams with effective supervision; competency-based curricula, reinforced through in-service training; enabling practice environments, including fair remuneration, appropriate incentives, access to necessary resources, and prevention of professional hazards; and supportive management practices.

Effective and functioning regulation Appropriate and flexible regulation, responsive to an evolving policy environment, and tailored to the national health system context, will ensure the quality and safety of care. The specific challenges of international migration should be addressed by putting in place the necessary regulatory, governance and information mechanisms, according to the provisions of the Code.

Invest for results

An adequate level of funding for health workforce development must be ensured through a combination of domestic and international resources. External contributions must be additional and complementary to domestic funding. Concerted action is required by development partners, global health initiatives and international agencies to provide predictable, long-term and flexible support, aligned to country priorities and national health plans. This will need to allow for investment in pre-service education, remuneration and improvement of working conditions of health personnel. Macro-economic policies that constrain investments in the health workforce should be addressed. The impact of investments could be maximized by supporting national efforts to establish robust health financing mechanisms for universal coverage. This should include closer links between resource allocation and needs, and support to community-based service provision as a key component of the health system. Better financial management mechanisms will foster accountability, and improve equity and efficiency.



The forum reviewed progress and exchanged experiences. It renewed the commitment to the Kampala Declaration and the Agenda for Global Action.

The task now is to take the momentum from Bangkok out into the wider world: to move together, from commitment into action, to translate resolution into results, and ensure that every person, wherever they are and wherever they live, has access to a health worker.

ANNEX I Conference Organizing Committee Members

Dr. Vicharn Panich Chair, International Award Committee and Scientific Advisory Committee Prince Mahidol Award Foundation Chairman, Mahidol University Council Bangkok, Thailand	Chairman
Dr. Francisco de Campos Board Member, The Global Health Workforce Alliance (the Alliance) Secretary of Human Resources Development Ministry of Health Brasilia, Brazil	Co-Chair
Dr. Carissa Etienne Assistant Director-General, Health Systems and Services World Health Organization (WHO) Geneva, Switzerland	Co-Chair
Mr. Kiyoshi Kodera Vice President Japan International Cooperation Agency (JICA) Tokyo, Japan	Co-Chair
Dr. Sigrun Mogedal Chair, The Global Health Workforce Alliance (The Alliance) Board Ambassador, Ministry of Foreign Affairs Oslo, Norway	Member
Dr. Mubashar Sheikh Executive Director The Global Health Workforce Alliance (The Alliance) Geneva, Switzerland	Member
Dr. Cristian Baeza Director for Health, Nutrition and Population The World Bank Washington DC, USA	Member

<p>Dr. Michel Sidibe Executive Director Joint United Nations Programme on HIV/AIDS (UNAIDS) Geneva, Switzerland</p>	Member
<p>Dr. Michel Kazatchkine Executive Director The Global Fund to Fight Against AIDS, TB, and Malaria Geneva, Switzerland</p>	Member
<p>Dr. Keizo Takemi Research Fellow Japan Center for International Exchange (JCIE) Tokyo, Japan</p>	Member
<p>Dr. Manuel M. Dayrit Director, Human Resources for Health Department World Health Organization (WHO) Geneva, Switzerland</p>	Member
<p>Dr. Ariel Pablos-Mendez Managing Director The Rockefeller Foundation New York, USA</p>	Member
<p>Mr. Yojiro Ishii Deputy Director General, Human Development Department Japan International Cooperation Agency (JICA) Tokyo, Japan</p>	Member
<p>Dr. Estelle Quain Senior Technical Advisor United States Agency for International Development (USAID) Washington, D.C., USA</p>	Member
<p>Dr. María Isabel Rodríguez Minister Ministry of Health San Salvador, El Salvador</p>	Member

Dr. Tawfiq Khoja Member
Director General
Executive Board of the Health Ministers Council for Gulf
Cooperation Council (GCC) States
Riyadh, Saudi Arabia

Dr. Salif Samake Member
Director of Planning
Ministry of Health
Bamako, Mali

Mr. Pape Amadou Gaye Member
President and CEO
IntraHealth International
North Carolina, USA

