Summary of 2nd AAAH Conference

"Human Resources for Rural Health and Primary Healthcare"

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By

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I. Introduction

The 2nd AAAH Conference was held in Beijing, China in 12-14 October 2007. The Conference was co-hosted by the Health Human Resources Development Center of Ministry of Health, P.R.China (HHRDC) and the AAAH. The theme of the 2nd AAAH Conference is "Human Resources for Rural Health and Primary Healthcare". Over 70 participants from 15 AAAH member countries, global and regional alliances and platforms, international organizations and other countries in the region have made their attendance. At the three-day conference, over 35 speakers shared experiences and knowledge on three thematic topics – developing and planning rural HRH strategy, strengthening community and rural health workers and primary healthcare, and fostering regional cooperation on HRH. Ten stimulating case studies selected from member countries were presented and shared at the Conference.

At the beginning of the conference, Dr. Lincoln C. Chen from GHWA has raised three important thematic questions for the participants to think on across all sessions:

- What lessons or knowledge can be shred across countries?
- From which sectors and groups does health sector need cooperation?
- Which activities conducted by AAAH and other global alliances and partners would be helpful to your country?

Herein are the key findings and recommendations from the 2nd AAAH Conference.

II. Definition and concept of "Healthcare worker"

Despite the WHO has respectively given the clear definitions on 10 kind of health workers, countries in the Asia-Pacific region still understand HRH elements in various ways, for instance what constitute the group of physicians, nurses, community health workers and other health professionals. Even though, SEARO has defined the health workers as "all people engaged in actions whose primary intent is to enhance health, including health service providers, and managerial and supportive staff".

III. Key findings from global and regional organizations and platforms

Five key challenges faced with the management and development of HRH have been unanimously indentified by WHO HQ, GHWA, SEARO, WPRO and Pan American Organization: 1) a massive global shortage of health workers; 2) skill imbalances—nearly all countries suffer from skill imbalance. In most countries, population based public health is neglected; 3) unplanned migrations—the movement of health workforce from the poor to

the rich countries, from rural and remote areas to urban areas, from public to private sectors have crippled the health systems in many countries; 4) poor work conditions; 5) weak knowledge bases—information is sparse, data fragmentary, and research deficiencies that must be remedied.

In response to those challenges, global and regional organizations have made their own efforts in different ways:

WHO with its regional offices have provided many resolutions in strengthening the health workforce internationally and regionally in the past two decades. The SEARO and WPRO have respectively developed their 2006-2015 regional strategic plans for HRH development in recent years. Furthermore, in 2007 the WHO launched the "Treat, Train, Retain (TTR)" plan in responding to the growing HRH crisis. The TTR will address the health workforce crisis in countries mostly affected by HIV. It consists of three elements: 1) Treat—a package of HIV treatment, prevention, care and support services targeted to health workers as vulnerable group; 2) Train—measures to empower health workers to deliver universal access to HIV services including pre-service, and in-service with special focus on task shifting; 3) Retain—strategies to enable public health systems to retain workers, including financial and other incentives, and measures to improve the workplace as well as initiatives to reduce the migration of health care workers.

GHWA, as the leading international HRH agency of WHO, has been donating its effort in five key areas: 1) accelerating country action; 2) solving global problems; 3) advocacy for HRH; 4) advancing the knowledge base; 5) focal point for global stakeholders. In the area of solving global problems, GHWA has already established four global task forces for targeting the major four topics: fast-track education; medical migration; health financing and universal access of healthcare. The outcomes of the four task forces' work will be generated in 2008 and 2009.

AAAH has commissioned Dr. F. Marilyn E. Lorenzo and her team from University of Philippines to develop the regional guideline for country strategic HRH planning. The guideline has suggested 10 steps for developing the HRH strategic plans:

1) doing situational analysis;
2) deciding on goals of the Master Plan;
3) deciding on a planning framework;
4) identifying key issues that needs to be addressed by master-plan; 5) identifying key result areas of the plan;
5) crafting effective and appropriate strategies;
6) accomplishing operational plan;
7) identifying key policies and programs to support plan;
8) crafting monitoring and evaluation scheme;
9) planning for annual plan review.

IV. Community health workers-past, present and future

After countries shift toward stronger primary health care systems in attend to pursue the objective of “health for all (HFA)”, the concept of community based health workers (CBHW) and community health volunteer (CHV) have been energetically developed. All **SEAR** countries intensified their action on development of CBHW and CHV to work actively with the community. The definitions of CBHW and CHV are:

CBHW: All health care workers who are part of the formal health organization, and have undergone formal training to carryout a series of specified roles and functions, and spend a substantial part of their working time actively reaching the community, discharging their services at the individual, family or at the community level.

CHV: Members from communities often selected by communities themselves and are answerable to them, who have undergone shorter training than professional workers, and are predominantly involved in health promotion and prevention of health related problems, and are supported by the health system but not necessarily a part of its formal organization.

