REPORT ON

THE 12TH AAAH CONFERENCE

Asia-Pacific Action Alliance on Human Resources for Health

A A A H

Strengthening

Resilience

Learning from COVID-19 Pandemic

STRENGTHENING HEALTH WORKFORCE AND HEALTH SYSTEM RESILIENCE

World Health Organization Eastern Mediterranean

JICA

World Health Organization Western Pacific Region

USAID FROM THE AMERICAN PEOPLE

World Health Organization South-East Asia

PMAC PRINCE MAHIDOL AWARD CONFERENCE

HPP Thailand

24th-25th January 2023
Bangkok, Thailand

Editors
Dr. Viroj Tangcharoensathien
Dr. Rapeepong Suphanchaimat
Dr. Panarut Wisawatapnimit
Ms. Parinda Seneerattanaprayul

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E-mail : aaahrh@gmail.com
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COUNTRY FOCAL POINT MEETING

23rd January 2023

WELCOME REMARKS
FROM THE CHAIR OF AAAH

DR. TIN TUN

Chairperson

AAAH Steering Committee

The Asia-Pacific Action Alliance on Human Resources for Health (AAAH) was launched in 2005 with 10 founding member countries and has increased to 18 member countries.

The AAAH has become an important and strong local organization for strengthening the human resources for health (HRH).

The AAAH Conference was held annually from 2006 to 2012 to facilitate the exchange of HRH knowledge and experience. Then, it has been altered to a biennial basis, and this year is the 12th AAAH Conference. The meeting will be a platform for discussing intersession activities and governance structure.

CHAIR

Dr. Tin Tun, Chairperson of the AAAH
Steering Committee

Moderator

Dr. Panarat Wisawatapnimit, the AAAH Secretariat

FOCAL POINT FROM 11 DELEGATES AS FOLLOW:

Onsite

1. Mr. Abu Rayhan Miah
   Deputy Secretary (GNSP) and Deputy Programme Manager,
   Bangladesh
2. Ms. Anna Kurniati
   Director for Deployment of Health Workforce Ministry of Health,
   Indonesia
3. Mr. Hussain Maaniu
   Deputy Director General, Ministry of Health,
   Human Resource Division, Maldives
4. Dr. Pai Thitsar
   Assistant Director (Foreign Relations) Department of Human
   Resources for Health (DHRH), Myanmar
5. Dr. Sunil De Alwis
   Additional Secretary (Medical Services), Ministry of Health,
   Nutrition and Indigenous Medicine Sri Lanka Country, Sri Lanka
6. Dr. Maniphet Phimmasane
   Department of Health Personnel Ministry of Health,
   Lao PDR
7. Ms. Agnes Pawiong
   The Executive Manager Strategic Policy Division,
   Papua New Guinea

8. Mr. Bhim Prasad Sapkota
   Senior Public Health Administrator, Health Coordination Division,
   Ministry of Health and Population, Nepal
9. Ms. Leni Kuwadavi
   Project Manager Office, Ministry of Health, Indonesia
10. Dr. Masahiro Zakoji
    Technical Officer, WHO WPRO
11. Ms. Sengtida Sivilay
    Ministry of Health, Laos PDR
12. Ms. Aishath Irufa
    Director, Ministry of Health, Maldives

Online

1. Dr. Thinakorn Noree
   Senior Researcher, International Health Policy Program,
   Thailand
2. Prof. Rowaida AlMaaitah
   President of the Board of Trustees
   Yarmouk University, Jordan
3. Mr. Josefa Draunidalo
   Director of Recruitment, Ministry of Health and Medical Services,
   Fiji
4. Dr. Pretchell P. Tolentino
   Director, Health Human Resource Development Bureau,
   Philippines

Rapporteur Team Members

1. Dr. Kamolrat Turner (Focal Point)
2. Dr. Sukjai Charoensuk
3. Dr. Kanokwan Wetasin

REPORT HRH COUNTRY SITUATION

[BY EACH COUNTRY FOCAL POINT]

Country	By 2020						
Milestones	1.1	3.1	3.2	3.3	4.1	4.2	4.3
1. Thailand	✓	✓	✓1st	✓	2nd	✓	
2.Bangladesh	✓	✓	✓	✓	✓	✓	✓
3. Indonesia	✓	✓	✓		✓	✓	✓
4. Myanmar	✓1st	✓2nd	✓	✓	✓	✓	✓
5. Maldives	✓		✓	✓		✓	✓
6. Nepal	✓	✓1st	✓	2nd	✓	✓	3rd
7. Fiji	✓	✓2nd	✓	1st	✓3rd		✓
8. Sri Lanka	✓	✓	✓		✓	✓	✓
9. Lao PDR	2nd	✓	✓1st		3rd	✓3rd	
10. Papua New Guinea	✓	✓	1st	✓	✓	✓	✓
11.Phillipines	✓	✓	✓	✓	✓	✓	✓

Note: ✓ = finished milestones
1st /2nd /3rd = First / Second / Third Priority

By 2030					
1.2	1.3	2.1	2.2	2.3	2.4
3rd					
2nd	1st			3rd	
3rd					
		1st		3rd	2nd
1st	2nd	3rd	1st	2nd	1st
1st			3rd		2nd
✓	✓		✓	✓	✓
2nd				3rd	
1st			2nd		3rd

The focal point from each country reported on their country's situation with respect to the 13 milestones of the Global Strategy on HRH Workforce 2030: seven of these were committed as fast-track milestones to be achieved by 2020, while the remaining six are to be achieved by 2030 as shown in Table 1.

TABLE 1
2020 MILESTONES AND 2030 MILESTONES: FINISHED,UNFINISHED, AND THE PRIORITY MILESTONES OR FLAGSHIP

There are four milestones that 10 countries have achieved by 2020, which are 1.1: all countries will have established accreditation mechanisms for health training institutions, 3.1: all countries will have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda, 3.2: all countries will have an HRH unit responsible for developing and monitoring policies and plans, and 4.2: all countries will have made progress in sharing HRH data through national health workforce accounts and annual submission of core indicators to the WHO secretariat. The milestone 4.1 that all countries will have made progress in establishing registries to track the health workforce stock, education, distribution, flows, demand, capacity, and remuneration of health workers, and 4.3 that all bilateral and multilateral agencies will have strengthened the health workforce assessment and information exchange were achieved by eight countries. The milestone that only six of 11 countries have achieved by 2020 is 3.3. All countries will have regulatory mechanisms to promote patient safety and adequate oversight of the private sector.

The milestone 1.2 that all countries will have made progress towards halving inequalities in access to health personnel is the first to be prioritized by 3 countries, while the milestones 1.3 that all countries will have made progress towards improving graduation rates in medical, nursing and allied health professionals training institutions, 2.1: all countries will have made progress towards halving their reliance on foreign-trained health professionals, implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel, 2.2: all bilateral and multilateral agencies will have increased synergies in official development assistance for education, employment, gender, and health to support national health employment and economic growth priorities, and 2.4: partners in the UN Sustainable Development Goals will have made progress on Goal 3c to increase health financing and health workforce recruitment, development, training and retention are prioritized by at least one country. The last milestone, 2.3 that partners in the Sustainable Development Goals will have made progress to reduce barriers to accessing health services by working to create, fill, and sustain at least 10 million additional full-time jobs in health- and social-care sectors to address the needs of underserved populations is considered as the second or the third priority

MAJOR ISSUES

The impacts of COVID-19 on HRH have become challenges, as reported by 3 countries, including Myanmar, Sri Lanka, and Lao PDR.

Rural retention, rapid turn-over rate and international migration of HRH are discussed as challenges by Indonesia, Maldives, Fiji, Sri Lanka, and the Philippines.

HRH data through national health workforce accounts is challenging for Thailand, Indonesia, Fiji, and Papua New Guinea.

SUGGESTIONS/ RECOMMENDATIONS

ONE

Increase HRH capacity building and employment opportunities through mechanisms, such as recruitment of health workers for civil service employment for government health facilities at the national, sub-national, and local levels.

TWO

Increase domestic production of health workers in accordance with the national target and the HRH requirement plan.

THREE

Engage or collaborate with all other key ministries/boards/ stakeholders to integrate an interoperable national health workforce database by developing a general consensus and agreement on implementing NHWA. The digitalize HRH information system (eNHIS) is also mentioned as a future plan by Papua New Guinea.

WAY FORWARDS

PRIORITIES OF THE ISSUES

ONE

PRIMARY HEALTH CARE WORKFORCE

TWO

QUALITY OF HEALTH WORKFORCE

THREE

NATIONAL HEALTH WORKFORCE ACCOUNTS

HRH
NEEDED
FROM FOCAL POINT MEETING

Rural retention and access health workforce

9 countries: Thailand, Indonesia, Myanmar, Maldives, Fiji, Sri Lanka, Philippines, Papue New Guinea, Bangladesh

HRH information data, NHWA

8 countries: Thailand, Indonesia, Myanmar, Fiji, Sri Lanka, Lao PDR, Papue New Guinea, Bangladesh

Private oversight

5 countries: Bangladesh, Indonesia, Nepal, Fiji, Sri Lanka

Accreditation

5 Countries: Bangladesh, Myanmar, Sri Lanka, Lao PDR, Papue New Guinea

Multilateral agencies

3 countries: Nepal, Fiji,
Papue New Guinea

Migration

3 countries: Maldives, Sri Lanka,
Philippines

CPD

2 Countries: Sri Lanka, Lao PDR

HRH Unit

2 countries: Thailand, Papue New Guinea

AAAH

STEERING COMMITTEE MEETING

23rd January 2023

CHAIR

Dr. Tin Tun, Chairperson of the AAAH
Steering Committee

Moderator

Dr. Panarat Wisawatapnimit, the AAAH Secretariat

STEERING COMMITTEE

Country representatives

1. Dr. Tin Tun
   Deputy Director General,
   Department of Human Resource for Health, Myanmar
2. Mr. Bhim Prasad Sapkota
   Senior Public Health Administrator, Health Coordination Division,
   Ministry of Health and Population, Nepal
3. Dr. Gamege Samantha Prabath Rabasinghe
   Director Primary Care Services and Acting Director Training, Sri Lanka
4. Dr. Sunil De Alwis
   Additional Secretary (Medical Service),
   Ministry of Health, Nutrition and Indigenous, Sri Lanka
5. Dr. Maniphet Pimmasane
   Ministry of Health, Lao PDR
6. Dr. Sengtida Sivilay
   Ministry of Health, Lao PDR
7. Dr. Pai Thitsar
   Department of Human Resource for Health, Myanmar
8. Mr. Saudat Sambahamfe
   Section Officer Ministry of Health and Population, Nepal

National Agency

1. Ms. Sato Rie
   Deputy Director Health Team 4, Health Group 2,
   Human Development Department,
   Japan International Cooperation Agency (JICA)
2. Dr. Masato Izutsu
   Chief Advisor, the Partnership Project for Global Health
   and Universal Health Coverage Phase 2 (JICA)
3. Ms. Meguru Yamamoto
   Project Coordinator, the Partnership Project
   for Global Health and Universal Health Coverage Phase 2 (JICA)
4. Ms. Sweta Saxena
   Health Systems Advisor, U.S. Agency for International
   Development (USAID), ASIA/ Technical Services.
5. Dr. Ibadat Dhillon
   Regional Advisor, Human Resource for Health Department of UHC/
   Health Systems & Life Course, WHO SEARO
6. Dr. Fethiye Gulin Gedik
   Coordinator, Health Workforce Development, WHO EMRO
7. Dr. Masahiro Zakoji
   Technical Officer, Health Workforce Policy and Health Care Deliver,
   Health Policy and Service Design, WHO WPR

Rapporteur Team Members:

1. Dr. Kamolrat Turner (Focal Point)
2. Dr. Sukjai Charoensuk
3. Dr. Yupawan Thongtanunam

SUMMARY

AAAH INTERSESSION ACTIVITY IN 2022 WITH THE PARTNERSHIP PROJECTS FOR GLOBAL HEALTH AND UNIVERSAL HEALTH COVERAGE PHASE 2

The AAAH secretariat reported on a series of Continuing Professional Development (CPD) workshops for nurses, an AAAH intersession activity in 2022. It aimed to provide an opportunity for the members to share their experiences. 10 countries participated in the workshop. The concept of CPD and the situation of CPD in each country were presented. There was a variety of CPD systems among the member countries. While some countries have a strong system, the system still needs to be developed in other countries. The main problem was assessing the quality and outcomes of the CPD system. The speciality and administration of CPD were mentioned at the 3rd workshop. The last workshop will be organised shortly in February 2023. It will focus on lessons learned from all 10 countries and support the countries that have started to develop the CPD system. In addition, the final workshop will focus on how to measure the impact of CPD.

