MYANMAR
HUMAN RESOURCES FOR HEALTH STRATEGY (2018-2021)

Ministry of Health and Sports
Republic of the Union of Myanmar

March 2018

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ACRONYMS

AMW	Auxiliary Midwives
AOP	Annual Operational Plan
ASEAN	Association of South East Asian Nations
BHS	Basic Health Staff
CHW	Community Health Worker
CPD	Continuing Professional Development
CPE	Continuing Professional Education
EHO	Ethnic Health Organization
EPHS	Essential Package of Health Services
FLW	Frontline Workers
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HRHU	Human Resources for Health Unit
HWF	Health Workforce
LHV	Lady Health Visitor
MMR	Maternal Mortality Ratio
MoHS	Myanmar Ministry of Health and Sports
NCDs	Non-communicable Diseases
NGO	Non-Governmental Organization
NHP	National Health Plan 2017-2021
NHWA	National Health Workforce Accounts
NIMU	NHP Implementation Monitoring Unit
PHC	Primary Health Care
PHS-II	Public Health Supervisor grade-II
RHC	Rural Health Centres
TB	Tuberculosis
TMO	Township Medical Officer
UHC	Universal Health Coverage
UCSB	Union Civil Service Board
U5MR	Under Five Mortality Rate
VBHW	Village Based Health Worker
WHO	World Health Organization

FOREWORD

The National Health Plan (NHP) 2017-21 has underlined human resources for health (HRH) as one of four Pillars for progress on universal health coverage (UHC). The Sustainable Development Goals too recognise that without an adequate and appropriate workforce countries shall not be able to progress towards achieving the health-SDGs.

The Ministry of Health and Sports has made notable efforts to strengthen HRH guided by the Health Workforce Strategic Plan 2012-17 and as reflected in the progress on health status in the past decade, including on the MDGs. However, significant challenges remain: shortage of public health workforce, inappropriate balance and mix of skills, inequitable distribution between levels of care and States/Regions, difficulties in rural deployment and retention especially due to lack of appropriate incentives.

The urgency to address these challenges in general and HRH issues in particular had led the NHP's first Annual Operation Plan 2017-18 to flag, as a priority, the need to develop a national HRH Strategy. For this, I tasked a Technical Working Group (TWG) with representation from across MoHS Departments and Chaired by Deputy Director General, Academic Affairs, Department of HRH. The TWG also consulted with officials working in States and Regions as well as a wider group of stakeholders including University Rectors, Professional Councils, WHO and other like-minded agencies. This inclusive process provided insights from all actors and their continued support shall be critical for successful implementation of the Strategy.

I must emphasize that implementation of the Strategy needed to be practical, all-inclusive and feasible. I am pleased to note the systematic guidance for operationalization through the three thematic areas and detailed actions outlined for each as well as related roles and timelines. This shall support the NHP in its primary health care approach in the first phase of UHC by strengthening frontline workers including, most importantly, Basic Health Staff.

The Myanmar HRH Strategy 2018-21 shall be the reference document for health workforce development in Myanmar for the current NHP period and I encourage all partners to collaborate fully its implementation to advance universal health coverage in Myanmar.

Dr Myint Htwe

Union Minister

Ministry of Health and Sports

ACKNOWLEDGEMENTS

The development of the Myanmar Human Resources for Health Strategy 2018-21 was led by the Department of Human Resources for Health with detailed contribution from the Technical Working Group (TWG) appointed by the Union Minister of Health and Sports. The TWG comprised of:

1.	Dr. Tin Tun, Deputy Director General (Academic Affairs) Department of Human Resources for Health	Chairman
2.	Dr. Thaung Hlaing, Deputy Director General (Public Health) Department of Public Health	Member
3.	Dr. Soe Oo, Deputy Director General(Civil Servant Affairs Division) Department of Medical Service	Member
4.	Dr. Kyaw Khine Oo, Director (Civil Servant Affairs Division) Department of Human Resources for Health	Member
5.	Dr. Nilar Win, Director (Human Resource Management Division), Department of Human Resources for Health	Member
6.	Dr. G Sign Taung, Director (Planning), Department of Public Health	Member
7.	Dr. Hla Moe, Director (Medical Supportive Section) Department of Medical Service	Member
8.	Dr. Kyaw Soe Nyunt, Director (Foreign Relations) Department of Human Resources for Health	Member
9.	Dr. May Thwe Hla Shwe, Assistant Director (Monitoring and Evaluation Division), Department of Human Resources for Health	Secretary

In addition to several rounds of internal discussions, the TWG consulted with representatives from States and Regions as well as broader stakeholders including University Rectors and Professional Councils and their valuable inputs are acknowledged with deep appreciation. Finally, technical assistance from WHO throughout the process is noted with thanks, especially from the senior consultant Dr Nilar Tin as well as funding support from 3MDG.