Dr. Pius Okong Member
Board Member, Partnership for Maternal, Newborn and Child Health
Head of Department Obs/Gyn
San Raphael of St. Francis Hospital Nsambya
Kampala, Uganda

Dr. Richard Horton Member
Editor-in-Chief
The Lancet
London, United Kingdom

Dr. Phyllida Travis Member
Secretariat
International Health Partnership (IHP+)
World Health Organization
Geneva, Switzerland

Dr. Julia Seyer Member
Secretariat
World Health Professions Alliance (WHPA)
Ferney-Voltaire, France

Representative Member
European Commission



Representative
African Union Commission

Member

Dr. Paichit Warachit
Permanent Secretary
Ministry of Public Health
Nontaburi, Thailand

Member

Mr. Theerakun Niyom
Permanent Secretary
Ministry of Foreign Affairs
Bangkok, Thailand

Member

Dr. Supat Vanichakarn
Secretary-General
Prince Mahidol Award Foundation
Bangkok, Thailand

Member

Dr. Suwit Wibulpolprasert
Senior Advisor on Disease Control
Ministry of Public Health
Nontaburi, Thailand

Member

Dr. Piyasakol Sakolsatayadorn
President
Mahidol University
Nakhon Pathom, Thailand

Member

Dr. Teerawat Kulthanan
Dean
Faculty of Medicine Siriraj Hospital
Mahidol University
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Member

Dr. Pongpisut Jongudomsuk
Director
Health Systems Research Institute (HSRI)
Nontaburi, Thailand

Member

Dr. Viroj Tangcharoensathien Member and Secretary
Director, International Health Policy Programme (IHPP)
Ministry of Public Health
Nontaburi, Thailand

Dr. Churnrurtai Kanchanachitra Member and Secretary
Vice President for Collaboration and Networking
Mahidol University
Nakhon Pathom, Thailand

Dr. Hirotsugu Aiga Member and Secretary
Coordinator
The Global Health Workforce Alliance (The Alliance)
Geneva, Switzerland

Dr. Jean-Marc Braichet Member and Secretary
Coordinator, Human Resources for Health Department
World Health Organization (WHO)
Geneva, Switzerland

Mr. Keiichi Takemoto Member and Secretary
Director of Health Division 4
Human Development Department
Japan International Cooperation Agency (JICA)
Tokyo, Japan





ANNEX II Conference Speakers/Panelists, Chairs/Moderators and Rapporteurs

Speakers	Leadership	Chair/Moderator	Rapporteurs
Keynote Address (27 Jan 2011 : 09.00 – 10.30)			
Robert E. Black			Jeff Johns
Pakdee Suebnukarn			Supon Limwattananon
P.D. Lalitha Padmini			Iyarit Thaipisitukul
Sigrun Møgedal			
Plenary session 1: From Kampala to Bangkok: Marking progress, forging solutions (27 Jan 2011 : 11.00 – 12.30)			
Mubashar Sheikh	David Mphande	Timothy Evans	Toomas Palu
Leochrist Shali Mwanyumba	Carissa Etienne		Hirotsugu Aiga
	Francisca Monebenimp		Passawee Tapasanan
	Thir Kruy		
	Bjorn-Inge Larsen		
	Kiyoshi Kodera		
Plenary session 2: Have leaders made a difference?: how leadership can show the way towards the MDGs? (27 Jan 2011 : 14.00 – 15.00)			
	Sam Zaramba	Carissa Etienne	Alison Osborne
	Denis Salord	Jason Gale	Viroj Tangcharoensathien
	Keizo Takemi		Rungsun Munkong
	Sheila Dinotshe Tlou		
Parallel session 1: Leading towards health workforce development at country level: what will it take? (27 Jan 2011 : 15.30 – 17.30)			
Mario Dal Poz		Suzanne Kodsi	Walaiporn Patcharanarumol
Gülin Gedik		Francisco Campos	Ding Yang
Jason Lane			Marjolein Dieleman
Alberto Joao Baptista			
Hilde De Graeve			
Elsheikh Badr			
Adang Bachtiar			
Christian Habineza			