ENDORSED THE AAAH AWARDEES IN 2023

The committee presented and endorsed the names of four AAAH awardees for 2023. The committee also approved nine AAAH recognitions. Some awardees may not be able to attend locally, so the focal point should prepare to receive the award on behalf of the awardee.

THE SCHEDULE OF THE 12TH AAAH CONFERENCE 2023

The schedule has to be revised due to the health of the speakers.

AAAH GOVERNANCE STRUCTURE

Review AAAH organisation structure

Currently, the AAAH has 18 member countries: 9 from the South East Asia Region (SEAR), including Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand; and 9 from the Western Pacific Region (WPR), including Cambodia, China, Fiji, Lao People's Democratic Republic, Mongolia, Papua New Guinea, Philippines, Samoa and Vietnam. The chairperson of the committee alternates between the representatives of the countries from SEAR and WPR. When a country from the Eastern Mediterranean Region (EMR) becomes a member, the representative from that country will also take a turn to chair the committee. The steering committee has approved this arrangement.

AAAH Workplan 2023-2024

The AAAH secretariat proposed 8 HRH issues needed to be addressed, including (1) rural retention and access to the health workforce, (2) HRH information data, National Health Workforce Accounts (NHWA), (3) private oversight, (4) accreditation, (5) multilateral agencies, (6) migration, (7) CPD, and (8) HRH unit. The committee discussed the priorities of the issues. After discussion, three issues were proposed, including (1) primary health care workforce, (2) quality of health workforce, and (3) national health workforce accounts. Finally, the committee agreed on the primary health care workforce issue that will strengthen universal health coverage.

Steering Committee: New member 2023-2024

The steering committee endorsed Jordan from EMR as a new member of AAAH.

Steering Committee: New Chair and Vice Chair

Dr. Mayfong, the vice chairman of AAAH from Lao PDR, will become the chairman next year.

Thus, the position of the vice chair will be vacant. Traditionally, the vice chair of the current term will be promoted to be chairman for the next term. The committee need to select the country where the representative will be the new vice chair. The committee selected Indonesia as the country in which the representative will serve as a new vice chairperson.

SELECTION OF THE HOST COUNTRY FOR THE 13TH AAAH CONFERENCE 2025

Traditionally, the AAAH meeting is hosted by the country in which the representative chairs the committee. The 11th AAAH Conference was held online because of the COVID-19 pandemic situation. Since the pandemic has improved, this year, the AAAH meeting is operated onsite as a side meeting of the PMAC. Therefore, the committee needs to discuss organising the 13th AAAH Conference.

Finally, the committee agreed to organize the meeting traditionally to organize for the next two years. However, the chair suggested that the representative from Lao PDR discuss this with the authorised person in the country.

THE 12TH AAAH CONFERENCE

24th-25th January 2023

Learning from COVID-19 Pandemic

STRENGTHENING HEALTH WORKFORCE AND HEALTH SYSTEM RESILIENCE

BACKGROUND

In 2005, AAAH, a regional partnership mechanism, was launched by 10 founding member countries in response to international recognition of the need for global and regional action to strengthen country capacity for human resource for health (HRH) planning and management. The AAAH is part of a larger movement to enhance HRH development as articulated in Kampala Declaration and the Agenda for Global Action. The AAAH membership is gradually expanded. From 2005 to the present, membership has increased to 18 countries; 9 from the South East Asia (SEA) region including Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka and Thailand, and 9 from the Western Pacific Region (WPR): Cambodia, China, Fiji, Lao PDR, Mongolia, Papua New Guinea, Philippines, Samoa and Vietnam. AAAH coordinates with partners to strengthen joint effort in advocating the HRH, provides technical support and augments country-level HRH development through regional collaboration. It aims to ensure sustained commitments addressing HRH needs through research, and contribution to policy development.

COVID-19
AND HEALTH SYSTEMS

As of November 2022, COVID-19 pandemic has resulted in 642 million infections and 6.6 million mortality worldwide, it has shown how fragile health systems and lack of universal health coverage, trust in government institutions and social cohesion result in poor control and catastrophic outcome—disproportionately affected the poor and vulnerable population. At the pandemic recovery phase, strengthening health system and community resilience especially in low and middle-income countries is essential in boosting preparedness and capacity to better respond to the next public health emergencies. Pandemic has adverse impacts on SDG,[1] where countries need to bring back on track their commitments. Dr. Tedros Adhanom Ghebreyesus, Director-General of the World Health Organization stated that "The COVID-19 pandemic has shown the importance of data and science to build back more resilient health systems and equitably accelerate towards our shared global goals."[2]

The impacts of COVID-19 affect the lives of people in all aspects: physical, mental, social, and financial. COVID-19 among people having some conditions, such as NCD and the elderly are more vulnerable to complications and death from COVID-19, while disruption of in essential care during COVID-19 can lead to mortality of inability to access to life threatening conditions.[3] Since this is the novel and emerging disease, new knowledge, evidence, and new health approaches are needed to manage and control the disease. Collaboration of all health professions are needed. Some health professional regulations are also adapted to enabling multi-disciplinary team members in supporting pandemic responses. However, to tackle these challenges, health policy cannot focus on COVID-19 and hospital. [3] Primary health care in community is essential to resilient health systems in response to COVID-19. Primary health workforce plays an important role in delivering health screening and health care service for people in communities during the acute phase of COVID-19, maintain services for people with chronic conditions, and promote health promotion and prevention, such as advocate and deliver COVID-19 vaccines, health education, and infection prevention and control. Therefore, the primary care systems and workforce are essential for health systems resilience.

IMPACTS OF COVID-19 **ON HEALTH WORKERS AND ACTION PLAN ON HEALTH WORKERS**

Health workers have faced with many challenges from the beginning of COVID-19 pandemic until present. It has dramatically affected lives and heath of health workers. Abdul, Fendt-Newlin, Al-Harahsheh, Campbell reported on "Our duty of care: A global call to action to protect the mental health of health and care workers" in 2022 that prevalence estimates of mental health symptoms among health and care workers during the pandemic range between 23 and 46 percent for anxiety and 20 and 37 percent for depressive symptoms. Health and care workers reported that burnout and moral distress, which affect mental health and wellbeing, and which have long plagued the health workforce, worsened because of the pandemic. Estimates of burnout during the pandemic ranged from 41—52 percent in pooled estimates. Physicians and nurses experienced the highest levels of burnout compared to other health professions. Burnout was associated with increased contact with COVID-19 patients, lack of personal protective equipment (PPE), and work stress. The Action Plan emphasizes the importance of the health and care workforce to the health of populations, to health systems resilience and to economic prosperity and focuses on three key and cross-cutting priority areas: planning and financing, education and employment, and protection and performance.[4]

In May 2022, the Seventy-fifth World Health Assembly adopted the Working for Health 2022—2030 Action Plan as a platform and implementation mechanism for accelerating investments in health and care worker education, skills, jobs, safeguarding and protection. It calls on Member States to implement the Working for Health 2022—2030 Action Plan and integrate, its objectives and actions into workforce planning and financing, education and employment, and protection and performance within their

health and care workforce strategies, investment plans and programmes at national and subnational levels. International, regional, national and local partners and stakeholders from across the health sector and other relevant sectors are also invited to engage in and support implementation of the Working for Health 2022–2030 Action Plan. This Action Plan[5] will support achievement of SDGs and Universal Health Coverage.

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AAAH
CONFERENCE PLATFORM

The conference is a main platform that AAAH has organized for learning and sharing knowledge related to HRH and strengthening HRH capacities among the member countries, HRH experts, and international agencies. The conference was held every year between 2006 and 2012, and then every two years since 2014. Since the COVID-19 pandemic, the 11th AAAH conference in 2020 had changed the conference format to be the webinar series and more focused on health crises on the theme "Addressing Health Care Workers' Challenges in Response to COVID-19: sharing experiences and drawing countries' lessons."

For the 12th AAAH conference, the conference platform will be a side meeting of PMAC conference in 2023 with hybrid approach that include onsite and online conference to gain more opportunities for participants to share their experiences and lesson learn about resiliency of health systems and health workers during post COVID-19.

Venue

Centara Grand & Bangkok Convention Centre
at CentralWorld and online
(hybrid platform)

Date of Conference

1.5 days between 24th and 25th January 2022

CONFERENCE
HOST & CO-HOSTS

World Health Organization
REGIONAL OFFICE FOR Eastern Mediterranean

JICA

Asia-Pacific Action Alliance on Human Resources for Health
A A A H

World Health Organization
Western Pacific Region

USAID
FROM THE AMERICAN PEOPLE

World Health Organization
REGIONAL OFFICE FOR South-East Asia

PMAC PRINCE MAHIDOL AWARD CONFERENCE

iHPP Thailand

OBJECTIVES

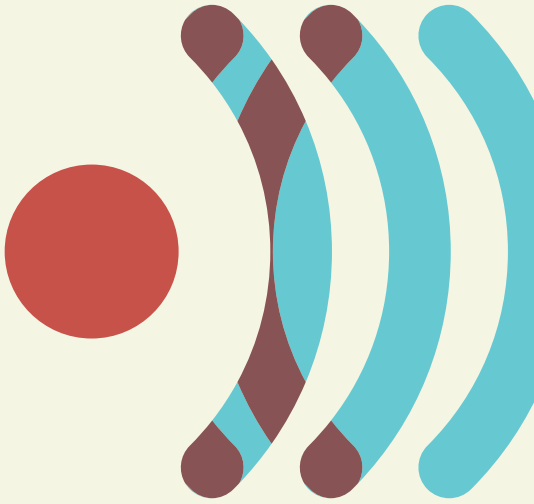
General
objectives

Resilience Strengthening

To update Global Human Resources for Health (HRH) policies, future scenario of health workforce contribution to 2030 Sustainable Development Goal (SDG) 3 commitment;

- impacts of COVID-19 on International migration of health workforce;
- health practitioner regulation and continuing profession education on public health function which support pandemic response;
- roles of Primary Health Care (PHC) workforce in response to population health needs and public health emergencies.

To share good practice on HRH strategies, implementation, and solutions to address challenges of HRH, population health needs and public health emergencies by AAAH members.



OVERVIEW

OF THE 12TH AAAH CONFERENCE

OPENING ADDRESSES

DR. POONAM KHETRAPAL SINGH

Regional Director

WHO South-East Asia Region

DR. TIN TUN

Chairperson

AAAH Steering Committee

OPENING ADDRESSES

DR. POONAM KHETRAPAL SINGH

Regional Director
WHO South-East Asia Region

KEY MESSAGES

It is critical for all countries to protect, safeguard and invest in HRH with a focus on strengthening health workers' production, distribution, employment and protection. It is evident that HRH strengthening has increased the density of doctors, nurses, and midwives by more than 30%, and almost all countries in the region have met or surpassed the original WHO threshold of 22.8 doctors, nurses and midwives per 10,000 population. Moreover, at least two countries, Bangladesh and India, have increased the number of medical colleges and medical students.

IT IS CRITICAL FOR ALL COUNTRIES TO PROTECT, SAFEGUARD AND INVEST IN HRH WITH A FOCUS ON STRENGTHENING HEALTH WORKERS' PRODUCTION, DISTRIBUTION, EMPLOYMENT AND PROTECTION

Smarter investments in HRH are required to align with current and future health needs that respond to labour market dynamics by optimizing the existing health workforce, strengthening multidisciplinary primary health care teams and increasing accountability through better governance. Health workers' safety, motivation, and satisfaction will also increase health worker retention. We need to optimize the existing health workforce, especially at the primary care level involving not only doctors, nurses, but also millions of community health workers.

The COVID-19 pandemic has brought new global interests in strengthening HRH, reorienting health system, and strengthening health security relevant to our regional strategic roadmap for health security and health system resilience in emergencies. In addition, how digital health infrastructure plays an important role aftermath of the pandemic to support primary health care teams should be considered.

Importantly, the Southeast Asia and Asia Pacific region must continue to lead the world in the ethical management of health worker migration. Over the past decade, the number of migrant doctors and nurses working in OECD countries has increased by 60%. In this case, diplomatic and legal issues, giving this, diplomatic and legal issues need to be thoughtfully managed to fine innovative solutions that are grounded in the WHO global code of practice for the international recruitment of health personnel.