EXECUTIVE SUMMARY

The Myanmar Human Resource for Health Strategy 2018-21 provides direction for strengthening the countries health workforce as a Pillar of the National Health Plan 2017-21 to phase-in delivery of the universal health coverage benefit package.

Based on available information, an analysis of the health and human resource situation in Myanmar highlights three areas for action to strengthening the health workforce: Planning, Quality and Governance and financing. These areas inform the Myanmar Health Policy Statement 2018-26 that lays down the long-term vision, mission and objectives for HRH. And, further, the areas also provide the structure for organising the Strategic directions and Actions:

1. **Planning** including *(a) Research, information & planning (b) Workforce classifications (c) Workforce numbers (d) Workforce recruitment (e) Workforce distribution (f) Workforce Retention (g) Non-MoHS health workforce and (h) Workforce migration and mobility.*
2. **Quality** including *(a) Education and training (b) Career development (c) Registration system (d) Standards for ethical conduct (e) gender and ethnic inclusivity (f) performance appraisal and (g) Common standard across the entire health workforce.*
3. **Governance and Finance** *including (a) Leadership (b) Roles and function (c) Regulation (d) Accountability (e) Occupational health and safety (f) Industrial relations (g) Remuneration (h) Special allowances (i) Budget and finance.*

Across these three areas, aligning to the National Health Plan approach of primary health care orientated health systems strengthening, implies a focus on frontline workers – specifically rural retention and strengthening the cadre of Basic Health Staff as well as volunteers.

The Strategic Actions proposes both responsible stakeholders as well as commencement timeline; and, Monitoring and Evaluation Framework is included to track progress on implementation. This document does not specify output/outcome targets and indictors but recommends that these be agreed between implementing stakeholders – guidance for this is made available in the overarching SDG indictor as well as more detailed Milestones from the WHO *Global Strategy on Human Resources for Health*: *Workforce 2030.*

The critical pre-condition for implementation is a Unit with the mandate to lead and coordinate comprehensively, across MOHS Departments on HRH under either the Permanent Secretary of MoHS or under the Minister's office.

INTRODUCTION

Background

In the National Health Plan (NHP) 2017-2021, the Government of Myanmar has committed to an ambitious path for a primary health care (PHC) orientated health system strengthening (HSS) as the means to achieving universal health coverage (UHC). This approach emphasizes human resources for health as a strategic pillar for delivery of the UHC essential package of health services (EPHS). Developing and strengthening HRH is therefore acknowledged as a priority for health in Myanmar.

Globally as well, the World Health Assembly recognised in 2014 that the health Sustainable Development Goal (SDGs) and targets, including the focus on equity and universal health coverage, can only be met through strategic investment in developing the health workforce. Availability, accessibility, acceptability and quality of human resources for health (HRH) shall be critical to achieving health and wider development objectives (WHO, 2016).