Speakers	Leadership	Chair/Moderator	Rapporteurs
Parallel session 2: Serving in the frontlines: personal experiences and country strategies for retention of HRH in rural areas (27 Jan 2011 : 15.30 – 17.30)			
Oluyombo Awojobi E. Grace Allen Young	Tetsuro Irohira Wimal Karandagoda Kim Webber Christophe Lemiere Carmen Dolea	Ian Couper	Carmen Dolea Supon Limwattananon Puwat Charukannoetkanok
Parallel session 3: Will the WHO Global Code stop the brain drain? What will it take to succeed? (27 Jan 2011 : 15.30 – 17.30)			
Percy Mahlathi Bjorn-Inge Larsen	Patricia A. Sto. Tomas Kazem Behbehani Francis Omaswa Colin McIlff	Mihály Kökény Manuel M. Dayrit	Suriwan Thaiprayoon Komalrat Turner Jim Buchan
Parallel session 4: Do GHIs contribute to equity in access to HRH? (27 Jan 2011 : 15.30 – 17.30)			
Ruairi Brugha David Sanders	Mary Ann Lansang John Palen Dorothy Namate	Masato Mugitani	Cha-aim Pachanee Sutayut Osornprasop Jennifer Frances dela Rosa
Parallel session 6: Overcoming HRH crises in conflict and post-conflict situations (27 Jan 2011 : 15.30 – 17.30)			
Fiona Campbell Ruchama Marton Salam Ismael Annette Mwansa Nkowane Fariba Al Darazi Noriko Fujita Roberto Esteves		Miriam Were Edward Mills	Thinakorn Noree Mwansa Nkowane Saipin Hathirat
Parallel session 7: High Level Roundtable: Working together for health workers (by invitation) (27 Jan 2011 : 15.30 – 17.30)			
	Carissa Etienne Mubashar Sheikh Richard Nduhuura Sanoussi Toure Gary Newton	Mongkol Na Songkhla Sigrun Møgedal	Weerasak Putthasri Tipicha Posayanond Giorgio Cometto

Speakers	Leadership	Chair/Moderator	Rapporteurs
Plenary session 3: Professional Education for 21st Century (28 Jan 2011 : 09.00 – 10.00)			
Lincoln Chen	Tomas Hall Vicharn Panich Zulfiqar Bhutta	Ariel Pablos-Méndez	Saipin Hathirat Junhua Zhang Cherdsak Iramaneerat
Parallel session 8: Building Capacity to Translate HRH Evidence into Action to Sustain HRH Policy, Decisions and System Strengthening (28 Jan 2011 : 10.30 – 12.30)			
	James Buchan Samuel Mwenda Fadi El-Jardali Irene Akua Agyepong	James McCaffery Abdul Ghaffar	Sutayut Osornprasop Jadej Thammathataree Abdurachman Saliman
Parallel session 9: Innovative solutions for strengthening HRH information systems (28 Jan 2011 : 10.30 – 12.30) progress and support management			
Mario Dal Poz Thembisile Khumalo Elikaanan Mwakalukwa Piya Hanvoravongchai		Timothy Evans Michael Friedman	Pinij Faramnuayphol Natalie Phaholyothin Teena Kunjumen
Parallel session 10: Scaling up HRH towards equity (28 Jan 2011 : 10.30 – 12.30)			
Zulfiqar Bhutta	Barbara Aranda-Naranjo Ann Phoya Francis Omaswa Fitzhugh Mullan Keat Phoung Fely Marilyn E. Lorenzo Diaa Eldin Elgaili Abu Bakr	Marc Danzon Lincoln Chen	Francesca Celletti Pattapong Kessomboon Sudarat Tuntivat
Parallel session 11: Seeking the stamp of good quality? Imperatives of HRH regulation and accreditation (28 Jan 2011 : 10.30 – 12.30)			
Genevieve Howse Thamer Kadum Yousif Al-Hilfy Samuel Wong Jan De Maeseneer		Salman Rawaf	Wanipol Mahaarcha Malee Sunpuwan Akib Kemas