OPENING ADDRESSES

DR. TIN TUN

Chairperson
AAAH Steering Committee
Director General
Department of Human Resources
for Health, Ministry of Health and Sports
Myanmar

KEY MESSAGES

AAAH was launched in 2005 with 10-member countries and then expanded to eighteen countries, including 9 countries from South East Asia Region and 9 countries from Western Pacific Region in 2023. The aim is to ensure sustainable commitments addressing HRH needs through research and contribution to policy development. The five priority activities include HRH advocacy, information monitoring, capacity strengthening, knowledge generation, and technology coordination.

Collaborative efforts for equity and quality improvement in the Asia-Pacific Region has conducted in advocating of the HRH, providing technical support, and augmenting country-level of HRH development through regional collaboration. The AAAH conference is the platform for learning and sharing knowledge, success, and lessons among member countries, HRH experts, and international agencies.

The COVID-19 pandemic caused more than 663 million cases and 6.7 million confirmed deaths as of January 20, 2023, showing significant vulnerability of the health system. Nobel healthcare workers have been at higher risk for COVID-19 than the general population. Healthcare workers have been exposed to various challenges and stressful threats. Therefore, the world must build a resilient and sustainable health system during this recovery phase.

WE,

AAAH MEMBERS AND ALL SECTORS INCLUDING INTERNATIONAL AGENCIES, NEED TO WORK TOGETHER CLOSELY AND CONTINUINGLY TO ADDRESS HRH ISSUES NOW AND IN THE FUTURE

WATCH THE FULL SESSION

OPENING ADDRESS

BY DR. TIN TUN

Chairperson
AAAH Steering Committee

AAAH Colleagues, Ministry of Health Delegates, Experts from the Member Countries, Members of the Academia, International Development Agencies, the Private sector, Human Resources for Health (HRH) Advocates, and Ladies and Gentlemen

As chairperson of the Asia Pacific Action Alliance on Human Resources for Health (AAAH) steering committee, I have the honor to welcome you to this 12th AAAH international conference.

As we all know, the Asia Pacific Action Alliance on Human Resources for Health (AAAH) – the regional partnership mechanism – was launched in 2005 as a part of the larger movement for enhancing HRH development articulated in the Kampala Declaration and the Agenda for Global Action. Since the day it launched with 10 founding member countries, the membership has been gradually expanded to 18 countries (9 from the South East Asia Region and 9 from the Western Pacific Region) – as of 2023.

The AAAH aims to ensure sustained commitments addressing HRH needs through research and contribution to policy development. Our five priority actions are

1. HRH Advocacy
2. Information Monitoring
3. Capacity Strengthening
4. Knowledge Generation, and
5. Technical Coordination

Therefore, we coordinate with partners to strengthen 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 by

- putting joint efforts in advocating the HRH,
- providing technical support and
- augmenting country-level HRH development through regional collaboration

The AAAH conference is the main platform that AAAH has organized annually up to the 7th conference and then biennially after 2012 for learning and sharing knowledge, success, and lessons learned related to HRH and strengthening health workforce capacities among the member countries, HRH experts and international agencies.

At respective AAAH conferences, we have looked at different perspectives on HRH strengthening, including:

- HRH for Rural Health and Primary Health Care
- Globalization and its Implications
- Getting committed health workers to the underserved areas
- HRH Challenges for Achieving MDGs and Moving Ahead in the post-2015 era for HRH Strategies and Actions towards Universal Health Coverage
- Building capacity for HRH management and Leadership development for health systems strengthening in the previous annual conferences.
- In addition, by using the AAAH conference as a platform, regional partners discussed Global HRH Strategies 2030: From Strategy to Implementation and reviewed progress updates and shared lessons on implementing the Global Strategy in HRH.

- When the COVID-19 global pandemic occurred in 2020, we put emphasis in addressing health workers' challenges in response to COVID-19 by sharing experiences and drawing countries lessons through virtual webinar series.

Distinguished Delegates, Experts from the Member Countries, and AAAH Colleagues,

As all know, COVID-19 started from December, 2019 and dramatically spread worldwide and becoming the global pandemic in March 2020. As of 20 January 2023, the pandemic had caused more than 663 million cases and 6.7 million confirmed deaths, making it one of the deadliest in history. The COVID-19 pandemic has significantly shown how vulnerabilities in our health systems. It has made an obvious impact in all healthcare sectors, especially in resource-limited countries.

Our Nobel healthcare workers are at higher risk of COVID-19 than the general population. It resulted in many infections and deaths among health workers and their families. They have faced with various challenges and stressful threats that affect their lives, physical, mental and social well-being until now.

The COVID-19 challenge gave a strong message to the world on the need to build a resilient and sustainable health system during this recovery phase. Experiences from the COVID-19 pandemic, we are looking to build swiftly and effectively more secure and resilient health workforce and health systems, suitable and workable to be better prepared for future crises, strengthen pandemic response and public health emergencies and bring back the strategies for SDG 2030 commitments.

Therefore, this year, we are organizing the 12th AAAH conference as the first ever onsite and online hybrid approach. As we come together today with the theme of "to share "Experiences and Learning from the COVID-19 Pandemic: Strengthening Health Workforce and Health System Resilience", we are going to

- Discuss global HRH policies and future scenario of health workforce contribution to 2030 Sustainable Development Goal (SDG 3) commitments
- Present and discuss the COVID-19 pandemic and subsequent economic crisis's impacts on international migration of health workforce
- Draw lessons in supporting pandemic responses: health practitioner regulation and continuing professional education
- Draw lessons from COVID-19: roles of primary health care workforce in response to population health needs and public health emergencies, and

- Discuss how to accelerate implementation of 2030 milestones.
- Therefore, I am sure that this two-day conference will be very interesting, intellectually stimulating, pollinating across member countries and bringing results and call for actions for strengthening HRH.

Distinguished Delegates, Experts from the Member Countries, and AAAH Colleagues,

To conclude my opening address,

I would like to express my sincere thanks to the AAAH Steering Committee and all the stakeholders and experts from 18 member countries, and other countries for your dedication, commitment and enthusiasm for strengthening HRH and health systems resilience.

As we move forward,

- Let us be proactive in health workforce strengthening which is the best response in combating crisis situations including global pandemic
- Let us act unitedly with solidarity to protect our health workforce and communities from the danger of COVID-19 and recover from the impacts of health emergencies and economic crisis
- Let us implement HRH strategic plans, health workforce retention policies and strategies at hard-to-reach and remote areas and making sure of accessibility, acceptability, affordability and quality (AAAQ) of health services delivery to all population regardless of where they live
- Let us think critically and creatively about the actions we can take to bring health safety and make positive changes in the world and strategies to meet the health workforce 2030 milestones
- Let us ensure that the coming years reveal the "best case scenario" for Health

Care Workers and Everyone!

Thank you very much for your attention.

CARE
WORKERS AND
EVERYONE!

KEYNOTE ADDRESS

GLOBAL HRH POLICIES AND FUTURE SCENARIO

OF HEALTH WORKFORCE CONTRIBUTION TO 2030 SDG3 COMMITMENT: TRENDS, CHALLENGES, AND OPPORTUNITIES

KEYNOTE ADDRESS

DR. JIM CAMPBELL

Director, Health Workforce
World Health Organization

KEY MESSAGES

World Health Organization (WHO) has recognized the of the health workforce importance in contributing to the achievence the SDGs by 2030. This year marks the halfway point of the SDGs, and it is time to reflect on the second half of the SDGs, measure progress, and look to the future.

The first half was affected by three Public Health Emergency of International Concern (PHEIC), including Zika, Ebola, and COVID-19. The latest, COVID-19, has had huge impact on health, economic, and education systems. Health systems were overwhelmed by more than 390 million reported cases and estimated 14.9 million deaths (2020-2021). The global economic crisis has worsened, and global poverty and financial inequality have increased. Educational development was disrupted, and nearly 1.6 billion students were affected by school closures and inequitable access to remote learning. Regarding HRH, there have been multiple impacts on health and care workers, including health, social and well-being, working conditions, and availability and distribution.

The second half must address threats to equity and universal health coverage. Although the global Health workforce has grown by 29% (2013 to 2020), half of the workforce serves one-fifth of the population. Global inequities have been evident, especially in the African Region, home to 15% of the world's population but less than 4% of the world's health workers. Although digital technologies will be excellent for the future, they do not replace human interactions. Moreover, workforce inequities are disaggregated by gender. About 67% of the global health and care workforce are women. However, women are undervalued, and the gender pay gap in the sector is approximately 24%. In addition, women are more likely to occupy jobs with larger wage gaps.

THE SECOND HALF MUST ADDRESS THREATS TO EQUITY AND UNIVERSAL HEALTH COVERAGE. ALTHOUGH THE GLOBAL HEALTH WORKFORCE IS GROWING BY 29% (2013 TO 2020), ONLY HALF THE WORKFORCE SERVES ONE-FIFTH OF THE POPULATION.

GLOBAL INEQUITIES HAVE BEEN EVIDENT

However, there will be opportunities at these significant meetings, including the 5th Global Forum on HRH, the 2nd High-Level Meeting on UHC, the 1st High-Level Meeting on Pandemic Preparedness, Prevention, and Response, the High-Level Meeting on Financing for Development. The 5th Global Forum on HRH will focus on three action areas, including 1) defining function and services, 2) competency-based education, and 3) mapping and measuring occupations.

MAJOR ISSUES

The impact of COVID-19 on HRH is a challenge to the health workforce's contribution to achieving the 2030 SDG3 commitment.

A threat to equity and "universal" health coverage. SDG3 indicator 3.c.1 focuses on density and distribution, but there is still a global shortage and maldistribution of HRH.

SUGGESTIONS/ RECOMMENDATIONS

The 5th Global Forum on HRH will be an opportunity for HRH contribution to 2030 SDG3 commitment aiming to:

ONE

Drive national multi-sectoral political engagement to address workforce challenges of UHC and essential public health functions, including emergency preparedness and response.

TWO

Develop consensus on priority workforce solutions to inform preparation for the United Nations High-Level Meeting on Universal Health Coverage and Emergency Preparedness in September 2023.

THREE

Inform and influence national and international investments in education and jobs.

FOUR

Launch a Multi-Sectoral Advisory Group of Experts (M-SAGE)

SESSION 2

WATCH THE FULL SESSION

COVID-19 AND SUBSEQUENT ECONOMIC CRISIS

IMPACTS ON INTERNATIONAL MIGRATION OF HEALTH WORKFORCE

SESSION 2

SPEAKERS

Dr. James Campbell
Director, Health Workforce, WHO HQ

Topic
WHO Global Code of Practice on the International Recruitment of Health Personnel

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Mr. Dave Howarth
Head of International Workforce
Department of Health and Social Care
United Kingdom (Pre-record)

Topic
International recruitment and long term trends response to COVID-19, using international recruitment; Government-to-Government agreements to boost internationally-recruited nurse numbers and the ethical framework

MODERATOR

Dr. Ibadat Dhillon
Regional Advisor
(Human Resources for Health)
Health System Development, WHO SEARO

KEY MESSAGES

The WHO Global Code of Practice on the International Recruitment of Health Personnel has been adopted since 2010 at the 63rd World Health Assembly. This Code includes four objectives with 10 articles, and the Member States agree on these articles, which are recommended as the basis for action. Dr. Jim Campbell highlighted the recommendations in the WHO Expert Advisory Group report on the relevance and effectiveness of the Code, which was held in 2020 during the COVID-19 pandemic and after the Code had been implemented for 10 years. Dr. Campbell emphasised that countries with low UHC Service Coverage Index and health professional density should be identified, supported and safeguarded. He said that WHO Secretariat would update the list alongside scheduled progress reports on the Code implementation to the WHA every three years. He indicated that the first report, "Health Workforce Support and Safeguards List, 2020", was published in 2021. Forty-seven countries with low UHC Service Coverage Index and health professional density were identified, supported and safeguarded. These countries should be prioritized for health personnel development and health system-related support, provided with safeguards that discourage active international recruitment of health personnel, and best practiced with the government-to-government agreements on health worker mobility from these countries. The impacts of COVID-19 on the Code implementation along with some sources of multiple economic and health vulnerabilities with the migration, are also highlighted. Dr. Campbell finally addressed that the Support and Safeguards List should respond to the additional vulnerabilities that emerged during the COVID-19 pandemic and identify countries requiring additional support and safeguards.