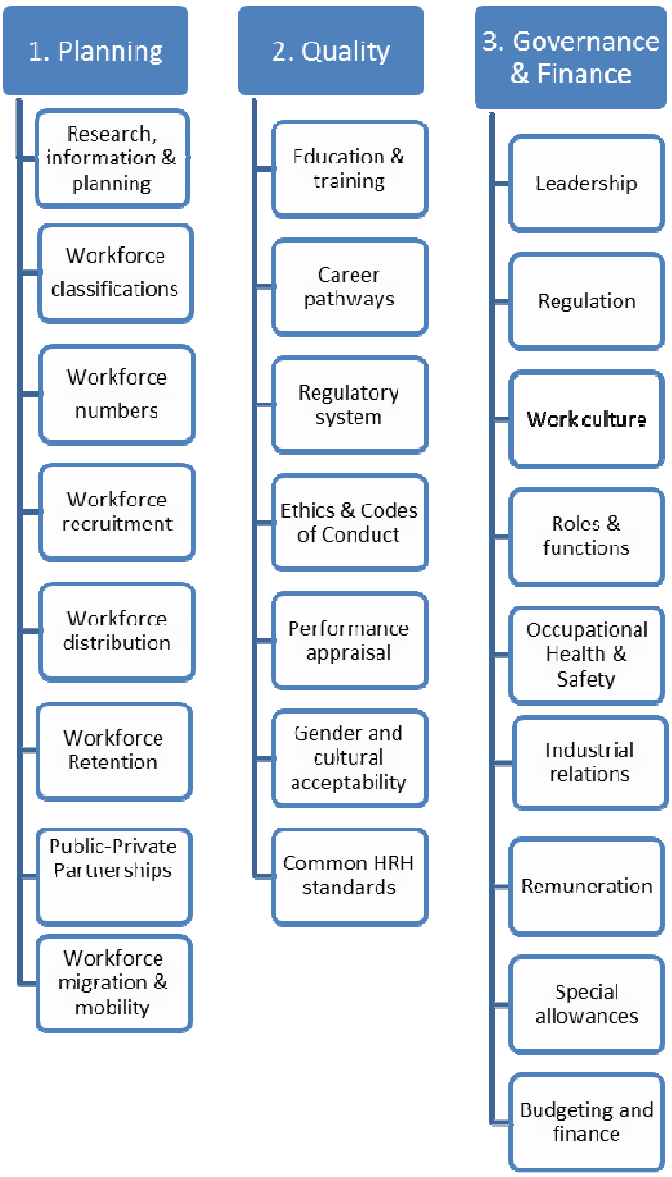
Purpose and structure

The purpose of the Human Resources for Health Strategic Plan 2018-2021 (the HRH Strategy) is to provide direction for strengthening the HRH Pillar of the NHP 2017-21. The document articulates the HRH Policy Statement (2018-2026) into implementable actions to deliver the UHC benefit package through a PHC approach, informed by the previous Health Workforce Strategic Plan (2012-2017) and in line with the NHP.

The formulation process for the HRH Strategy was led by the Ministry of Health and Sports (MoHS) with consecutive drafts reviewed by the Technical Working Group (TWG) appointed by HE Minister for this specific purpose; and, consultation with a wide range of stakeholder from across ministries and administrative levels including States and Regions.

Part 1 of the document lays down a comprehensive situation analysis of the current health system challenges and opportunities to enhance HRH. Based on this, in Part 2, HRH Policy identifies three long-term Objectives corresponding to three Strategic Areas: Planning, Quality, and Governance & Financing as shown in the Policy Map in Figure 1 below. These three themes are used to structure the HRH Strategy in Part 3 which further details a set of feasible and contextualised actions to operationalise the broader Policy Objectives over a four-year timeframe in Part 4. In Part 5 a Monitoring and Evaluation Framework provides a guide to implementation and facilitates assessment of progress as well as highlights key indicators to track progress on related SDGs.

Figure 1: Human Resources for Health Policy Map showing three Strategic Areas and associated groupings of policy activity



Part 1. SITUATION ANALYSIS

1. Introduction

Health services in Myanmar are provided by the public, private and non-government organisation (NGO) sectors and ethnic health organisations (EHO). The health system is decentralised, with services being offered to patients at the ward/village, township, district, state/regional and national levels.

Human Resources for Health (HRH) are critical inputs in the health system. The previous Health Workforce Strategic Plan (2012-2017) outlined a number of HRH challenges in Myanmar, many of which remain. These include critical shortages, inappropriate balance and mix of health workers, inequitable distribution and chronic difficulties with both recruitment and retention. All figures in the following analysis are drawn from the 2017 HRH Country Analysis unless otherwise indicated.

The Myanmar National Health Plan 2017-21 has underlined the importance of HRH for universal health coverage (UHC) with the Essential Package of Health Services (EPHS) by 2030. Specifically, the Annual Operation Plan (AOP) 2017-18 prioritizes the formulation of an HRH Strategy to strengthen primary health care to deliver a Basic Package of EPHS in the current NHP plan period; and, to lay the foundation for subsequent expansion to the next phases of EPHS.

2. General health profile of the country

According to the 2014 Census, Myanmar had a population of 51.48 million, of which 51.78% were female. The health status of the Myanmar population is poor both in absolute terms and by comparison to other countries in the region. Life expectancy at birth in Myanmar is 64.7 years, the lowest among ASEAN countries (National Health Plan 2017-21). The maternal mortality ratio (MMR) is the second highest among ASEAN countries at 200 deaths per 100,000 live births. The under-five mortality rate (U5MR) is 51 deaths per 1,000 live births, as compared with 12 in Thailand and 29 in Cambodia. Malnutrition is highly prevalent with over a third of children under-five stunted (National Health Plan 2017-21). Human Immunodeficiency Virus (HIV) prevalence (361 per 100,000), and TB incidence (373 per 100,000) are the third and second highest respectively among Association of Southeast Asian Nations (ASEAN) countries (WHS 2015). Despite little available data, rates of non-communicable diseases (NCDs) are believed to be increasing rapidly with an estimated 40% of mortality attributable to NCDs.