For meeting with the emerged and re-emerged challenges in the new millennium, SEARO has established three strategic pillars for the development of CBHW and CHV: identification of the need for CBHW and CHV in a changing environment; development of the CBHW and CHV movement and ensuring supportive environmental factors for effective functioning of CBHW and CHV. Furthermore, SEARO has considered the principles of primary health care (PHC) still remain valid and appropriate in the region. It is recommended to the SEAR countries to strengthen their health systems using PHC approach, and it is necessary to develop the health workforce in a sustainable and community-based way.

Community Health Workers in different country:

In **Sri Lanka**, the primary health care services are delivered through public health midwife (PHM) and public health inspector (PHI). The success of PHM and PHI can be reflected by the coverage of maternal and child health services at national level and its ultimate impact in the health indices. The main reasons for success are: simple and effective system application, favorable government policies, and consistent support from professional organization.

It is also important that the focus of CHW in the MOH system is provision of primary health care rather than curative care. When Integrating the primary health care services into the curative sector, there should be an action to examine how these integrated services could be delivered at the peripheral level without creating a deleterious effect on the preventive services, by keeping the focus of CHW on primary health care.

Furthermore, application of methods to increase the community participation is important. PHM and PHI has to build and maintain the capacity of health volunteers in the community. Effective methods of using these health volunteers possibly with implementation of village health committees would make the work of community health workers easier. At a regional level it would be useful to study and document how the different countries have organized the relevant workforce in the delivery of primary health care services. There will be many lessons that could be learnt from each other.

The CHV in **Bangladesh** are called Shasthya Sebika (SS), who are a group of females aged 25 or above, married with children not below 2 years old. The SS receives a 3 weeks residential training in one BRAC's regional offices across the country. Each SS covers 250 households and usually visits 15 households daily. The provision of services by the SS is supported and supervised by Shasthya Kormis (SK) who is paid health workers of BRAC with minimum 10 years of professional schooling. The SS is not paid worker of BRAC. But they are expected to earn from the sales of essential medicines and health commodities and some charges for specific services provided in community. SS is also allowed to get an additional loan over the current loan she has got for income-generating activities. However, there is still around 10-15% annual drop-out among SSs. It is mainly due to dissatisfaction from inadequate monetary return against the time and labor invested. Therefore, it is suggested that the importance of health workers should be recognized by the public sector and measures should be undertaken to develop their capacity in a planned way so as to ensure a minimum acceptable level of care for the poor in the short-term.

In **Thailand**, Village Health Volunteers (VHV) are considered extremely valuable. In 2006, there are totally 791,383 VHVs in the country, more than 35% of them were recruited in less than five years. The male to female ratio of VHVs rose from 1:1.7 in 1993 to 1:2.34 in 2006. This shift toward feminization of volunteer workforce points to a new possibility of potential areas of work such as prevention of domestic violence, alcohol consumption control, and caring of the elderly. 86.9% of the VHVs have no more than basic primary school education. Only 7.3% of them were college graduates and 1% holds a bachelor degree. 51.1% were farmer and 13.4% worked as waged labor. VHVs in Thailand were found to perform comparatively well on short-termed task such as health survey, periodic collecting data or disease prevention campaign. On the other hand, they did not do fare well, in the areas of work that need long-term, continuing dedication, such as caring of chronically ill patients. This may due to the fact that the majority of volunteers were economically constrained. It is recommended that: (1) Official health authority needs to shift its role to being promoter of health volunteerism in various appearances. (2) Public health organizations should be encouraged to create its own network of volunteer workforce. (3) Pluralization of community health volunteers is needed. New forms of community health volunteer need to be experimented. (4) Civic organizations should serve as platforms to foster volunteer spirit in society. (5) Self-governing mechanism for village should be strengthened to make health volunteer a non-partisan affair. (6) Public health officers need to be encouraged to work as volunteer themselves in order to better

appreciate volunteerism as a core value of public health work.

The most crucial community based health workers in **China** are the village doctors who were famously known as “barefoot doctors”. Since 1984, the title of “barefoot doctor” has been abolished; the title of “village doctor” has been established. Those “barefoot doctors” who passed the local health examination were nominated as village doctors; those failed in the examination were classified as health assistants. To be employed at village clinics, they need to get approval from the township governments with registration to the county's health bureau. It was found that between 1995 and 2005, the number of village clinics and doctors had been decreasing, as the number of clinics reduced by 221,000, and number of village doctors and assistants decreased by 414,000 or nearly one third. This is due to four main causes: 1) along with the institutional reform held in China, many townships (composed by few villages) have been urbanized resulting in a reduction in the number of villages; 2) rural cooperative medical scheme has been abolished in certain districts; 3) due to economic hardship, many villagers in very remote areas have left for employment in urban cities; 4) the combination of cities and townships in many provinces results in village clinics being replaced by community health centers.