Based on the experience of the Code implementation facing vulnerabilities that emerged during the COVID-19 pandemic, Dave Howarth illustrated how the UK responded to COVID-19 with regards to the international healthcare workforce, how these governments made agreements to boost the recruitment of healthcare workers in a managed way, and how they ensured that international companies acted ethically. Before the COVID-19 pandemic in the UK, two major policy commitments

impacted international health workers' recruitment. The first commitment was that there would be 50,000 more nurses working in the National Health Service. The second commitment was the introduction of the NHS visa, which later became known as the Health and Care Visa. It is cheaper and quicker for nurses, doctors, or healthcare professionals to come to the UK on the fast track. Clearly, the UK needed to rely heavily on international agreements to increase the number of nurses, as training 50,000 nurses domestically was very challenging.

During COVID-19, the UK took necessary actions to protect international staff with health services. The visas that were due to expire in the next six months were automatically renewed free of charge. The extended visas were renewed for another two years as COVID-19 continued. The UK also engaged heavily with groups of HRH leaders to ensure that overseas staff do not put themselves at greater risk by taking on too many shifts or failing to speak up. The UK also had to increase special privileges for nurses to meet the 50K target. Therefore, the UK launched a program where employers would be incentivized to recruit health professionals rapidly to meet this target and respond to the COVID-19 pandemic.

In 2020, the UK signed a Memorandum of Understanding with Sri Lanka, Malaysia, Kenya, and Nepal to build new supply chains for nurses coming to the UK. It formalized the relationships with India to the formation of a health workforce agreement and the government of the Philippines. However, working in new countries was challenging. The application process and the requirements were discussed regarding managing and controlling the process when nurses directly applied for jobs in the UK. An approach of the pool was to work hand in hand with the government, ensuring their safeguards were in place in the process of support side. The government pool would be responsible for sourcing candidates and ensuring their trainees were prepared to work in the UK.

THE UK NEEDED TO RELY HEAVILY ON INTERNATIONAL AGREEMENTS TO INCREASE THE NUMBER OF NURSES, AS TRAINING 50,000 NURSES DOMESTICALLY WAS VERY CHALLENGING

In terms of recruitment agencies, they had to be recognized when offering the same level of services to employ more capital. Red list countries were the countries where the UK did not allow recruiters unless a government brought them into place.

The UK plan was to start with the group campaign in the next couple of months or would initially enrol about 100 nurses. The government controlled the flow of working part of the government to give opportunities for nurses to come and work in the UK. Many countries facilitated short-term placements for nurses from two to three years for nurses to gain their experience in the UK's National Health Service before they came back and used their skills in their home countries. However, employers mostly wanted to employ nurses on a long-term basis. They did not want to invest time, resources, and energy in training someone who would leave within two years. These employers finally did not meet the code of the migration practice, while the UK wanted to be sure that this was ethical to do so at all times. To be ethical for the source country, the process requirements had to be fair and transparent and not contribute to workforce shortages and healthcare sectors that least afforded or grained training. This process was commonly known for a reason which was fully committed to the WHO lists of countries that should not be targeted for active recruitment.

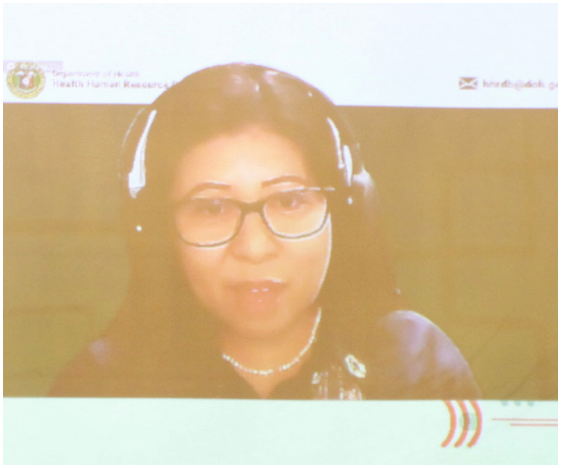
In early 2021, the new revised UK code of Practice was published which included four key principles, which were 1) international migration of healthcare talent, 2) no active recruitment from red list countries, 3) ensuring the migrants understand the approval process and are not charged for a job seeking, and 4) recruiting people who were well-skilled, had excellent English, and met the job experience requirements.

COUNTRY REFLECTION

Dr. Gamege Samantha Prabath Ranasinghe
Director Primary Care Services
and Acting Director Training
Representative from Sri Lanka

Dr. Pretchell P. Tolentino
Director of the DOH Health Human Resource
Development Bureau, Philippines
Representative from Philippines (online)

Dr. Myrna Doumit
Associate Professor
The American University of Beirut (AUB)
Representative from Lebanon (online)



REFLECTION

Mr. Lluis Vinals Torres
Coordinator, Health Policy and Service Design
WHO WPRO

Dr. Awad Mataria
Director
Universal Health Coverage/Health Systems
WHO EMRO (Online)

COUNTRY REFLECTION

The impacts of the COVID-19 pandemic on the international migration of the health workforce were indicated. Sri Lanka had three waves of COVID-19 pandemics with different numbers of COVID-19 cases. Several country activities were done in response to the pandemic, such as infrastructure development, patient transportation, staff training, staff wellbeing (Mental well-being, incentives, special leave, accommodations etc.), intermediate care centers, task shifting and task sharing, and guidelines and protocols (Patients management, Transportation, PPE usage).

The COVID-19 pandemic profoundly impacted Sri Lanka with a large state service. The government sorted measures to reduce the number of government employees by encouraging retirement and promoting foreign employment on a no-pay basis to the government sector, including the healthcare sector. Skilled citizens of Sri Lanka started searching for foreign employment to escape the growing economic constraints. Sri Lanka faced the challenges of health manpower management with the recent government policies of foreign and local leave schemes,

STRENGTHENING PRIMARY CARE THROUGH EDUCATION AND CERTIFICATION WAS FIRST IMPLEMENTED TO ENCOURAGE HEALTH PROFESSIONALS TO STAY

EXPANDING AND BOOSTING PRE AND POST-SERVICE SCHOLARSHIPS WERE ALSO PROVIDED TO THE HEALTH PROFESSIONALS.

which impacted the migration of all health professionals. The migration of highly skilled and experienced health professionals was found especially from Sri Lanka to well-developed countries. The migration of other allied health professionals was also observed due to the high demands of these professionals in different countries with easy registration systems.

Because of dramatic migration situations above, contingency measures were being drawn up to address the possible shortcomings by redistributing the available health workforce and increasing production in Sri Lanka. By 2025, Sri Lanka expects to increase the number of enrolled health-related students, especially physicians and nurses, to fill the gap of medical workforce shortages.

The low HRH production and high migration rates were found in the Philippines, resulting in HRH shortages in health facilities. Based on the SDG indicators, the HRH demand was higher than the HRH supply with low HRH production in the Philippines. The number of health professional migrants was high. Of the 819,099 registered health professionals, around 340,423 professionals annually migrate. The number of nurses represented only 50% of the demand. Nurses were the highest migrating health professionals. The migration of health professionals was even higher during the pandemic than at other times.

Moreover, the uncontrolled or easing deployment of HRH might cause collapses in the future workforce as the number of health workers that migrated out was almost equal to the retained workforce in the Philippines. Hence, the Philippines had to apply several strategies to maintain a healthy workforce in the country, including increasing investments in health workforce recruitment and production, capacitating the health workers for all health situations, building on the retention strategies such as providing more benefits and intensive, controlling HRH migration, and utilising multi-sectoral managements.

Nowadays, all strategies are continued to improve the situation of HRH workforce shortages and diminish the migration rate. Strengthening primary care through education and certification was first implemented to encourage health professionals to stay. Expanding and boosting pre and post-service scholarships were also provided to the health professionals. Next, the proposed deals to improve the compensation and benefits for health professionals were managed. The additional ongoing work was improving the working conditions of health professionals, such as career parts, scholarships, and compensations. The final ongoing one looked at implementing a deployment cap among health-related occupations in the mission of critical skills and delisting occupations with no available data and information.

Lebanon also faced a high rate of nursing migration during the pandemic in 2019. Dr. Myrna Doumit from Lebanon provided data and emphasised several important points regarding the country's experience. She firstly indicated that the country lost many experienced nurses, especially those were able to speak other languages as they moved to work in other countries. Lebanon tried to work on strengthening the infrastructure to keep nurses in the country.

Nevertheless, the nurses in the country faced an economic crisis because they needed more money to spend on living and caring for their parents and family. These nurses had to find other ways to earn more money by seeking new job opportunities or even travelling to another country. To protect these nurses, Lebanon developed strategies to promote them to work in the country by providing resources to improve their quality of life, ensure safety in the workplace, and promote inclusivity. The ultimate goal of retaining the health workforce, especially nurses in Lebanon, is to balance demand and supply. Therefore, to improve patient safety and quality of care in health care systems, providing a positive working environment

NEXT, THE PROPOSED DEALS TO IMPROVE

THE COMPENSATION AND BENEFITS

FOR HEALTH PROFESSIONALS WERE MANAGED

for the health workforce is imperative to promote nurses to have their rights to work and stay in a safe working environment and have adequate remuneration, access to resources, education, and participate in the decision-making process. Nurses' opinions must be represented at the highest level of health leadership, and their opinions should be integrated into decision-making to empower them. Dr. Doumit finally called for NHS, ICN, WHO, and other key people who were major players in the healthcare arena to support the nursing workforce worldwide.

REFLECTION AND DISCUSSION

Resilience

Strengthening

Transferring knowledge and experiences learned from all countries when facing situations of health workforce shortages to the policy at the national and international levels is required. However, mostly the data about the health workforce shortage came from the public sector, while the situation of the shortage from the private sector, which has been taking part in health service for almost 30 years, was unclear. Hence, the data of the private sector situation had to be transparent and gathered in order to understand the health workforce situations and add the data from the private sector in the country workforce platform. As this was a global issue, not only should the Member States consider the quantity of the nursing profession in the health system, but they should also focus on the quality of health care followed by the health workforce shortage issue. The Member States should support the nursing institutions to produce more highly qualified nurses in the health system.

MAJOR ISSUES

How Member States manage challenges of migration issues and service deliveries

Current impact on services and the country's ability to address issue

Strategies that can be used to deal with migration issues and retaining and bringing back trained providers to home countries

The salary gap between nurses and other health personnels and physician

SUGGESTIONS/ RECOMMENDATIONS

Sri Lanka is still facing workforce shortages due to the economic crisis. Healthcare professionals have left the country for better remuneration and welfare. Although they overseas for training, some of theme did not come back to serve the country. Therefore, migration severely affected the numbers of the health workforce, and Sri Lanka had to increase domestic production to support population health needs.

Although having approach platforms, Indonesia was unable to stop nurses from working overseas as they earn more income. Hence, the government need to balance the economy and health. Indonesia focused on sustaining production, improving production, and balancing the health workforce's production and migration.

Based on the question regarding the difference of the salaries among physicians, nurses, and other health personnel, the panel agreed that the Member States had to pay more attention to salary balance. Living expenditure needs to be addressed rather than salary comparison among different professions.

Their continuing education and career paths had to be addressed for the physical and psychological health workforce.

Finally, in terms of the migration issue, the Member States had to set up the global regulation and policies to keep nurses and other health workforce in the country, such as the limitation of working period, the permission to move from country to country, and the provision of the safe working environment for nurses, putting nurses in a proper position on an equal footing with other health workforce, so that their voices can be heard.

SESSION 3

WATCH THE FULL SESSION

HEALTH PRACTITIONER REGULATION AND CONTINUING PROFESSION EDUCATION

DRAWING LESSONS IN SUPPORTING PANDEMIC RESPONSES

SESSION 3

PRESENTERS

Dr. Ibadat Dhillon
Regional Advisor
(Human Resources for Health) Health System Development, WHO SEARO

Assoc. Prof. Dr. Haruka Sakamoto
Tokyo Women's Medical University
JICA Ogata Research Institute

CHAIR

Dr. Fethiye Gulin Gedik
Coordinator
Health Workforce
WHO EMRO

KEY MESSAGES

THE GAPS IN HEALTH SYSTEMS AND THE HEALTH WORKFORCE WERE EXPOSED OBVIOUSLY DURING THE COVID-19 PANDEMIC.

... THE QUALITY OF HRH NEEDS TO BE IMPROVED THROUGH CPD

Health practitioner regulation, as a core mechanism to mediate the health labor market and ensure health workforce quality, is not always aligned with health system needs and service delivery priorities. The gaps in health systems and the health workforce were exposed obviously during the COVID-19 pandemic. Progress in service delivery and poverty alleviation was interrupted. Although the number of health workers, especially physicians and nurses, has increased in many countries in response to the pandemic, the quality of HRH needs to be improved through CPD.