Approximately 70% of the Myanmar population live in rural areas. To serve this population the health system is networked by 1,815 rural health centres (RHCs) under the administration of Township Medical Officers. Each township serves approximately 100,000 to 300,000 people and is responsible for providing primary and secondary care services.

Urban areas are served by township hospitals, urban health centres, maternal and child health centres and school health teams. In rural areas, township health departments oversee 1-3 station hospitals and 4-9 RHCs. Each RHC has 4-7 satellite sub-rural health centres; each of which is staffed by a midwife and a public health supervisor grade-II (PHS-II). Outreach services are provided by midwives supported by volunteer auxiliary midwives (AMWs) and community health workers (CHWs) (Myanmar SRMNAH Workforce Assessment 2016).

Substantial health disparities exist along geographic, ethnic and socio-economic lines. MMR ranges from 357 (in the Chin State) to 213 (in Yangon) per 100,000 live births, and U5MR ranges from 108 (in Magwe) to 48 (in Mon) per 1,000 live births. The 2014 Census demonstrated that children from poorer households were more than twice as likely to be malnourished compared to better-off households. Only 69.5% of the population have access to improved drinking water (2014 Census) and 74.3% have access to improved sanitation (2014, Census).

Box 1. Key attributes of health in Myanmar:

Health Status. Myanmar has made good progress on health indicators but did not fully achieve the health related Millennium Development Goals (MDGs), so inequities in health outcomes and coverage remain.

The burden of disease is now shifting towards non-communicable diseases – an emerging challenge for future health planning and actions in Myanmar.

Health systems. Out-of-pocket personal spending constitutes a disproportionately large share of total health spending in Myanmar; and public investment remains low for achieving the UHC vision. The availability and distribution of human resources and health infrastructure is unequal across the country. Information for evidence-based decision making is limited – both in its availability and use.

Multi-sector context. There are increasingly complex influences on health status and outcomes, with both causes and effects beyond the health sector, requiring a multi-sectoral approach to population health and sector development.

Box 2. Inequities in U5MR within Myanmar

U5MR by State and Regions. Five states and regions (Ayeyarwady, Magway, Sagaing, Shan, and Mandalay) contribute over 65% of all under-five deaths overall and 83% of all under-five deaths in rural areas. *U5MR is an important proxy indicator of health system performance.*

Acknowledgements: Myanmar Country offices of UNFPA and UNICEF

Table 1. Myanmar Health Status: MDG indicators at a glance showing good progress on key health indicators but that all health-related MDGs were not achieved.

Indicator	MDG target	Myanmar	
		Baseline*	2013**
Under-5 mortality (per 1,000 live births)	Reduce by 2/3	109	51
Maternal Mortality (per 100,000 live births)	Reduce by 3/4	580	200
Deaths due to HIV/AIDS (per 100,000 population)	Halt and Reverse	17.3	21.5
Deaths due to Malaria (per 100,000 population)	Halt and Reverse	7.1	5.4
Deaths due to TB among HIV negative people (per 100,000 population)	Halt and Reverse	135	49

* 1990 for under-five mortality and maternal mortality, 2000 for other indicators
** 2012 for deaths due to HIV/AIDS and Malaria, 2013 for other indicators
Source: WHO, 2015

Box 3. Inequities in health coverage within Myanmar

By income quintile. Only 12.4% of women in the poorest quintile accessed facility-based deliveries compared to 77.5% among the wealthiest quintile.

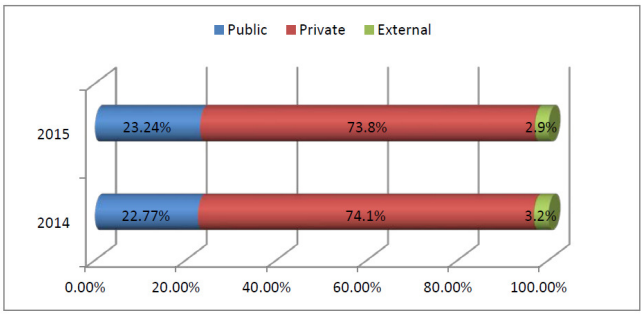
By stigma and discrimination. People who are poor or marginalized due to their behaviour such as sex workers, men who have sex with men, or drug users report difficulties accessing public health services due to stigma and discrimination.

By rural-urban. 85% of all hospitals provide basic emergency obstetric care compared to only 7% of rural and sub-rural health centres.

By level of care. Large differences exist between different levels of health facilities in the availability of at least 7 life-saving RH medicines (around 80% for secondary and tertiary levels vs. 38% on primary level).

Acknowledgements: Myanmar Country Offices of UNAIDS, UNFPA and UNICEF.