Speakers	Leadership	Chair/Moderator	Rapporteurs
Parallel session 12: Financing health worker education and training (28 Jan 2011 : 10.30 – 12.30)			
	Nigel Crisp Tarun Seem Marie-Odile Waty	Maurice Middleberg Rozenn Le Mentec	Magnus Lindelow Charamporn Holumyong Sawarai Boonyamanond
Parallel session 13: Dedicated Spirit: The Charm and Charisma of HRH (28 Jan 2011 : 10.30 – 12.30)			
Pakdee Suebnukarn Saidou Ekoye Leochrist Shali Mwanyumba P.D. Lalitha Padmini Karamoko Nimaga Ebele Omeke Micheal Ho Thi Thanh Hoa Daw Nan Than Than Oo	Barbara McPake Carmen Dolea	Bridget Lloyd	Tipicha Posayanond Jennifer Frances dela Rosa Thinakorn Noree
Parallel session 14: The UN Secretary General Global Strategy for Women's and Children's health: what will be done about the workforce? (28 Jan 2011 : 10.30 – 12.30)			
Helga Fogstad	Masato Mugitani Angelique K. Rwiyereka A.F.M. Ruhai Haque Rebecca Affolder Carol Jenkins	Gustavo Gonzalez Canali Sarah Boseley	Giorgio Cometto Mwansa Nkwane Acharawan Topark-Ngarm
Plenary session 4: Making HRH Innovation Work for Strengthening Health Systems (28 Jan 2011 : 14.00 – 15.00)			
Fauzia Tariq Oluwafunmilola Dare Leana R. Uys		Mark Stirling Francisco Campos	Jeff Johns Natalie Phaholyothin Chanwit Tribuddharat
Parallel session 15: Building capacity to generate evidence in HRH action oriented research (28 Jan 2011 : 15.30 – 17.30)			
Mickey Chopra Frances Baum Harriet Nabudere Raphael De Aguiar		Pisake Lumbiganon A. Metin Gulmezoglu	Weerasak Putthasri Nucharee Srivirojana Ji Xu

Speakers	Leadership	Chair/Moderator	Rapporteurs
Parallel session 16: Innovative education and training for HRH (28 Jan 2011 : 15.30 – 17.30)			
Manuel M. Dayrit	Vinícius Oliveira Berhanu Feyisa Tilla Hideomi Watanabe Babara McPake	Ian Couper	Nonglak Pagaiya Tripop Lertbunnaphong Rebecca Bailey
Parallel session 17: HRH situation and trend in developed countries and their potential implications to developing countries (28 Jan 2011 : 15.30 – 17.30)			
Mark Pearson Bjorn-Inge Larsen Linda Aiken	Chris Rakoum Jean Marc Braichet Elizabeth Adams Beth Slatyer	Mark Pearson	Laura Stormont Pongsadhorn Pokpermdée Pini J Farungmuayphol
Parallel session 18: Trade in health services and impact on HRH (28 Jan 2011 : 15.30 – 17.30)			
	Nick Drager Nigel Crisp John Hancock Rangarirai Machedze	Cristian Baeza Nick Drager	Chutima Akaleephan Alison Osborne Suriwan Thaiprayoon
Parallel session 19: Self reliance to health and well being through local resources and knowledge (28 Jan 2011 : 15.30 – 17.30)			
Qi Zhang Govindaswamy Hariramamurthi Steve Xue Yahaya Sekagya		Vichai Chokevivat	Chalermpol Chamchan Ding Yang Thaksaphon Thamarangsi
Parallel session 20: Skills mix to achieve universal access to essential health care (28 Jan 2011 : 15.30 – 17.30)			
Zulfiqar Bhutta	Otmar Kloiber Frances Day-Stirk David C. Benton Maxensia Nakibuuka Sairam Saadat Salman Rawaf	Sheila Dinotshe Tlou Bjarne Garden	Sakkarin Niyomsilpa Luis Huicho George Pariyo

Speakers	Leadership	Chair/Moderator	Rapporteurs
Parallel session 5: Economic fluctuations, universal health coverage and the health workforce (28 Jan 2011 : 15.30 – 17.30)			
Hannes Danilov	Juan Pablo Uribe	Phusit Prakongsai	
Ann Phoya	David Evans	Magnus Lindelow	
Kampeta Sayinzoga		Puwat Charukamnoetkanok	
Supon Limwattananon			
Conference Synthesis Session: Summary, Conclusion and Policy Recommendations			
			Viroj Tangchareonsathien
			Junhua Zhang
			Toomas Palu
			Jeff Johns