The situation of COVID-19 pandemic has raised concerns about healthcare workforce preparedness and quality assurance. New knowledge and skills of HRH in response to intensifying health challenges, including the rise of NCDs, the increasing frequency and severity of new pathogens, and the impacts of demographic, economic, social, and climate changes, are

needed. Dr. Haruka Sakamoto reported on how the country compensated for the shortage of HRH during the pandemic by increasing the number of HRH by reducing the relative workload and mobilizing HRH from overseas or other provinces, as well as recruiting volunteers from health profession students and retired personnel. It raised questions about the preparation of those HRH and the patients' outcomes between specialists and those mobilized for the pandemic.

The COVID-19 pandemic also opened the opportunity to enable the PHC-oriented health system. The HRH in PHC included traditional medicine professionals, associate professionals, and community health workers. Health partners in the community, both public and private sectors, should collaborate to monitor and provide health care for COVID-19 patients at home using a holistic approach.

The advanced information and communication technologies have been used to improve the quality of care and to reduce the burden on healthcare providers during the pandemic. Professor Rowaida Al Maaitah suggested that data guide evidence-based policy and decisions. The accurate HRH data are needed for better management, including task shifting, personnel mobilizing, capacity building, providing incentives and compensation, and organizing health services.

THERE IS WIDESPREAD CONCERN THAT THE HEALTH PRACTITIONER REGULATORY SYSTEM OFTEN SERVES A RENT EXTRACTION RATHER THAN IMPROVING THE QUALITY OF EDUCATION AND PRACTICE

Health practitioner regulatory systems across the country are under pressure. This is due to the increasing share of the private sector in health profession education, the importance of previously unregulated occupations, new occupations, emergencies and humanitarian crises, international mobility, cross-border service delivery, consumer demand, expectation and knowledge. The diversity of each country's context and health system has led to differences in health practitioner regulation. There is widespread concern that the health practitioner regulatory system often serves a rent extraction rather than improving the quality of education and practice.

COUNTRY PRESENTATION

Ms. drg. Leni Kuswandari
Project Management office
Directorate General of Health Workforce, Indonesia
Representative from Indonesia

Prof. Rowaida ALMaaitah
HE Professor
Board Member of JNC Board of Directors
President, Board of Trustees at Yarmouk University, Consultant for Her Royal Highness Princess, Jordan
Representative from Jordan (online)

Ms. Sengthida Sivilay
Ministry of Health Lao PDR
Representative from LAO PDR

REFLECTION

Prof. James Buchan
WHO CC, UTS
Australia (online)

Dr. Thinakorn Noree
Senior Researcher
International Health Policy Program (IHPP)
Thailand

MAJOR ISSUES

The COVID-19 impacted not only patients but also the health care providers, especially the mental and physical health of the HRH. Burnout and mental health of healthcare workers are major issues in all countries.

Health practitioner regulations are not always aligned with health system needs and service delivery priorities. The increasing volume of the private sector in health profession education raised an issue of how to align health workforce regulations with the role and function of the public and private sectors for maximizing population benefits.

The CPD needs to be transformed to ensure the quality of the health workforce and complete consumer expectations regarding disease control, curing, and recovery at the tertiary, secondary, and primary healthcare levels. The undergraduate and continuing education curriculum needs to be adapted to match the increasing demands.

PREPAREDNESS IS KEY

SOLUTIONS/SUGGESTIONS/ RECOMMENDATIONS

It is important to prepare HRH during time without a health crisis or emergency as Dr. Haruka said, “Preparedness is key”

As a country where natural disasters occur frequently, Japan is well prepared for emergency situations. During the COVID-19 pandemic, many training programs were developed and implemented for medical professionals by the Ministry of Education and the Ministry of Health while proper preparation will equip the HRH with knowledge and skills, appropriate incentives and compensations are also needed.

Interrelated thematic areas, including HRH for the private sector, service delivery, community health, preparedness for emergencies, planning, and governance, should be discussed for feasibility and priority in order to formulate short term actions within 1-2 years, medium-term actions within 2-5 years, and long-term actions over 5 years.

The health curriculum should focus not only on specialization but also training curriculum to serve primary health care, utilization of digital platforms, disease control, case management, and humanize health care.

SESSION 4

WATCH THE FULL SESSION

ROLES OF PHC WORKFORCE IN RESPONSE TO POPULATION HEALTH NEEDS AND PUBLIC HEALTH EMERGENCIES

DRAWING LESSONS FROM COVID-19

SESSION 4

PRESENTERS

Ms. Ariella Camera
Local Capacity and Partnership Advisor
Accelerating Primary Health Care Collaborative (APHC-C), USAID

Dr. Fethiye Gulin Gedik
Coordinator, Health Workforce
WHO EMRO

MODERATOR

Ms. Sweta Saxena
Health Systems Advisor
USAID/ASIA

COUNTRY PRESENTATION

Situation of health practitioner regulation and continuing profession education in response to the COVID-19 pandemic, challenges, and its solution

Dr. Komain Tewthong
Deputy Director
Bureau of Primary Care Support
Office of Permanent Secretary
Ministry of Public Health, Thailand
Representative from Thailand

Ms. Agnes Pawiong,
The Executive Manager
Strategic Policy Division
Representative from Papua New Guinea

Dr. Ahmad Nejatian
Technical Deputy and Director
International Affairs of Undersecretary
for Development and Resource Management
of the MoHME
Representative from Iran

REFLECTION

Dr. Liaquat Ali
Founder
Pothikrit Institute of Health Studies (PIHS)
Bangladesh
Expert on SEAR PHC Strategy

Dr. Elsheikh Badr
DG of Human Resources for Healt
President of Sudan Medical Specialty Board
Representative from Sudan (Online)

KEY MESSAGES

WE SHOULD FORGET ABOUT LIMITED CONCEPTS OF PRIMARY HEALTHCARE BASED ON THE AREA.
WE SHOULD THINK ABOUT REAL SERVICES OF PRIMARY HEALTHCARE

DR. LIAQUAT ALI

Dr. Gedik mentioned that the COVID-19 pandemic has significantly impacted primary healthcare, leading to changes in how healthcare is delivered in many countries. He also stated that primary healthcare implanted at policy level and that the definition requires improvement. In addition, Ms. Pawiong asserted that the primary healthcare and services are essential meeting population health needs in the pandemic to prevent and control the spread of the virus. Ms. Camera also stated that primary healthcare is essential for strengthening the health system and universal health coverage to achieve the SDGs. Dr. Nejatian explained that in response to COVID-19, primary healthcare in Iran has changed the system structure, system content, and program and designed outpatient treatment protocol at the first level of care.

Meanwhile, Dr. Tewthong described that Thailand had developed the primary health care model through the comprehensive Covid-19 response team and the mechanism of community participation in management and inflection control. Moreover, Ms. Pawiong added that primary healthcare in Papua New Guinea has responded to emergencies and health needs to help vulnerable groups cope with anxiety, maintain the delivery of essential health services, and enhance existing surveillance to strengthen risk communication and community engagement. Dr. Ali reflected that despite the catastrophes of the COVID-19 pandemic, many opportunities have emerged for a paradigm shift in health care, including rectifying over-medication in health, better understand socio-environmental determinants and multi-sectoral nature of health, scoping

to communicate the message to policy-makers and to people, and understanding the global crisis and collective responsibility. Primary healthcare can provide care to patients in need specialised good.

Ms. Camera mentioned that USAID, the AAAH, and all sectors must work together closely and continuously to address the HRH issue and reform international immigration law, which focuses on capacity and government collaboration). Dr. Gedik stated that countries must work to ensure that international migration of health personnel should not undermine the ability of countries, particularly developing countries, to meet the health needs of their population. Ms. Camera also suggested that strategic and systems-oriented investments in the region that fosters regional and country ownership and capacity building for local institutions leveraging the USG are investments for accelerated impact to ensure greater coordination across programs and alignment with regional and government priorities. USAID should collaborate with AAAH to strengthen primary healthcare by investing in a comprehensive workforce. Moreover, leveraging opportunities across donors supports primary healthcare efforts in Asia and should identify lessons learned and best practices to inform HWI and APHC-C efforts across countries. Dr. Gedik pointed out that addressing HRH issues requires health governance capacity, high-level commitment, and multisectoral collaboration to ensure that international migration of health personnel should not undermine the ability of countries, particularly developing countries, to meet the health needs of their population. Ms. Pawiong emphasised that Papua New Guinea also needs social services in the coordination sector to provide education potentiation, transformative services, and development partners to meet the principles of primary healthcare.

THUS, THE SUCCESS OF PHC DEPENDS ON AN INTERSECTORAL APPROACH

DR. LIAQUAT ALI

ADEQUATE QUANTITY, COMPETENCY LEVELS AND DISTRIBUTION OF A COMMITTED MULTIDISCIPLINARY PRIMARY HEALTH CARE WORKFORCE THAT INCLUDES FACILITY- OUTREACH- AND COMMUNITY-BASED HEALTH WORKERS SUPPORTED THROUGH EFFECTIVE MANAGEMENT, SUPERVISION, AND APPROPRIATE COMPENSATION

WHO
CITED BY
DR. FETHIYE GULIN GEDIK

Dr. Gedik pointed out that health workers play an important role in contact tracing and delivering primary healthcare. Dr. Badr also said that the multidisciplinary PHC workforce is a crucial tool utilized and mobilized throughout the country to support healthcare services during the COVID-19 pandemic for patients who need specialized care. He said, "The multidisciplinary primary healthcare workforce is a key instrument utilized and mobilized throughout the country to support healthcare services during the COVID-19 pandemic." Ms. Pawiong suggested strengthening PHC workforce availability, competency, and performance of a multidisciplinary PHC workforce team, decentralization, and PHC data to increase the likelihood of survival, reduce function loss, and reduce the risk of infection transmission to contacts and health workers. Dr. Nejatian mentioned that the health workforce also requires ethical principles and professional standards. Dr. Nejatian also stated that Iran used the maximum potential of community health workers, including leave for mothers with breastfeeding or staff with chronic diseases and increasing the length of compulsory service duty of health professional graduates. Dr. Gedik concluded that countries need to create decent working conditions and appropriate compensation for health professionals and other health personnel working at the primary healthcare level to address people's health needs in a multidisciplinary context effectively.

INVESTMENTS IN THE PRIMARY HEALTHCARE WORKFORCE IS A CORE AGILITY AND HEALTH SYSTEM WITH THE MOST SIGNIFICANT INEQUITIES AND LOW AND MIDDLE-INCOME COUNTRIES

MS. ARIELLA CAMERA

Ms. Pawiong and Dr. Tewthong pointed out that the ability to respond to the outbreaks of infectious diseases during the COVID-19 pandemic has highlighted the need for countries to have robust healthcare systems. Dr. Gedik addressed that governments need to invest in the education, training, recruitment, development, motivation, and retention of primary healthcare workers with an appropriate skill mix. Dr. Gedik and Dr. Tewthong said that essential public health competencies are crucial to educating the public about COVID-19. These include preventive measures and symptom management, health promotion, health protection, emergencies, communication, public health service, and research required in the health workforce to develop quality care. For example, after the Covid-19 pandemic, human resource managers in Thailand have created and performed training courses using a "system-based approach" (Local training) to build the capacity for the multidisciplinary team-based approach on the "Triple AIM" target, incentive mechanism, recruitment, and service delivery model.

Meanwhile, Ms. Pawiong said that Papua New Guinea also needs social services in the coordination sector to provide education potentiation, transformative services, and development partners to meet the principles of primary healthcare. Healthcare regulation and CPD are essential but need to be improved and tailored to the country's context, Dr. Gedik said. He also stated that the primary healthcare workforce is a central element of primary healthcare, according to WHO.

Dr. Gedik stated that providing financial resources also plays a significant role in response to the COVID-19 pandemic; many international organizations, including the World Health Organization (WHO), have provided financial resources to support the response to COVID-19. In addition, countries need to invest in HRH research and outcome evaluation for using the research findings to formulate evidence-based policy and guide the direction of implementation. Ms. Camera concluded that strategic and systems-focused regional investments foster regional and country ownership and capacity building for local institutions and leverage USG investments for accelerated impact to ensure greater coordination across programs and alignment with regional and government priorities.

MAJOR ISSUES

Ms. Camera pointed out that ongoing efforts to integrate local health systems addressed issues that affect health systems. For example, incorporating referral networks through primary care provider networks and advocating for pooled health financing into the special health fund is a new acceleration model. Dr. Tewthong addressed that the comprehensive COVID-19 response team and the mechanism of community participation in management and infection control are essential factors in responding to the pandemic.