Figure 2. Myanmar health expenditure by source



Source: MoHS NHA

3. The Status of HRH

Myanmar is in the process of developing a Consolidated Human Resources for Health Information and Planning System (CHiPS) although this is not yet complete. By one estimate (Health System Review, 2014 cited in the HRH Country Analysis) there were 88,975 health workers in Myanmar in 2010/11 – inclusive of those employed by MoHS, Ministries of Labour and Defence and those in the private sector. A critical and ongoing issue is the lack of a central HRH database and lack of private sector information which makes it difficult to track current trends and project future health workforce needs.

Current stock: Health workforce density in Myanmar has increased in the past ten years from 1.58 to 2.45 per 1,000 population (Table 2).

Table 2. Health workers at national level 2006-2007 and 2015-2016

Health Occupational Categories/Cadres	2006-2007		2015-2016	
	Total	HW/1000 population (Pop. 46,605,278)	Total	HW/1000 population (Pop. 51,486,253)
Medical practitioners	20,501	0.44	32,861	0.35 (0.63)*
Health assistants	1,778	0.04	3,506	0.06
Graduate/registered nurses	21,075	0.45	32,609	0.69 (0.63)*
Midwives	17,703	0.38	22,258	0.43
Dentists	1,732	0.04	9,603	0.18
Lady health visitors	3,137	0.07	1897	0.03
Public health supervisors I & II	1,923	0.04	16705	0.32
Traditional medicine practitioners	5,841	0.13	7,200	0.13
Total	73,855 (73,690)*	1.58	126,639	2.45

** Note: Calculation error in reported figures*
Source: HRDI 2017, CSO 2016

The National Health Plan, 2017-2021 notes that Myanmar had 1.33 health workers per 1,000 population, compared with WHO's recommended threshold of 4.45 per 1,000 population required for Universal Health Coverage (WHO, 2016).

At each RHC, an average of 20,000 people is served by a team of health workers collectively known as **Basic Health Staff (BHS)**. The minimum set of sanctioned staff in each RHC and its sub-centres is 15 personnel: one Health Assistant (who heads the RHC), one lady health

visitor (LHV), six midwives (two in main centre and four in sub-centres), six public health supervisor II (two in main centre and four in sub-centres) and one watchman.

Between 1988-2007 the number of medical doctors increased more than doubled. Over the same period, however, the number of midwives increased by just 11% (Tin et al, 2010). An assessment of 20 townships in 2011 showed that only 8 of the 108 Rural Health Centres surveyed had the minimum standard of 13 BHS at that time, while 71% had less than 9 staff (GAVI HSS township assessment). The minimum standard for RHC staffing is now 15 BHS nationwide with the addition of one midwife and one Public Health Supervisor II (PHS2).

In 2011 the ratio of midwives to PHS2 was 11:1 as compared to the intended ratio of 1:1. Starting from 2014 PHS2 were recruited in large numbers: nearly 3,000 per year for three consecutive years, so that by 2017 the ratio had become nearer to 1:1. (13,529 midwives: 10,207 PHS 2), (Department of Public Health, MoHS). Although this appears to be a positive outcome, recruiting PHS2 in large numbers raises questions on the quality of training and the competence of graduates. To combat this there is some internal arrangement conducted by some Township Medical Officers (TMOs) to provide orientation training to newcomers PHS2 by attaching them at one RHC for one month and training on data entry of Health Management Information System (HMIS). Another month training at township level for data compilation of HMIS so that they would become acquainted with the primary health care activities of RHC. Also newly trained PHS2 have to attend more training on disease control and preventive actions. This should be standardized in the whole nation. (Input from State/Regional Public Health Directors and TMOs meeting).

Current mix: The current mix of the health workforce is skewed. Of all BHS available in the 2016-2017 Fiscal Year, midwives comprised 61.78%, Public Health Supervisors 1 (PHS1) comprised 1.74%, PHS2 comprised 21.53%, Lady Health Visitors (LHV) comprised 9.71% and Health Assistants (HA) comprised 5.24% of the total. As referred to the 2016 Central Evaluation Workshop of the DPH, there was a total of 39,272 voluntary health workers (VHW) functioning across the country. Among VHW, Community Health Workers (CHW) contributed to 62.55% and the rest were Auxiliary Midwives (AMW).