ANNEX III: List of Side meetings and Workshops

Monday, 24 January 2011

- 08.00-18.00 **HRH in Africa Day: Producing Evidence and Policy through Joint Collaboration** by World Bank, African Development Bank, African HRH Platform, Capacity Project (USAID), WHO
- 10.00-12.00 **The Global Health Workforce Alliance Pre-Conference Briefing (to Board Members, Champions and Partner-Donors)**
- 16.00-19.00 **WHO Forum Coordination Meeting** by WHO
- 12.00-18.00 **GHD Curriculum Development Meeting**

Tuesday, 25 January 2011

- 08.00-10.00 **Alliance Members' Platform - Taking the HRH Agenda forward** (pre forum session) by the Global Health Workforce Alliance
- 08.30-10.30 **Midwives and others with midwifery skills: the key resource for MDGs 5 and 4** by UNFPA
- 09.00-11.00 **Understanding Health Workers' Preferences to Address HR Issues** by London School of Hygiene & Tropical Medicine (CREHS) / IHPP
- 09.00-12.00 **Lancet Series on Health in Southeast Asia Informal Consultation in Celebration of Publication** by the China Medical Board, the Rockefeller Foundation, The Lancet and the Prince Mahidol Award Conference
- 09.00-12.00 **HRH management for Francophone African countries -HRH information system and HRH Observatories** by NCGM/JICA
- 09.00-12.00 **Choosing the most appropriate interventions for rural retention of health workers: a methods workshop** by WHO
- 09.00-12.00 **HRH in Africa : A New Look at the Crisis** by World Bank
- 09.00-12.30 **Transformative scale up of medical, nursing and midwifery education** by WHO-HRH/IHPP
- 09.00-13.00 **From Crisis to Stability: Lessons from Malawi** by MSH
- 09.00-16.00 **Connecting Health Organizations for Regional Disease Surveillance** by CHORDS
- 09.00-17.00 **Positive Practice Environments** by International Council of Nurses, World Health Professional Association, and International Hospital Federation

- 09.00-17.00 **Enhancing Personal Resilience for a Sustainable Health Care Workforce** by World Medical Association
- 09.00-17.00 **Delivering eLearning for Human Resources in Health** by AMREF
- 11.00-13.00 **African Platform on Human Resources for Health Business Meeting** by African Platform
- 11.30-12.40 **Community Health Worker Strategy in Zambia** by CHAI
- 11.30-13.00 **What will it take set a truly ‘actionable’ global policy agenda to address the global HRH shortage?** by HWAI
- 11.30-13.00 **E-health Capacity Building** by IntraHealth
- 13.30-15.30 **Participatory management activities of 5S-KAIZEN-TQM for promoting mind-set change and leadership** by JICA
- 13.30-15.30 **The Italian systemic effort in strengthening human resources for health in developing countries: looking for increased coordination and policy coherence** by AMREF
- 13.30-16.30 **(1) ‘Working together’ , Increasing the capacity of health advocacy NGOs
(2) ‘Health Workers Speak’ – research from 4 countries on staff motivation, morale and attrition** by VSO
- 13.30-16.30 **Why HRH Planning and how to prevent failure in planning and implementation** by AAAH
- 13.30-16.30 **Global Pharmacy Education Taskforce** by The International Pharmaceutical Federation (FIP)
- 13.30-16.30 **Strengthening Linkages between the Faith-based Health Care Providing Community and Ministries of Health for Quality Health Care for All** by Capacity Plus
- 13.30-16.30 **Generating evidence to inform human resources for health policy** by World Bank
- 13.30-17.30 **PEPFAR and the 140,000 Health Worker Target: A Combination Approach to Strengthening Pre-Service Education** by PEPFAR
- 13.30-17.30 **Country Coordination and Facilitation process : Addressing the HRH challenges through multi-sectoral approach** by the Global Health Workforce Alliance
- 14.00-16.00 **Global mapping of medical, nursing & other health professional schools** by WHO

16.00-17.30 **Strengthening the contribution of civil society networks in tackling the global HRH crisis – a UK case study** by UK Working Group on HRH, under Action for Global Health