Dr. Ali stated that one of the concepts that have been markedly changed is the concept of primary healthcare, which is now emphasizes more on "equity" and "multidisciplinary team," especially Strategic Action 7 of Southeast Asia (SEA) Regional Strategy for Primary Health Care 2022-2030: strengthening the availability, competence, and performance of a multidisciplinary primary healthcare workforce team.

EMPHASIZES

EQUITY AND

MULTIDISCIPLINARY TEAM

Ms. Camera reported that health workers' burden for prolonged work in healthcare systems to support performance is a concern. Strengthening primary health care addresses the fragility of global health systems and overburden workers. She also stated that maximizing the use of resources in the country and mobilizing additional resources and partnerships with country governments, and optimizing health systems delivery of integrated services by skilled healthcare workers play an essential role in response to COVID-19. She also addressed that changing the organizational culture between physicians and nurses can improve efficiencies and service delivery and strengthen resilience. Ms. Pawiong stated that using partnership and people empowerment in effectively providing essential health services that are community-based, accessible, acceptable, and sustainable at an affordable cost for the community and the government can reduce the health workforce's burden.

Dr. Gedik said that the quality and performance of the healthcare workforce play a significant role in creating guidelines to develop a workforce competency framework for essential public health functions consisting of identifying staff development needs; creating the required skills and experiences, assessing current capacity, informing the development of training plans and strategies, serving education and training at undergraduate and postgraduate and CPD levels in response to population health needs and public health emergencies drawing lessons from COVID-19. In addition, Dr. Nejatian claimed that the work of participatory healthcare teams should include contact tracing teams, home healthcare teams, supervisory teams, and support teams and correspond to each healthcare team's role in response to COVID-19.

SUGGESTIONS/ RECOMMENDATIONS

Dr. Ali suggested that primary health care should form an integral part of the health system as it is the first level of contact between the individual and the community, bringing healthcare as close as possible to where people live and work. In addition, he also recommended that primary healthcare should be the nucleus of the community's overall social and economic development.

Dr. Gedik suggested that WHO should analyse the health labor market and generate improved data and evidence on the health workforce to offer beeter policies to develop strategic plans for health workers' health and well-being. In the policymaker's point of view, this issue plays a significant role in making a clear cut to categorize for PHC workers. Moreover, enhancing education capacity building should be emphasised as an essential aspect of the response to the COVID-19 pandemic at the international level.

WE NEED TO

REVITALIZE THE NATIONAL PUBLIC HEALTH INSTITUTE

TO ESTABLISH A COMPREHENSIVELY DECENTRALIZED MODEL BY LINKING TO THE LOCAL GOVERNMENT TO HAS BEEN A TREMENDOUS SUCCESS IN THE EMPLOYMENT AND DETENTION OF THE PHC WORKFORCE

WE NEED TO

FOCUS ON THE PUBLIC HEALTH WORKFORCE IN TERMS OF THE TRAINING PROGRAM AND DETENTION,

PARTICULARLY IN RURAL HEALTH CARE SETTINGS, SUCH AS IMPROVING THE WORK ENVIRONMENT TO BE SAFER

DR. ELSHEIKH BADR

Dr. Gedik suggested that WHO should secure adequate funding to invest in the production and employment of health workers, strengthen health workforce governance and regulation and provide an enabling working environment, and benchmark the functions, sub-functions, and tasks in delivering Essential Public Health Functions (EPHFs).

INVESTMENTS IN THE PRIMARY HEALTHCARE WORKFORCE IS A CORE AGILITY AND HEALTH SYSTEM

WITH THE MOST SIGNIFICANT INEQUITIES AND LOW AND MIDDLE-INCOME COUNTRIES

MS. ARIELLA CAMERA

PHC HWF MUST BE PART OF THE POST-COVID STORY BOTH TO DIG THE WORLD OUT OF THE COVID DITCH AND TO PREVENT SIMILAR CATASTROPHES FROM FUTURE OCCURRENCE

IN CONCLUSION, UNLESS THE PRESENT COMMUNITY-DISSOCIATED HEALTH SYSTEM LEADING TO EXTREME INEQUITY IS REVISITED RIGHT NOW AND ACHIEVING UNIVERSAL HEALTH COVERAGE (UHC) AND SUSTAINABLE DEVELOPMENT GOAL (SDG) 3 WILL REMAIN A DREAM

DR. LIAQUAT ALI

SESSION 5

WATCH THE FULL SESSION

ACCELERATE IMPLEMENTATION OF 2030 MILESTONES

AND CONFERENCE WRAPS UP

Resilience Strengthening

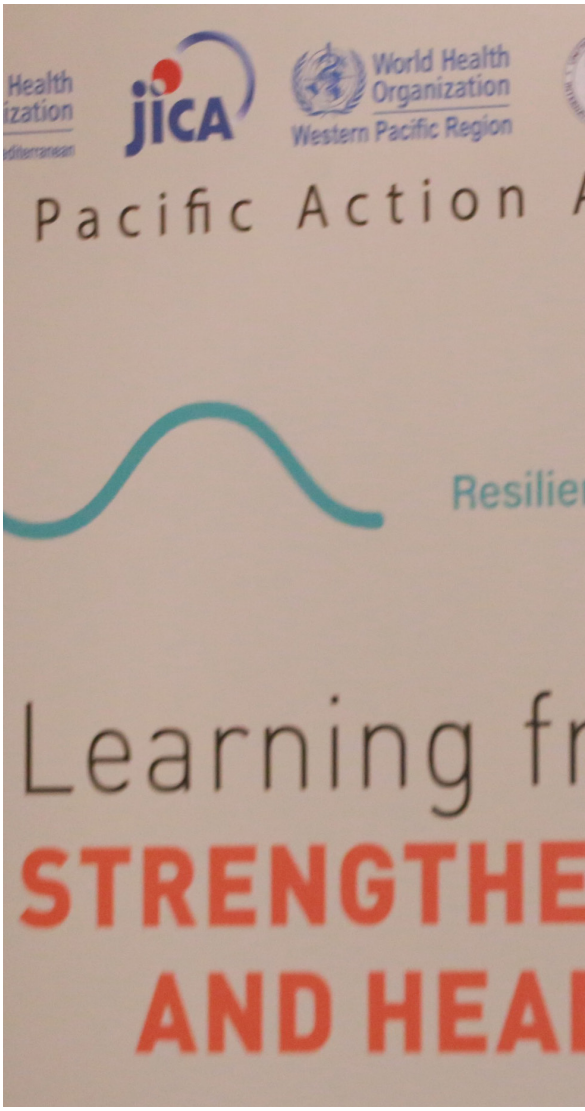
SESSION 5

CHAIR

Dr. James Campbell
Director, Health Workforce
WHO HQ

GROUP DISCUSSION

- Priorities and how to accelerate implementation of unfinished 2020 milestones and 2030 milestones at COVID-19 recovery period
- Forward looking and drawing lesson from COVID-19



CONFERENCE WRAPS UP BY AAAH SECRETARIAT

- Conference wrap up by Dr. Panarut Wisawatapnimit, AAAH and Faculty of Nursing, Praboromarajchanok Institute, Thailand
- Reflection and commitment from countries and partners towards HRH and 2030 milestones

KEY MESSAGES

Dr. James Campbell, Director Health Workforce, WHO HQ, encouraged the participants to prioritise the milestones and the first set of tasks to complete after attending the conference. The participants were divided into three groups to discuss these issues.

GROUP DISCUSSION

Increasing the quantity of all health professionals, including doctors, nurses, and other health care workers, was the first priority of discussion among participants in the first group, who were from Myanmar, Indonesia, Bhutan, and Lao PDR. The representative from Lao PDR identified three other priorities, including the establishment of accreditation mechanisms for health care training institutions and the licensing process for health care workers, the development of policies for HRH to support the HRH 2030 milestones, and the use of ICT to develop systems to collect data from the private and other sectors.

Primary health care was the first priority of the second group, whose members came from Bangladesh, Sri Lanka, Myanmar, Nepal, and Namibia. The focus was on increasing investment in primary health care across all four dimensions of health care services, health expenditure, and health care delivery. One member of the group emphasised primary health care locations, budget proportions, and increase in investment in primary health care. The primary health care package was also addressed by one of the members.

The unfinished milestones in 2020 was prioritised by the last group who they addressed the goals being achieved and new path could be used to support the milestones. Recently, new emerging diseases have been found in several countries, such across North America, Europe, and India.

Dr. Cambell summarized two key points mentioned by member states. The discussion centred on primary health care and the commitment across the countries that have learned from the pandemic to strengthening health systems. The question is how to achieve the next milestones related to the reported data. WHO will ensure that member states are able to replicate them. The assessment was not only about primary health care but also about the capacity of institutions to assess and report on primary health care annually. This is an obligation of the Ministry of Health to develop strategies. Regarding primary health care, the real challenges were that the Member States had different experiences, used different primary health care models, and had different primary health care classifications.

The AAAH will lead a conversation on how countries can learn from each other by sharing information on country classification criteria that are explicit in-country national policies.

A Thai representative shared a success story about the primary health care workforce that Thailand has a large primary health care workforce. Public employers evaluated the contribution of primary care services towards the primary health care workforce. The primary care services in Thailand were evaluated based on the percentage of accessibility.

Dr. Cambell provided a definition of the primary care workforce that is internationally recognized, which included all workforces contributing to primary care tasks. He conveyed the idea of a categorising group of different professions, such as emergency service workforce, public health workforce, and primary care workforce, which need to be explicitly divided based on models, functions and inclusion criteria to compare tasks across countries. He talked about the details of the possibility of the AAAH work programs this year. There could be an explicit focus or action on trying to have all 18 countries achieve the 2023 milestones, specifically addressing the primary care workforce. The focus was on how each country classifies groups of occupations to describe them in primary health care. This focus included primary health care initiatives, classification to describe primary health care workers, and explicit classifications of inclusion criteria. Member states were able to learn about these focuses from each other.

Ms. Lluis Vinals Torres, Coordinator, Health Policy and Service Design, WHO WPRO, added more details about the global definition of primary health care. Some members defined it in terms of locations, the others in terms of functions. At the country level, every country sought definitions related to tracking and comparison. He asked: 'What do I define to make a country policy level? Is it different from the global definition?'

Finally, Dr. Cambell exemplified WHO perspectives that primary care occurred not only in primary care settings and included primary care practices in secondary and tertiary health care settings. Therefore, the classification needed to be explicit.

MAJOR ISSUES
OR PROBLEMS BEING DISCUSSED

This year, planning to focus on the primary care workforce is challenging due to differences in the implementation of primary health care.

Currently, the classification of the health workforce is not clearly defined and varies among Member States. These differences make it difficult to learn from each other.

SUGGESTIONS/ RECOMMENDATIONS

ONE

National Workforce Accounts, linked to the ILO through occupational classifications, and WHO handles the implementation of primary health care services should be promoted. Mechanisms are already in place related to the primary care workforce consideration program.

TWO

Groups of health workforce with different professions/ occupations should be classified using the same criteria to be able to compare tasks in different countries.

THE CONFERENCE WRAPS UP BY AAAH SECRETARIAT

Dr. Panarut Wisawatapnimit, AAAH Secretariat and Associate Dean, Faculty of Nursing, Praboromarajchanok Institute, Thailand, summarized the conference theme which was "Learning from COVID-19 pandemic: strengthening health workforce and health system resilience". Three groups of awardees were recognized, including MD, nurse and midwife, and non-MD were presented. The MD award went to Dr. Anukul Thaitanundr, Thailand

Director of Ratchaburi Hospital, Ratchaburi Province, Thailand. The nurse and midwife awards went to Ms. Chhimi Lhamo, Deputy Nursing Superintendent/Infection Prevention and controlled focal person Jigme Dorji Wangchuck National Referral Hospital (JDWNRH) and Ms. Tshering Dema, Deputy Nursing Superintendent Jigme Dorji Wangchuck National Referral Hospital (JDWNRH), Ministry of Health, Thimphu Bhutan. The non-MD award went to Mr. Bhim Prasad Sapkota, Senior Public Health Administrator, Ministry of Health and Population, Kathmandu, Nepal.

Dr. Wisawatapnimit revisited two general and three specific objectives that were fulfilled with the following

13 KEY MESSAGES

With strategic HRH policies and collaboration at the national, regional, and global levels, some HRH issues have been improved; COVID-19 and the subsequent economic crisis have affected health systems, health workforce, and health financing. This has had a variety of impacts on health and healthcare workers.