4. Management of HRH

4.1. Production: Approximations (2017 HRH Country Analysis) indicate that training schools are currently producing 1,900 MBBS graduates annually, 2,000 nurses, 1,300 midwives, 120 Health Assistants, and approximately 140 LHV. In mid-2016 there were 29,528 students enrolled in all health-related courses, including 12,016 (41%) in generalist medical training (an exponential increase on previous years), 26% in nursing and midwifery training, and 33% for all other cadres combined. The increasing number of medical enrolments raises the issue of the availability of academic supervision and clinical exposure to accommodate increased numbers of students - on the other hand, underproduction of all BHS cadres has

become a major concern for health planners. As one response, efforts are underway to strengthen screening of applicants through a separate medical school entrance examination to both reconfirm scholastic aptitude (in addition to high-school marks) as well as interest/commitment to career in medicine.

Table 3. Number of HRH graduates by year 2008-2016

Health Professional Group/Cadre	Number of graduates				
	2008	2009	2010	2011	2016
Generalist medical practitioners	2,603	2,474	2,108	2,108	1894
Specialist medical practitioners	271	329	294	294	908
Health assistants	231	164	244	122	129
Advanced practice nurses				27	23
Nursing personnel (Bachelor)	1,660	1,625	1,620	360	547
Nursing personnel (Diploma)				1,196	1402
Midwives	749	807	879	913	1173
Dental workers	299	162	257	460	251
Pharmaceutical workers	395	299	298	228	216
Laboratory and medical imaging technicians	322	278	263	159	154
Physiotherapists			5	88	77
Public health specialists				285	80
Lady health visitors	123	114	105	61	158
Traditional medicine practitioners	2,478	2,631	2,838		3601
Total	9,131	8,883	8,911	6,301	10613

Source: HRDI 2017

Table 4. Approximate current annual HRH production by cadre

Cadre Type	Annual Production (in absolute number)
M.B.,B.S	~1900
B.D.S	~210
B.Pharm	~200
B.Med.Tech	~210
B.N.Sc	~480
B.Comm.H	~120
Midwives	~1000

Source: Department of HRH, Ministry of Health and Sports, 2017

4.2 Recruitment & Deployment/Distribution:

HRH recruitment and deployment are guided by government protocols. Recruitment of doctors is the responsibility of the MoHS which is required to justify the need for doctors to the Ministry of Planning and Finance (MoPF) and also to the Union Civil Service Board (UCSB). Doctors who have completed their internship need to apply individually for a license to practice. For posting into the public service, they are required to sit an examination set by the UCSB and apply for a posting. Final recruitment is recommended by the Cabinet.

Table 5. Distribution of health workers by urban/rural areas in 2008

Health Occupational Categories/Cadres	Total	Urban		Rural	
		%	HW/1000 population (Pop. 15,394,153)	%	HW/1000 population (Pop. 31,856,162)
Generalist medical practitioners	2,472	84.7	0.14	15.3	0.01
Specialist medical practitioners	1,713	100.0	0.11	0.0	0.00
Graduate/registered/professional nurses	9,363	89.4	0.54	10.6	0.03
Midwives	105	100.0	0.01	0.0	0.00
Midwifery associate professionals	21,789	0.0	0.00	100.0	0.68
Generalist dental practitioners	484	98.3	0.03	1.7	0.00
Specialist dental practitioners	62	100.0	0.00	0.0	0.00
Dental technicians and assistants	10	100.0	0.00	0.0	0.00
Pharmacists	32	100.0	0.00	0.0	0.00
Pharmaceutical technicians and assistants	877	68.1	0.04	31.9	0.01
Physiotherapists	146	100.0	0.01	0.0	0.00
Nutritionists and dieticians	14	100.0	0.00	0.0	0.00
Optometrists	27	100.0	0.00	0.0	0.00
Medical and pathology laboratory technicians	2,681	100.0	0.17	0.0	0.00
Medical imaging and therapeutic equipment technicians	466	100.0	0.03	0.0	0.00
Medical and dental prosthetic technicians	22	100.0	0.00	0.0	0.00
Environmental health and hygiene professionals	4,500	64.1	0.19	35.9	0.05
Community health workers	12,998	16.9	0.14	83.1	0.34
Non-health professionals not elsewhere classified	2,193	100.0	0.14	0.0	0.00
Ambulance workers	145	100.0	0.01	0.0	0.00
Traditional and complementary medicine associate professionals	5,953	88.2	0.34	11.8	0.02
Personal care workers	442	100.0	0.03	0.0	0.00
Clerical support workers	320	100.0	0.02	0.0	0.00
Domestic and ancillary workers	20,989	76.2	1.04	23.8	0.16
Total	87,803	52.7	3.00	47.3	1.31

Source: WHO Myanmar HRH Country profile 2011 (unpublished)

Currently the production of doctors is far in excess of those recruited into the public sector. Graduates who are not able to find employment upon completing their training are allowed to work in the private sector. In 2016, it was estimated that 12,489 doctors (58%) were deployed in the public sector, compared to 9,201 in the private sector. Recruitment mechanisms need review to give priority to rural areas and to achieve an ethnic balance.