16.00-18.00 **Human resource development in community health** by JICA

Friday, 28 January 2011

07.00-08.30 **Achieving the MDGs→: Accelerating the HRH Agenda for Global Action** by WHO / the Global Health Workforce Alliance

12.30-14.00 **Education for Health Professionals in the 21st Century**

17.30-19.00 **Advisory Board Meeting for the State of the World's Midwifery Report** by UNFPA

17.30-20.00 **Consultative Meeting on Health Information System Components for Human Resources within Health Systems** by WHO/IER

17.45-18.30 **Report Launch: Universal Access to HIV/AIDS SERVICES-Can MDG 6 Be Achieved With The Health Workforce We Have?** by the Global Health Workforce Alliance

18.00-19.30 **Turning Whispers to Voices: Strengthening Southern CS engagement in Global Health Dialogue and Accountability** by Centre for Health Sciences Training, Research and Development (CHESTRAD)

Saturday, 29 January 2011

13.30-15.00 **Alliance Members' Platform - Taking the HRH Agenda forward (post forum session)** by the Global Health Workforce Alliance

14.00-16.30 **International Organizing Committee Meeting** by PMAC

Sunday, 30 January 2011

08.30-17.00 **11th the Alliance Board Meeting** by the Global Health Workforce Alliance



ANNEX IV: List of Marketplace Posters and Awards Winners



The Marketplace at the Second Global Forum showcased posters of the 36 successful case stories nominated for Awards for Excellence and also hosted the “Hall of Fame”, a special area featuring 12 posters of dedicated health workers nominated for Special Recognition Awards.

The most outstanding 6 case stories and 2 individual health workers were selected for Awards for Excellence and Special Recognition Awards respectively. The winners and finalists are listed below.



2 Winners for Special Recognition Awards (for health workers)



Ms. Daw Nan Than Than Oo
Midwife, Myanmar

Ms. Than Oo is a midwife in Lwe-Satone sub-Rural Health Center which covers nine villages with a total population of 5,000 people with an additional estimated nomadic population of 3,000. She caters to 120-130 pregnant women yearly and provides immunization to over 200 children under one year of age every year. Driven by her motto of “no maternal mortality”, she encourages the community to support her efforts through a network of village health volunteers. In 2010, she achieved 78% antenatal coverage, no maternal deaths, and contraceptive prevalence rate reached 62% in her area.



Dr. Karamoko Nimaga
Doctor, Mali

Dr. Karamoko Nimaga built his own clinic in Markakoungo, 80 km from Bamako. The clinic is located in a village of 5,000 but serves an area with a population of 13,000. He is a real pioneer in the fight against epilepsy and onchocerciasis (about 10 for every 1,000 Malians suffer from epilepsy) thanks to thorough research conducted over three years in 23 villages. He found that the fight against epilepsy and onchocerciasis were effective when using ivermectin, and this research was quickly validated by the scientific world. He has become a model for young doctors as he provides them with another vision of rural healthcare by confirming it's not a sacrifice, but a lifestyle.

Finalists for Special Recognition Awards (for health workers)

- Dr. Pakdee Suebnukarn, Doctor, Thailand
- Mr. Therawat Daengkrapao, Primary care worker, Thailand
- Dr. Wang Tangyao, Doctor, China
- Dr. Wu Dengyun, Doctor, China
- Dr. Saidou Ekoye, Doctor, Niger
- Ms. Leochrist Shali Mwanyumba, Nurse, Kenya
- Mrs. P.D. Lalitha Padmini, Midwife, Sri Lanka
- Dr. Ebele Omeke Micheal, Doctor, Uganda
- Ms. Ho Thi Thanh Hoa, Community health worker, Vietnam
- Ms. Collette Botchomoli, Matron, Republic of Congo





6 Winners for Awards for Excellence (for case stories)

- **Health Workers for Health Services in Remote, Underserved, Country Borderline Areas and Small Islands** by Ministry of Health, Republic of Indonesia
- **Establishing a Robust and Sustainable Human Resources Information System in Kenya** by Ministry of Medical Services (MoMS) and Ministry of Public Health and Sanitation (MoPHS), Kenya
- **Counterpart Technical Support between Urban Tertiary Hospitals and Rural Hospitals in China** by Ministry of Health, China
- **Rebuilding Health Services after a Health Workforce Crisis in Zimbabwe** by Ministry Of Health and Child Welfare, Zimbabwe
- **Improving Government District Hospitals Through an Integrated Programme of Health Worker Environmental Support in Nepal** by Nick Simons Institute and National Health Training Center, Nepal
- **Developing Multiple, Integrated Strategies to Address Ethiopia's Human Resources for Health Needs** by Federal Ministry of Health (FMoH), Ethiopia

