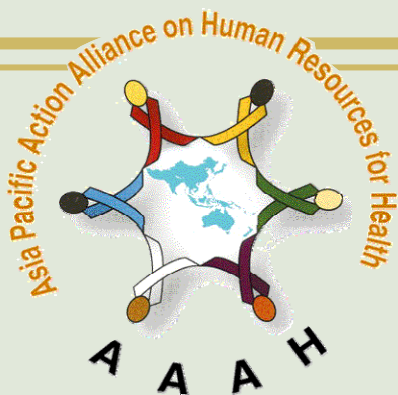


AAAHAH NEWSLETTER

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“ Strengthened HRH planning and management capacity toward adequate, equitable, efficient and effective HRH and health systems for health equity and quality improvement in the Asia-Pacific region ”

INSIDE THIS ISSUE:

- From the 4th AAAH conference in Hanoi, interventions to retain health workers in underserved area were raised in six areas; what they are and how AAAH country members implemented them.
- This issue introduced our new partners in human resources for health, CapacityPlus. Their strength in building capacity will be useful for our country members.
- Focal point from Myanmar, Dr. Nilar Tin, kindly provided current situations and HRH activities in Myanmar.
- Check out HRH events and interesting meetings

Update HRH events and news at

<http://www.aaahrh.org>

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HRH Interventions and key issues raised at the 4th AAAH Annual Conference

The theme of the fourth Annual Conference (Joint WHO/AAAHA Conference) was “Getting committed health workers to underserved areas: a challenge for health systems.” Six parallel sessions focused on different interventions used to for the purpose of health worker retention in underserved areas. From the discussions, a common recommendation was raised, focusing on the need to have cross-sector engagement in order to address the HRH challenges.

1. Education interventions

Nearly all countries, whether rich or poor have education interventions aimed at retention of health workers in remote and rural areas. Examples of what has been carried out in AAAHA member countries include the social accountability framework for medical education in Nepal which is aimed at addressing priority health issues and responding to community needs. In Thailand, some of the recruitment methods favor students from rural backgrounds who are more likely to work in rural areas. Certain recruitment methods in Vietnam favor students from rural backgrounds and some programs are available to health workers to upgrade training.

2. Regulatory interventions

Regulatory interventions which include measures such as compulsory service in rural areas, scholarships in exchange of rural service and producing new types of cadres are also utilized in AAAHA member countries. For example, in China, health workers are willing to work in rural areas provided that working conditions and salary are satisfactory. More research and case studies are needed in the Pacific Island countries where rural service is not yet mandatory.

Countries need to adapt recommendations regarding regulatory interventions according to their contexts. Suggestions raised at the conference included linking compulsory service to licensing and engaging other sectors, in particular education finance, labor, civil society, and professional associations.

3. Financial interventions

The common message from this session was that financial incentives work well when combined with other interventions. In Vietnam this includes working conditions, career advancement and in-service training. A study in Thailand indicates that higher salaries, better opportunities for specialist training, faster career promotion and less overtime work will determine a doctor's decision to work in rural hospitals.

From discussions, participants felt that financial incentives must be combined with other interventions that reflect the spiritual dimension and other intrinsic factors underpinned by sufficient resources and long-term sustainability.

4. Working environment and management

This intervention covers a wide range of issues including living conditions in Bangladesh, and Japanese management models used in Sri Lanka to improve job satisfaction and potentially retention.

Several management challenges are common to many countries, especially those with the most severe shortage of health workers. Vertical disease programs which pull away from rural areas, gaps in M&E and costing, and lack of HR management capacity especially among managers of rural providers are a few examples.



5. Social and spiritual motivation

A study in Bangladesh found that simple recommendations including taking oaths of service regularly, improving entertainment facilities, etc. could have a positive impact on health workers in remote areas. India and Sri Lanka highlighted the need for bundled approaches that build confidence and motivation of health workers. A case from Thailand emphasized that duty plus heart and soul equals continuous quality improvement and a happy workforce.

Recommendations included: creating awards and ceremonies at local, national and international levels; developing a social contract with the community to help foster a strong sense of belonging and accountability; providing supportive supervision; addressing issues related to gender; improving not only the social but formal recognition of rural health service; and addressing the faith dimension of motivation by engaging with faith based organizations that provide health services in rural communities.

6. External factors affecting retention in underserved areas

This parallel session focused on three main concerns: what information is needed for the identification and analysis of important external factors; how to accommodate these external factors in the selection of bundles; and how to monitor their impact.

Experiences from public service reform in Cambodia highlight the opportunity to enhance the quality of public services, including health services and the challenge of brain drain of civil servants. Speakers from Indonesia, Lao People's Democratic Republic and Thailand agreed that decentralization brought opportunities to improve working conditions, rural recruitment, flexibility in hiring health staff, and incentives and management.