The public-sector recruitment processes for nurses, midwives and BHS are managed by the Department of Medical Service (DMS) and the Department Public Health (DPH) and in accordance with relevant approval processes. 2016 data suggest that two-thirds of all nurses, and most of the available BHS were deployed in the public sector. Recruitment and deployment processes for both medical doctors and BHS require review and reform to improve transparency and efficiency.

Table 6: Distribution of sanctioned health-worker posts by States and Regions

Region/ State	Doctors per 1000 population	Nurses per 1000 population	Midwives per 1000 population	Doctors, nurses and midwives per 1000 population	Discrepancy Index
Mon	0.06	0.10	0.17	0.33	0.48
Kayin	0.07	0.12	0.22	0.41	0.60
Bago (West)	0.06	0.10	0.25	0.41	0.60
Rakhine	0.07	0.12	0.27	0.46	0.68
Sagaing	0.08	0.19	0.24	0.51	0.75
Bago (East)	0.09	0.20	0.22	0.51	0.75
Ayeyawady	0.09	0.21	0.22	0.52	0.76
Taninthayi	0.11	0.22	0.22	0.55	0.81
Shan (North)	0.10	0.24	0.22	0.56	0.82
Magway	0.13	0.20	0.24	0.57	0.84
Shan (East)	0.16	0.28	0.25	0.69	1.01
Shan (South)	0.15	0.33	0.31	0.79	1.16
Mandalay	0.23	0.39	0.18	0.80	1.18
Kachin	0.18	0.38	0.32	0.88	1.29
Yangon	0.46	0.55	0.15	1.16	1.7
Kayar	0.26	0.45	0.65	1.36	2.00
Chin	0.59	1.60	0.89	3.08	4.53
Union	0.17	0.28	0.23	0.68	1.00

Source: Myanmar Health Systems Review 2014

The geographic distribution of HRH is skewed. Although only 30% of the country's population is located in urban areas they are serviced by 50% of health workers, including the majority of highly skilled and specialist health workers. The Myanmar health workforce is also highly feminized (75%) with almost all nursing professionals and over half of medical practitioners being female.

***4.3 Retention*:** A Central HRH Database System is currently being developed. HRH information collection of all (7) Departments of the MoHS is in process. The output and results will be available in the near future and will be essential for HRH strategic direction. However, it is known that BHS and voluntary health workers have higher rates of workforce instability and turnover compared to medical doctors; and that rural HRH have higher rates of instability and turnover compared to urban HRH. In 2012 (HRH Profile 2012) the annual attrition of medical doctors was 2.02% compared with 15-20% for CHWs and 5-10% for AMWs.

Measures have been taken in the past to retain health workers in rural areas, such as developing health professions' training schools outside of major cities; nursing and midwifery schools at the States/Regions levels; recruiting local people to serve in their home towns and villages; improving access to continuing professional education (CPE), such as opening career pathways for BHS with years of service and completed trainings; providing in-service training for skill development and the provision of double salary for BHS working in hard-to-reach areas.

Yet, there are several documented issues influencing poor retention for rurally based BHS, such as:

- Job descriptions and role delineation that are no longer in line with existing functions
- No formal support system and weak supervision
- Insufficient transport allowances, per diems or hardship allowances for rural health workers
- Insufficient compensation for overtime and the expectation of being on-call 24 hours a day
- Poor health facility infrastructure and inadequate supply of drugs and clinical equipment
- Cultural and linguistic barriers to patient-provider engagement in the ethnic minority areas
- Chronic understaffing, leading to overwork and 'task creep' particularly for midwives
- Poor housing, lack of educational opportunities for children and lack of access to other services
- High levels of stress

The Annual Operation Plan of 2017 commenced the review and revision of the job descriptions of BHS to align them with the NHP, including the need to deliver the Basic Package of Health Services and to work with Township Health Working Groups, Village Health Committees and Village Based Health Workers to improve accountability, responsiveness and job satisfaction. In addition, other measures, such as investment in rural infrastructure, housing for BHS, the provision of transportation allowances and increasing infrastructure investment are included in Township Health Plans to support the retention of rural BHS.

4.4 Performance and supervision.

Although supervision of BHS has been conducted it requires strengthening. Checklists have been developed but require integration with programme objectives. Supervision remains weak at all levels of health care, including at the voluntary health workers level. Despite these limitations health workers' dedication to their work and communities remains strong as exemplified by the prominent examples below in Box 4. These champions and many others working in public health should be supported to create networks for sharing their experiences and to serve as models to lead a system of assessing and rewarding performance through recognition, further training, incentives and other means.