Finalists for Awards for Excellence (for case stories)

- **Coherent training for community health workers and paramedics in rural Bangladesh** by RTM International, Bangladesh
- **Reducing pressure on health systems by more effective home-based care and reducing the burden of care on women and girls** by VSO Malawi
- **Facilitating knowledge sharing internationally for health (Malawi, Philippines, Zimbabwe)** by VSO International
- **Human Resources for Health Leadership Development Programme in Kenya** by Management Sciences for Health (MSH)
- **Strengthening leadership and ownership of HR information management (United Republic of Tanzania)** by Japan International Cooperation Agency (JICA)
- **Leading the Way: pre-service training institutions in Nicaragua and Uganda prepare students to lead health programmes** by Management Sciences for Health (MSH)
- **Development of a human resources Management Information System for the Malawi Ministry of Health** by VSO Malawi
- **Community Health Workers at the Millennium Villages Project increase access to the health workforce** by The Millennium Villages Project (MVP)
- **Improving human resources for sexual and reproductive health and maternity services in Somaliland through performance-based pay** by Health Poverty Action
- **Improving management and supervision for Health Surveillance Assistants in Malawi** by VSO Malawi
- **Human resources improvement collaboration in Niger's Tahoua Region** by United States Agency for International Development (USAID)
- **Extending lifesaving HIV services by expanding community health counseling and testing in Mozambique** by Ministry of Health, Mozambique and Jhpiego-Mozambique
- **Highlighting health workers' concerns through focused research: supporting studies in Malawi, Cambodia, Uganda and Sierra Leone** by VSO International



- **Using e-learning to address health worker shortages in Kenya** by AMREF Kenya
- **Quality assurance in pharmacy education: a cornerstone for strengthening the pharmacy workforce in India** by International Pharmaceutical Federation (FIP) Pharmacy Education Taskforce
- **Private international cooperation for healthcare workers' training and capacity building in HuiLi County Hospital, Sichuan, China** by Tan Tock Seng Hospital, Singapore
- **Facilitating policy development: the role of a public health institution in Pakistan** by Health Services Academy, Pakistan
- **Heralding a health revolution: female Community Health Workers in rural Rajasthan, India** by State ASHA Resource Centre and State health system resource centre
- **The Tanzania Nursing Initiative: using the HRH Action Framework to strengthen Tanzania's healthcare workforce** by The Tanzania Nursing Initiative
- **Nigeria Midwives Service Scheme** by National Primary Health Care Development Agency, Nigeria



- **The Foreign Placement Coordinating Centre in Sri Lanka** by Dr A De Silva, Dr T De Silva, Dr Kumalatilake, Dr Pradeep
- **The contribution of Public Health Midwives to better health in rural communities in Sri Lanka** by Dr. A. Pubudu de Silva
- **Zambia's National Community Health Worker Strategy** by Ministry of Health (MoH)
- **Lesotho Nursing Initiative** by Ministry of Health and Social Welfare (MOHSW) and the Clinton Health Access Initiative (CHAI)
- **Developing regional capacity and leadership on HRH** by HRH Research and Development Program International Health Policy Program, Thailand (IHPP) Ministry of Public Health
- **Mechanisms to ensure evidence-based HRH policy development in Thailand** by HRH Research and Development Program International Health Policy Program, Thailand (IHPP) Ministry of Public Health
- **Stemming and reversing the out-migration of human resources for health in Lesotho** by Lesotho-Boston Health Alliance (LeBoHA)
- **Using information to improve allocation and management of HRH: the Zambia optimization model** by Ministry of Health, Zambia
- **Shifting tasks to save lives: the example of AMREF-trained clinical officers in Southern Sudan** by AMREF Southern Sudan
- **Community Health Workers – an important resource towards achieving the MDGs** by AMREF Tanzania





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