Currently, we are in the post-COVID-19 phase. It is time for countries to learn the lessons of COVID-19 and move forward with health systems resilience and universal health coverage, including addressing health needs (emerging diseases, climate change, etc.) and HRH issues.

The Pandemic accord "Protect, safeguard, and Invest" agreed by WHO Member States in early 2023 should be further discussed and lead to further action.

To address HRH issues, health governance capacity, high-level commitment and multisectoral collaboration must become active.

Countries need to invest in the supply, accessibility, acceptability, and quality of health workers and adopt strategic policies and implementation measures, including HRH monitoring and HRIS/NHWA.

Countries need to invest in the education, training, recruitment, development, motivation, and retention of the PHC workforce with an appropriate skill mix.

Countries need to invest in HRH research and outcome evaluation to use research findings to formulate evidence-based policy and guide implementation.

The health workforce should not only meet the population's health needs but also the needs of the health workers (education, safety, safe environment, salary, welfare, and quality of life).

International migration raises awareness and concern among many AAAH members. The WHO Global Code of Practice on the international recruitment of health personnel and ethical framework should be focused on, and countries facing this issue need to take action to address this issue as it affects the health systems of the countries. Bilateral agreements and mechanisms to repatriate health workers are needed, as well as labor market studies and projections.

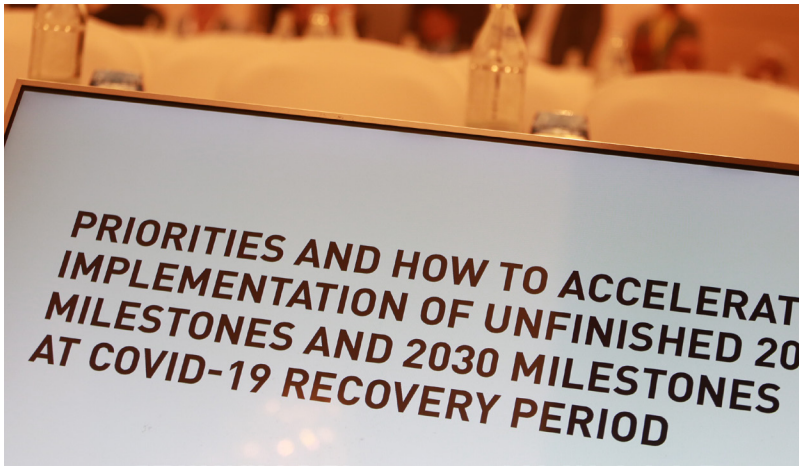
Some AAAH member countries have many private hospitals and facilities. Therefore, private hospitals and facilities need to be oversight and monitored for quality.

Because the quality and performance of health professionals are important, health regulations and CPD are important but need to be improved and considered based on the country's context.

Primary health care is important to strengthen health systems, provide universal health coverage, and employ the PHC workforce to meet population health needs and respond to pandemics. However, the definition and delivery of services need to be clear and further discussed as the concepts of PHC have changed. Strengthen PHC workforce availability, competence, the performance of a multidisciplinary PHC workforce team, decentralization, and PHC data are needed.

Assessment of the impacts, achievement, and contribution of PHC to the health system is needed.

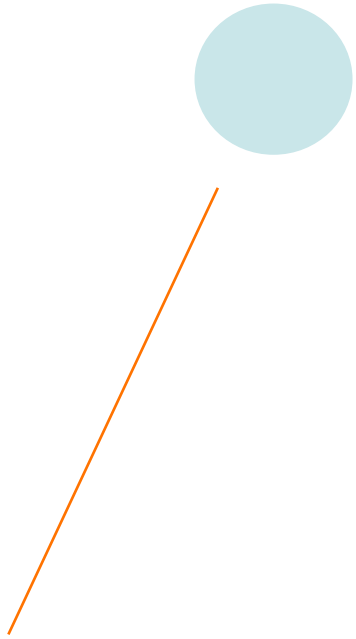
AAAH members and all sectors, including international agencies, must work together closely and continuously to address HRH issues now and in the future.



Dr. Wisawatapnimit addressed the important phrase achievement on universal health coverage, health systems, and SDGs and leave no one behind.

She finally summarized the conference overview. Nineteen Member States have joined the AAAH, and the total population of AAAH member states represents 46.03% of the world's population.

The total number of participants in the 12th AAAH Conference 2023 was 144, including 78 onsite from 30 countries and 66 online from 19 countries.



ACHIEVEMENT ON UNIVERSAL HEALTH COVERAGE, HEALTH SYSTEMS, SDGS AND LEAVE NO ONE BEHIND

CLOSING ADDRESS

PROF. DR.MAYFONG MAYXAY

Vice reactor
University of Health Sciences
Ministry of Health Vientiane
LAO PD

Elected Chairperson
AAAH Steering Committee

CLOSING ADDRESS

PROF. DR.MAYFONG MAYXAY

Vice reactor
University of Health Sciences
Ministry of Health Vientiane
LAO PD

KEY MESSAGES

Prof. Dr. Mayxay restated the objectives of the 12th AAAH Conference on "Learning from COVID-19 pandemic: strengthening health workforce and health system resilience'' held in Bangkok. He expressed gratitude for the organization of the conference, including the atmosphere, Q&A sessions, and the exchanges between the country members and experts.

He also expressed his sincere gratitude to the AAAH steering committee, all stakeholders and experts and hoped that AAAH member countries would continue to implement the regulations and policies to protect the health workforce and communities from difficulties and conflicts, especially from the impact of COVID-19 and to implement and achieve the milestones of Global HRH 2030. He congratulated Dr. TIN TUN, the current chair of AAAH, for the conference's success and admired his great effort and commitment. Dr. Mayxay expressed his utmost pleasure to take responsibility as the Chair of the AAAH steering committee for the next 2 years. Finally, he invited AAAH members to participate in the 13th AAAH Conference in Vientiane, Lao PDR, in 2024.

AAAH

MEMBER COUNTRIES WILL CONTINUE TO IMPLEMENT THE REGULATIONS AND POLICIES TO PROTECT OUR HEALTH WORKFORCE AND COMMUNITIES FROM ANY DIFFICULTIES AND CONFLICTS PARTICULARLY THOSE FROM THE IMPACT OF THE COVID-19, AND

TO IMPLEMENT AND MAKE AN EFFORT TOWARD MILESTONES OF GLOBAL HRH 2030

WATCH THE FULL SESSION

CLOSING ADDRESS

BY DR.MAYFONG MAYXAY

Elected Chairperson
AAAH Steering Committee

Chairman of AAAH Steering Committee, Excellencies, Distinguished Delegates, Experts from the Member Countries, Ladies and Gentlemen

We are about to end our 12th AAAH Conference in a few minutes and on behalf of chairman and AAAH steering committee, I am indeed honored and delighted to deliver the closing remarks.

As we all know, The AAAH is a regional partnership mechanism that was launched in 2005 in response to international recognition of the need for global and regional action to strengthen country capacity for human resource for health (HRH) planning and management. Until now, 18 countries have become the membership of this alliance and this year, we are welcome Jordan from EMRO for the new membership.

The AAAH organizes the conference every 2 years and this year, we organize the 12th AAAH conference under the theme "Learning from COVID-19 pandemic: strengthening health workforce and health system resilience'' in Bangkok – the very charming and beautiful city of Thailand. The main objectives of the conference are (1) to update Global HRH policies, future scenario of health workforce contribution to 2030 SDG3 commitment; impacts of COVID-19 situation on international migration of health workforce; (2) to review health practitioner regulation and continuing profession education which aim to strengthen pandemic response; (3) to review the roles of PHC workforce in response to population health needs and public health emergencies.

According to the wrap up by AAAH secretariat, I found that the conference was conducted fruitfully and successfully with a very good atmosphere. There are many Q&A from many participants, lesson-learned exchanges of the countries and experts

from session 1 to session 5 of the conference. I believe that the AAAH country members have learnt and got a lot of experience from the discussion and will be able to apply them for the implementation towards HRH and 2030 milestones in your respective countries.

In next 2 years, we have preliminarily planned to organize the 13th AAAH Conference in Vientiane – the beautiful and peaceful capital city of the Lao PDR. We are extremely honored and looking forward to hosting this important event in our homeland, to show you our very charming culture and tradition as well as many famous sights in our country and we do hope that we can organize an onsite rather than online conference. For the theme of the next conference will maybe discussed about PHC workforce or quality control health regulation, it will be further decided by steering committee and we will inform all member countries later.

To conclude my closing remarks,

- Firstly, I would like to express my sincere thanks to the AAAH steering committee and all stakeholders and experts from 19 member countries, and other countries for their excellent partnership in strengthening Human Resources for Health, ensuring sustained commitments addressing HRH needs through research and contribution to strategies and policy development;
- Secondly, I would like to congratulate Dr. TIN TUN for his great efforts, commitments and achievements that he brought for as the chair of AAAH during his term despite some difficulties and challenges during Covid 19 pandemic;
- Thirdly, It is my great pleasure and privilege to take up responsibility as the chair of the AAAH Steering Committee for the next 2-years. I look forward to working closely with all of you and I also look forward to welcoming you all to Lao PDR when we host the 13th AAAH Conference in 2024;
- Lastly, I do hope that the AAAH member countries will continue to implement the regulations and policies to protect our health workforce and communities from any difficulties and conflicts particularly those from the impact of the COVID-19, and to implement and make an effort toward milestones of Global HRH 2030.

Now, We reach the end of the 12th AAAH Conference, and I would like to express my sincere thanks to all of you for joining this important meeting and I wish you all happiness, good luck and great success in your work and life. See you in the next 2 years in Vientiane, Lao PDR!

SEE YOU IN
THE NEXT 2 YEARS

AAAH
CONFERENCE 2025

VIENTIANE
LAO PDR


PMAC
PRINCE MAHIDOL
AWARD CONFERENCE
Thailand
Resources fo
h


AND HEALTH SYSTEM RESILIENCE
2023

WATCH THE FULL SESSION

THE AAAH HUMAN RESOURCES FOR HEALTH AWARD 2023

KEYNOTE SPEECH

BY AAAH AWARDEES

DR. ANUKUL THAITANUNDR

Director
Ratchaburi Hospital
Thailand

MEDICAL DOCTOR AWARDEE

Samut Sakhon province was affected by COVID-19 from December 2020 to September 2021. Its situation was severe due to the huge number of legal and illegal migrant workers from neighboring countries. However, thanks to close cooperation between health care providers, all levels of the government sector, the private sector, police officers, soldiers, monks, and all Samut Sakhon residents, the situation was brought under control. The vaccination campaign in Samut Sakhon province was also successful.

MS. CHHIMI LHAMU

Deputy Nursing Superintendent/
Infection Prevention
and control focal person
Jigme Dorji Wangchuck
National Referral Hospital (JDWNRH)
Thimphu, **Bhutan**

NURSE AND MIDWIFE AWARDEE

Many challenges and issues emerged in a crisis-ridden environment, with the world under pressure from the COVID-19 pandemic. Fortunately, the work team, family, and friends extended all their support, resulting in a successful outcome in the end. The experiences will be very useful in dealing with similar situations in the future, leading to improve the health system as a whole.

MS. TSHERING DEMA

Deputy Nursing Superintendent
Jigme Dorji Wangchuck
National Referral Hospital (JDWNRH)
Thimphu, **Bhutan**

NURSE AND MIDWIFE AWARDEE

Ms. Dema stated that the AAAH award motivates and inspires her team. She thanked 1) His Majesty the King of Bhutan for his selfless leadership, 2) the Bhutanese people for their faith, and 3) her fellow nurses and midwives for their team spirit. Bhutan has been affected by the COVID-19 pandemic in various aspects. However, an effective nursing and workforce management system is urgently needed during the crisis. She attributed her success story to strong leadership, trust, and faith between the people and the healthcare workers, teamwork, and ICT.

MR. BHIM PRASAD SAPKOTA

Senior Public Health Administrator
Ministry of Health and Population
Kathmandu, **Nepal**

NON-MEDICAL DOCTOR AWARDEE

Mr. Sapkota said that during the COVID-19 pandemic, the health workforce in primary care settings lost confidence in dealing with health problems. We have no option, which is almost inaccessible to poor people geographically and financially. We aspired to be equipped with the skills to provide various health services in the rural community. The health workforce in primary care settings is essential for health systems' resilience. Therefore, this award is dedicated to all primary health care workers working in hard-to-reach and underprivileged communities.