CapacityPlus

A well-trained, well-distributed health workforce provides the conduit to vital health care information, services, and commodities. Yet there is a global shortage of 4.3 million health workers, and the World Health Organization has named 57 crisis countries that are facing an especially critical shortage.

CapacityPlus is a new five-year global project to strengthen the human resources for health (HRH) needed to help reach the Millennium Development Goals. Placing health workers at the center of every effort, the vision of CapacityPlus is to build powerful constituencies to shape the global HRH agenda while achieving demonstrable progress in the health workforce in a set of focus countries. The project expands the successful efforts of USAID's Capacity Project, which worked in 47 countries to strengthen workforce planning, development, and support.

The objectives of CapacityPlus are in alignment with the Global Health Initiative's integrated approach to public health and the US President's Emergency Plan for AIDS Relief. As President Obama said in announcing the Global Health Initiative, "... we will not be successful in our efforts to end deaths from AIDS, malaria, and tuberculosis unless we do more to improve health systems around the world...."

CapacityPlus uses global expertise and evidence to address both the number of health workers needed and the quality and performance of those workers. Through working to ensure that the right health workers are in the right place at the right time, the project will build capacity in service delivery, thereby increasing access to high quality family planning/reproductive health, HIV/AIDS, malaria, tuberculosis, maternal and child health, and other services. Specific results areas include:

- Fostering global leadership and advocacy to address the HRH crisis
- Enhancing HRH policy and planning, including strengthening HR management and information systems
- Improving HRH workforce development, including preservice education, in-service training, and continuing professional development systems
- Strengthening HRH performance support systems to improve health worker retention and productivity
- Generating and disseminating knowledge to promote use of evidence-based HRH approaches.

CapacityPlus

CapacityPlus Partnership

- IntraHealth International, Inc. (lead partner)
- Abt Associates
- IMA World Health
- Liverpool Associates in Tropical Health (LATH)
- Training Resources Group, Inc. (TRG)

Associate Partners

- African Population & Health Research Center (APHRC)
- Asia-Pacific Action Alliance on Human Resources for Health (AAAH)
- West African Institute of Post-Graduate Management Studies (CESAG)
- Partners in Population and Development (PPD)

CapacityPlus together with AAAH will hold workshops focusing on issues of relevant to the AAAH member countries. CapacityPlus and regional associate partners will also be carried out case studies on private sector education.

AAAH will participate in human resource management (HRM) technical consultation meeting in May, 2010 in order to work on HRM strategy formulation. The meeting will include technical discussion, contribution and understanding of HRM systems and functions.

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Myanmar: updated country profile and HRH activities

Source of information: Myanmar AAAH focal point; Dr. Nilar Tin



Myanmar (population 57 million) is a Union of 14 States and Divisions, and a country of significant geographic and ethnic diversity, made up of 135 national groups speaking over 100 languages and dialects. Myanmar's Fourth Short-Term Five-Year Plan has set out the nation's main development objectives, one of which is to extend education and health sectors for human resource development. The country is networked by 1,492 Rural Health Centres and 6,663 Sub Rural Health Centres under the administration of the

Township Medical Officer (TMO) and Township Health Team⁽¹⁾.

Townships (n = 325) having a catchment area of 100,000 - 200,000, are responsible for management of all secondary and primary care services, which includes within its jurisdiction 1-2 station hospitals, and 4-7 rural health centres. Each RHC has 4 sub-centres covered by a midwife and public health supervisor grade 2 (PHS 2) at the village level. In addition there are voluntary health workers--community health workers (CHW) and auxiliary midwives (AMW)-- in outreach villages providing Primary Health Care to the community⁽²⁾.

The Township Health Officer (THO), Township Health Assistant (THA), Township Health Nurse (THN) and Health Assistant (1) (HA-1) assist the TMO for monitoring and supervision of urban and rural health services in the community as well as for training of health personnel within the

township.

Myanmar, despite of progress in health achievements through primary health care approach, is still beset with significant communicable disease and health system access problems, particularly as affecting mothers and children in hard to reach areas.

Barriers that are seen in Human Resource entail especially to the Basic Health Staff (BHS) that are serving the 70% of total population in rural areas. The numbers, distribution, and mix of health staff at the most peripheral level of the health system such as midwife and Public Health Supervisor grade 2 (PHS 2) at the sub rural health centre are the most significant resources challenged. Since 1988, the number of medical graduates has doubled, but at the same time the absolute numbers of midwives have increased by only 10%⁽³⁾.