V. Innovative education and scaling-up for rural health workers

In **India**, to scale-up the rural health workers, a new band of community based functionaries, christened as Accredited Social Health Activists (ASHAs) has been created recently. ASHA is envisaged to be female village resident with formal education up to class VIII and in age group 25-45. ASHA provides services in universal immunization, newborn care etc. with flexible work schedule. Till July 2007, 430,000 ASHAs have been selected in states, out of which 283,000 have been trained. The ASHA initiative has been implemented over two years, the major learning from the experience of the initiative are: 1) it is possible to envision a nation wide model of CHW but the same has to be acutely sensitive to local ground realities. The contours of available flexibilities need to be clear to all stakeholders including the health system which has to be geared to respond affirmatively to referral connectivity with the CHW; 2) focus of CHW has to be local and scope of activities limited to the key activities only. Location of the CHW would also determine the modeling; 3) the planners should seed the community with CHWs and expand slowly, learning from the early phases. Rapid up-scaling sows seeds of failure. It is also not necessary to wipe out the locally developed NGO based models in favor of a single crop of Government sponsored CHWs; 4) the capacity of health delivery apparatus in the state also needs to be expanded to support the demands generated by a well performing CHW; 5) contours of selection are the single most critical set of determinant for successful implementation of the CHW Program. The CHW can not be without any formal education but should not be over qualified either.

VI. Financing and incentives for rural health workers retention

In **Indonesia**, since May 2006 the MOH has further introduced new policies such as shortening service period and higher financial incentive for PTT service (contractual doctors and midwives/PTT). The minimum service period for PTT doctors and dentists in very remote areas is 6 months while in remote areas is 1 year. The financial incentive is only given to those working in very remote areas. After the policy being implemented for more than one year, the number of health workers in the rural healthcare centers has not been remarkably improved. The reason for that is mainly due to the criteria for remoteness classification which were not established nationally but locally. Different interpretation of areas with similar characteristic is found in various local governments. In addition, the policy has not been coupled with strong monitoring mechanism due to the financial constraint in the local governments. As the policy is only applicable to selected types of health workers, social jealousy and dissatisfaction could easily be generated among other health workers who work in the same location.

Therefore, to build up a effective financial incentive system for the health workers: the incentive must be considered to be based on individual performance indicator; must be integrated within the health system, in line with the goal and objective of the health development, and must be objective; must be perceived not only in term of money but also integrated with other non material incentives, and there must be a clear defined role of the central and the local government in the provision of incentives.

Starting from 2004, Ministry of Public Health in **Thailand** has further developed the special incentives for health workers working in rural area into three levels based on the type of professionals and the hardship of the workplaces. However, the problem of inequitable distribution of doctors still exists. For example, while the amount of financial incentives to new medical graduate has risen for several times in the past two decades, the total fine for breaching the three-year contract is still staying steady at $10,000. This may lead to a possibility for the graduates to easily pay the fine, break the bonding contract and leave the rural earlier for urban living and private practices. In order to optimize those strategies, a new decentralized financial management system has been employed for creating a better distribution of health care budgets for more equitable redistribution of human resources.

VII. Public Sector Reform, Decentralization and Rural Health Workforce

In **Vietnam**, parallel with the government's public administrative reform, the health system has undergone reform process focused on the change in organizational structure. The key changes in term of health structure are: new health administrative institution at district level has been created; for services provision, District Hospitals and District Preventive Medicine

Centers have been set up based on the old organizations—District Health Centers. The new structure has been proved an appropriate model to strengthen and improve quality of services, especially preventive service provision. However, there are challenges in term of human resources: newly created institutions are in short of health workers, and the existing workers are not familiar with the new function and responsibilities of the new organization; autonomous brings hospitals considerable new skills needs, especially in management competencies. It is suggested that the health managers should be equipped with the management skills in order to enhance their skills in financial, human resource, equipment and supplies, planning and information management. In-services training is important to improve capacity of health workforce, particular in preventive service provision.

In **India**, Tamil Nadu State model has been proved successful in the management of public health workforce. The main reasons are: 1) the state has brought the public health mangers from the municipalities to the intermediate level. The decentralization of functions and authorities has been well implemented. 2) The state has a relatively well equipped logistics network which has also resulted in a streamlining of management functions. 3) Having a clearly defined line of professionally qualified and experienced district managers is a definite improvement over a random and varied succession of clinical specialists at the helm of system. There is a significant difference in the quality of supervision and a greater ability to address and rectify day to day issues. The continuity factor is also crucial in building a team ethos. The lesson of the Tamil Nadu experience is simply that that having a specialized line of trained public health specialists to manage public health programmes does make for better outcomes and more effective service delivery. To generalize, having the right people for a job alone does not necessarily guarantee success, but the absence of such persons might well be an impediment to achieving that success anyway.