MEDICAL DOCTOR
AWARDEE

DR. ANUKUL THAITANUNDR

Director of Ratchaburi hospital
Ratchaburi province
Thailand

RECOGNITION

DR. KESANG NAMGYAL

Head of Medical Critical Care Unit
Jigme Dorji Wangchuk
National Referral Hospital Thimphu
Bhutan

DR. NANDA WIN

State Health Director Mon State
Myanmar

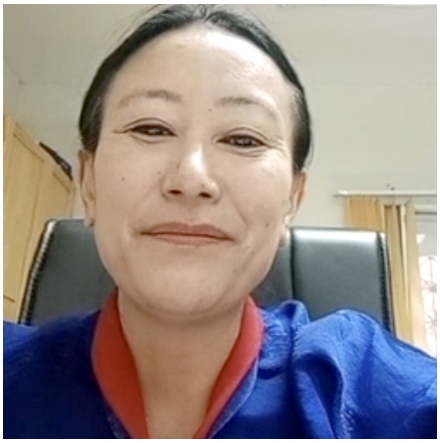
DR. ALONGKONE PHENGSAVANH

Vice Dean
Faculty of Medicine
University of Health Sciences
Lao PDR

NURSE AND MIDWIFE
AWARDEES

MS. CHHIMI LHAMU

Deputy Nursing Superintendent/
Infection Prevention and control focal person
Jigme Dorji Wangchuck
National Referral Hospital (JDWNRH)
Thimphu, **Bhutan**



MS. TSHERING DEMA

Deputy Nursing Superintendent
Jigme Dorji Wangchuck
National Referral Hospital (JDWNRH)
Thimphu, **Bhutan**

RECOGNITION

MR. RAHMAT HIDAYAT

ICU room is as a team leader
Dharmais Cancer Hospital
Indonesia

MS. PRAMESTI WIDYASTININGSI

ICHC Program Coordinator
(Integrated Child Health Checkup)
in Collaboration With JICA
(Japan International Cooperation Agency)
Indonesia

MRS. TITAREE CHUEPHRAM

Registered Nurse Professional Level
Acting Director of Public Health Division
Songkhla Provincial Administrative Organization
Thailand

NON -MEDICAL DOCTOR **AWARDEE**

MR. BHIM PRASAD SAPKOTA

Senior Public Health Administrator
Ministry of Health and Population
Kathmandu, **Nepal**

RECOGNITION

DR. MUHAMMAD HIRZI NUGRAHA

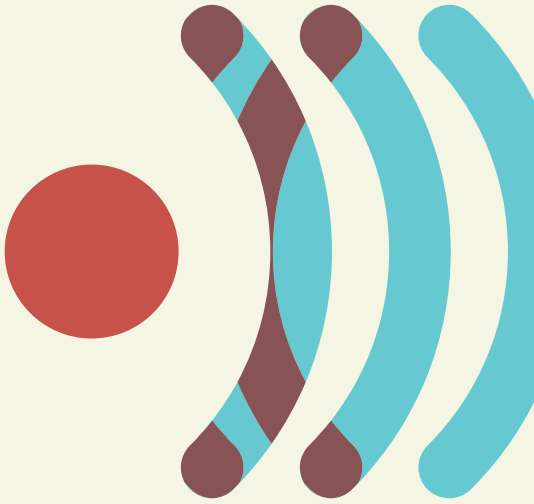
A Civil Servant (PNS)
Hulu Sungai Selatan Regency
The Kalumpang Health Center
Indonesia

MRS. REAPI T. WADALI

Acting Principal Administrative
Officer- Performance Management
Discipline/OHS/IR
Ministry of Health & Medical Services
Fiji


The 12th
AAAH
Conference
World Health Organization
Eastern Mediterranean
JICA
World Health Organization
Western Pacific Region
USAID
FROM THE AMERICAN PEOPLE
Asia Pacific Action Alliance on
DR. MUHAMMAD HIRZI NUGRAHA
MRS. TITAREE CHUEPHRAM


World Health Organization
South-East Asia
PMAC
PRINCE MAHIDOL AWARD CONFERENCE
iHPP
Thailand
Human Resources for Health
Learning from COVID-19 Pandemic
STRENGTHENING HEALTH WORKFORCE
AND HEALTH SYSTEM RESILIENCE
24-25 January 2023
DR. ALONGKONE PHENGSAVANH
DR. NANDA WIN



SUMMARY

OF THE 12TH AAAH CONFERENCE

ATTENDEES
OVERVIEW

PARTICIPATION **ONSITE**

30 COUNTRIES
78 PARTICIPANTS

- Australia
- Bangladesh
- Bhutan
- Egypt
- Fiji
- Germany
- India
- Indonesia
- Iran
- Japan
- Lao PDR
- Latvia
- Lebanon
- Malaysia
- Maldives
- Myanmar
- Nepal
- Papua New Guinea
- Philippines
- Republic of Moldova
- Singapore
- Spain
- Sri Lanka
- Switzerland
- Thailand
- Timor-Leste
- Turkey
- United Arab Emirates
- United Kingdom
- United States of America

PARTICIPATION **ONLINE**

19 COUNTRIES
66 PARTICIPANTS

- Bhutan
- Egypt
- Fiji
- Germany
- India
- Indonesia
- Japan
- Lao PDR
- Latvia
- Malaysia
- Myanmar
- Nepal
- Philippines
- Singapore
- Switzerland
- Thailand
- United Arab Emirates
- United Kingdom
- United States

MODERATORS, KEYNOTE SPEAKERS, SPEAKERS, COMMENTARY SPEAKERS CHAIRS, PANELISTS AND RAPPORTEURS
OVERVIEW

26
SPEAKERS

A total of 5 Sessions
of the 12th AAAH conference
Total 26 Keynote speakers,
Speakers, Commentary speakers,
Chairs, Panelists and Moderators.

3 KEYNOTE SPEAKERS
6 SPEAKERS
8 COUNTRY REFLECTIONS
3 CHAIRS
5 REFLECTIONS
1 MODERATOR

♀11 ♂12

Session 1:
Opening ceremony

Dr. Poonam Khetrapal Singh	Regional Director WHO Regional Office for South-East Asia	India
Dr. Tin Tun	Chairperson AAAH Steering Committee	Myanmar
Dr. James Campbell	Director Health Workforce Department WHO HQ	Switzerland

Rapporteur Team Members
Dr. Sukjai Charoensuk (Focal point)
Dr. Pornruedee Nitirat
Dr. Matanee Radabutr

Session 2: COVID-19 and subsequent economic crisis impacts on International migration of health workforce

Dr. Ibadat Dhillon	Regional Advisor (Human Resources for Health) Health System Development, WHO SEARO	
Dr. James Campbell	Director Health Workforce Department WHO HQ	Switzerland
Dr. Dave Howarth	Head of International Workforce, Department of Health and Social Care	United Kingdom
Dr. Gamege Samantha Prabath Ranasinghe	Deputy Director General Medical Services I, Ministry of Health	Sri Lanka
Dr. Pretchell P. Tolentino	Director DOH Health Human Resource Development Bureau	Philippines
Dr. Myrna Doumit	Associate Professor The American University of Beirut (AUB)	Lebanon
Mr Lluis Vinals Torres	Coordinator Health Policy and Service Design WHO WPRO	
Dr. Awad Mataria	Director Universal Health Coverage/Health Systems WHO EMRO	

Rapporteur Team Members
Dr. Sukjai Charoensuk (Focal Point)
Dr. Thongsouy Sitanon
Dr. Yupawan Thongtanunam

Session 3: Health practitioner regulation and continuing profession education: drawing lessons in supporting pandemic responses

Dr. Fethiye Gulin Gedik	Coordinator Health Workforce Department of Health Systems Development WHO EMRO	Egypt
Dr. Ibadat Dhillon	Regional Advisor (Human Resources for Health) Health System Development WHO SEARO	
Assoc. Prof. Dr. Haruka Sakamoto	Associate Professor Tokyo Women's Medical University and JICA Ogata Research Institute	Japan
Ms drg. Leni Kuswandari	Project Management office Directorate General of Health Workforce *Representative from Indonesia*	Indonesia
Ms.Sengthida Sivilay	Ministry of Health Lao PDR *Representative from LAO PDR*	LAO PDR
Prof. Rowaida ALMaaita	HE Professor Board Member of JNC, Board of Directors President, Board of Trustees Yarmouk University Consultant for Her Royal Highness Princess *Representative from Jordan*	Jordan
Prof. James Buchan	WHO CC, UTS	Australia
Dr. Thinakorn Noree	International Health Policy Program (IHPP)	Thailand

Rapporteur Team Members:
Dr. Sukjai Charoensuk (Focal Point)
Dr. Yupawan Thongtanunam
Dr. Matanee Radabutr

Session 4: Roles of PHC workforce in response to population health needs and public health emergencies: drawing lessons from COVID-19

Ms. Sweta Saxena	Health Systems Advisor, USAID/ASIA	United States of America
Ms. Ariella Camera	Local Capacity and Partnership Advisor Accelerating Primary Health Care Collaborative (APHC-C, USAID)	United States of America
Dr. Fethiye Gulin Gedik	Coordinator Health Workforce Department of Health Systems Development WHO EMRO	Egypt
Dr. Komain Tewthong	Deputy Director Bureau of Primary Care Support, Office of Permanent Secretary Ministry of Public Health, Thailand *Representative from Thailand*	Thailand
Ms. Agnes Pawiong,	Executive Manager Strategic Policy Division *Representative from Papua New Guinea*	Papua New Guinea
Dr. Ahmad Nejatian	Technical Deputy and Director International Affairs of Undersecretary for Development and Resource Management of the MoHME *Representative from Iran*	Iran
Dr. Liaquat Ali	Founder Pothikrit Institute of Health Studies (PIHS) Bangladesh and expert on SEAR PHC Strategy	Bangladesh
Dr. Elsheikh Badr,	DG of Human Resources for Health President of Sudan Medical Specialty Board *Representative from Sudan*	Sudan

Rapporteur Team Members:
Dr. Kamolrat Saksomboon Turner (Focal Point)
Dr. Matanee Radabutr
Dr. Kanokwan Wetasin

Session 5:
Accelerate implementation of 2030 milestones

Dr. James Campbell	Director Health Workforce Department WHO HQ	Switzerland

The conference wraps up by AAAH Secretariat

Dr. Panarut Wisawatapnimit	AAAH and Faculty of Nursing, Praboromarajchanok Institute	Thailand

Closing ceremony

Prof. Dr.Mayfong Mayxay	Vice reactor University of Health Sciences Ministry of Health Vientiane	LAO PDR

Rapporteur Team Members:
Dr. Kamolrat Saksomboon Turner (Focal Point)
Dr. Pornruedee Nitirat
Dr. Thongsouy Sitanon

AAAH
STEERING COMMITTEE

NATIONAL AGENCY

Ms. Sato Rie
Deputy Director Health Team 4, Health Group 2,
Human Development Department
Japan International Cooperation Agency (JICA)

Dr. Masato Izutsu
Chief Advisor
The Partnership Project for Global Health
and Universal Health Coverage Phase 2
Japan International Cooperation Agency (JICA)

Ms. Meguru Yamamoto
Project Coordinator
The Partnership Project for Global Health
and Universal Health Coverage Phase 2
Japan International Cooperation Agency (JICA)

Ms. Sweta Saxena
Health Systems Advisor
U.S. Agency for International Development (USAID)
ASIA/ Technical Services.

Dr. Ibadat Dhillon
Regional Advisor
Human Resource for Health Department of UHC/
Health Systems & Life Course, WHO SEARO

Dr. Fethiye Gulin Gedik
Coordinator
Health Workforce Development, WHO EMRO

Dr. Masahiro Zakoji
Technical Officer
Health Workforce Policy and Health Care Deliver
Health Policy and Service Design, WHO WPRO

COUNTRY REPRESENTATIVES

Dr. Tin Tun
Deputy Director General
Department of Human Resource for Health
Myanmar

Mr. Bhim Prasad Sapkota
Senior Public Health Administrator
Health Coordination Division
Ministry of Health and Population
Nepal

Dr. Gamege Samantha Prabath Rabasinghe
Director
Primary Care Services and Acting Director Training
Sri Lanka

Dr. Sunil De Alwis
Additional Secretary (Medical Service)
Ministry of Health, Nutrition and Indigenous
Sri Lanka

Dr. Maniphet Pimmasane
Ministry of Health, Lao PDR

Ms. Sengtida Sivilay
Ministry of Health, Lao PDR

Dr. Pai Thitsar
Department of Human Resource for Health
Myanmar

Mr. Saudat Sambahamfe
Section Officer
Ministry of Health and Population
Nepal



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