Analysis of studies^(4,5) upon the workload of midwives indicates lack of clarity of function for the midwife, overload with administration and role confusion and conflict with PHS 2. Midwives are difficult to motivate and retain in more remote areas where there are geographical, cultural and language barrier, resulting in a lot of unfilled posts and consequent lack of service access for these populations.

In order to develop Strategic Plan for HWF development at Township Level it should highlight considerable points such as (325) townships having different epidemiological, geographical and socio-economic background and challenges. Some of the reasonable actions that have been considered during a National level Multi-Sector workshop on development of HWF strategic plan (29-30 September 2008) were ⁽⁶⁾:

- Fill up posts to full strength of BHS in all RHCs at the townships as some of the RHCs that were established earlier have only half strength of the new standard of (13) BHS;

- Support basic needs--- housing, transportation means, salary and bonus (performance-based), supply of Essential Drugs, equipments and stationeries;

- Strengthen the supportive supervision and monitoring from State/ Divisional level and Central level

- Updated information and resources to TMO and BHS by different Health programs

- Develop a mechanism by continuous monitoring and supervision to high-light Skill mix/shift amongst HWF even to private sector (GP, pensioners, volunteers)

- Develop/maintain decentralization mechanism at Township level

- Create sense of ownership as regards performance in each category of HWF

- Allotment of time frame/funding for Continuous Medical/Health Professional Education at township level

- Analytical, problem identification and solving bottom up needs for training of different categories of HWF

- Strengthening management and leadership capacity of other categories of HWF such as Dental Surgeons/Team leaders/clinicians/nurses

- Management and leadership training to TMOs and BHS and follow up after training for assessment (performance-based indicators)

- Long term plan for Master in PH to lead the Township Health Team and further to lead the Rural Health Team

Out of these one of the biggest issues is accessing health services in hard to reach areas and this could be achieved by strengthening the community based health volunteers. Myanmar has been recruiting CHWs since Alma Ata Declaration of Primary Health Care and there have been many success stories as well as failures as there was a lot of attrition previously, mainly due to moving out from the community or selecting old persons in the first place.

However CHWs in the communities should be considered as helping hands for the Basic Health Staff especially midwives. As they are not paid or full time workers their contributions towards health system depends upon individual's willingness, the acceptability and development of the community and the appreciation and acknowledgement from health sector⁽⁷⁾.

Nowadays there is an improvement of community based activities in health programs recruiting a variety of commu-

nity based volunteers in the country by different organizations that had created a perplexity in the community based volunteers of the country. Nevertheless whether they are community owned resource persons(CORP) conducting community case management of malaria by Malaria control program, community based health promoters by Women and Child Health Development (WCHD) program, community support group (CSG) by Behavior Change Communication project or CHWs recruited by Basic Health

Section all the organizations that are accomplishing community based volunteerism should have a standardized and clear principles in managing CHW.

By strengthening the community based health volunteerism in the country and sharing information to CHWs of different names the community empowerment could be created so as to overcome the barriers of different epidemiological, geographical and socio-economic issues and reaching every community with helpful hands.

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UPCOMING EVENTS

Event: **The moderated discussion on MID-LEVEL HEALTH WORKERS**

Date: 8-18 April 2010

Where: GHWA, Geneva, Switzerland

Event: **Global Consultation on Community Health Workers**

Date: 29-30 April, 2010

Where: Montreux, Switzerland

Event: **Third Geneva Conference on Person-centred Medicine**

Date: 3-5 May, 2010

Where: Geneva, Switzerland

Event: **Improving Routine Health Information Systems Performance Training**

Date: 3-21 May, 2010

Where: Dakar, Senegal

Event: **The moderated discussion on MID-LEVEL HEALTH WORKERS**

Date: 4-18 May, 2010

Where: GHWA, Geneva, Switzerland

Event: **Sixty-third World Health Assembly**

Date: 17–21 May 2010

Where: Geneva, Switzerland

Event: **International Conference on Research in Human Resources for Health**

Date: 9-11 June, 2010

Where: Rio de Janeiro, Brazil

INTERESTING EVENTS

Event: **African Platform on Human Resources for Health, 1st Human Resources for Health Consultation**

Date: 5-7 July, 2010

Where: Nairobi, Kenya

The African Platform on Human Resources for Health will host its first Consultation/Forum since its launch in 2005. The Consultation/Forum will bring together a broad base multi-stakeholder representation of organization, institutions and agencies from public, private sector and non-governmental organizations from continental Africa interested in human resources for health and health systems strengthening.

The overall objective of the Consultation is to review the progress made since the establishment of the African platform on human resources for health, draw lessons for taking its agenda forward, and share experiences, innovations and lessons in five critical areas affecting the health workforce in Africa to advocate for increased commitment from African institutions and stakeholders at the global level.