Box 4. Champions of public health

Dr Myint Thein Tun has been working in the Ministry of Health for over 23 years, serving in various townships, as an Assistant Surgeon, Station Medical Officer, and TMO. He won the Asia-Pacific Action Alliance on Human Resource for Health (AAAH) award in 2012 for devoting his knowledge and creativity to building up capacity in his organization to promote health through innovative measures.

Dr Nanda Win, TMO from Ingapu township was given Citizen of Burma award from US in 2015 for his outstanding social work in tackling social determinants of health. Dr Nanda Win initiated a low-cost food programme for poor families that has grown substantially with significant impact on the nutrition and health of both children and adults.

Daw Nan Than Than Oo

Midwife
Myanmar

Daw Nan Than Than Oo was appointed as a midwife in 1982 and 1987 at the Htin Shu Taung sub-Rural Health Centre (RHC) in Mogok Township and at the Shwe Nyaung Pin sub-RHC respectively. In both positions, there wre no maternal nor child deaths. In July 1989, she was transferred to Kyun Gyi sub- RHC, her native town, where she won a prize for best performance of immunization and nutrition services. During the cholera outbreak in 1991-1992, Ms. Than Oo actively assisted patients day and night and helped chlorinate the water and provide health education.

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Award winner Midwife Than Than Oo from Myanmar

More recently, Ms Than Oo was transferred to Lwe-Satone sub-RHC where she's been working since 2000. The health centre is situated near the Thai border and the sub-RHC covers nine villages with a total population of 5 000 people with an additional estimated nomadic population of 3 000. She caters to 120-130 pregnant women yearly and provides immunization to over 200 children under one year of age every year. Given her exceptional work over the years, Ms. Than Oo received the "outstanding health worker" in 2002 issued by the Department of Health Planning/UNFPA.

© GHWA/OnAsia/L.Duggleby
Award winner Midwife Than Than Oo from Myanmar receiving the award from Dr Mugitani, GHWA Board Chair

Driven by her own motto of "no maternal mortality", she encourages the community to support her efforts through a network of village health volunteers. She also trains auxiliary midwives to improve skilled birth attendance. In 2010, she achieved 78% antenatal coverage, no maternal deaths, and contraceptive prevalence rate reached 62% in her area.

4.5 Status of health professional education and training.

Pre-service training of all health workers in Myanmar is the responsibility of the Department of Human Resources for Health (DHRH) within the MoHS. Myanmar has five (5) universities of medicines; two (2) for Dental Medicine; one (1) for Public Health; two (2) for Pharmacy; two (2) for Medical Technology; two (2) for Nursing and one (1) for Community Health. The University of Community Health (Magway) trains Public Health Supervisors I and II, and Health Assistants who become team leaders of RHCs. There are 50 nursing and midwifery training schools (25 nursing schools, 22 midwifery training schools and 3 related schools). The Lady Health Visitor Training School in Yangon produces approximately 100-200 LHVs each year, which is not sufficient to meet the need. From a national HRH perspective, inadequacies exist in the intake (and thus production) of certain health worker categories –

notably BHS – that are much needed in the system. In addition, there is one university of Traditional Medicine managed by the Department of Traditional Medicine.

Across all institutions, teaching capacity is limited by inadequate numbers of well-qualified teachers and by learning materials. Student intakes are often not related to the capacity of institutions to provide quality education (i.e. too many students, insufficient faculty, limited space and limited opportunities for clinical practice). Notably, teacher shortages are most marked in the University of Community Health which is responsible for BHS training, with a 1:12 teacher to student ratio, compared to other universities where ratios are between 1:5 (e.g. University of Medicine and University of Pharmacy) and 1:7 (University of Nursing). Currently almost all training institutions are in major cities except for some nursing and midwifery schools, which present both geographic and financial barriers to enrolment for the rural population.

Accreditation of training institutions: Myanmar Medical Council (MMC) and Myanmar Nurse and Midwife Council (MNMC) are currently developing accreditation standards and guidelines for education. Some universities have commenced implementing activities for internal quality assurance systems. Although not officially announced, MNMC is in the process of formulating a competency-based assessment for out-of-practice midwives and nurses to facilitate their relicensing and re-entry into the workforce.

Continuing Medical Education (CME): CME has gradually been decentralized to separate areas of health and is largely funded by donor agencies. In-service training is currently project oriented and is the joint responsibility of the DPH and the DMS.

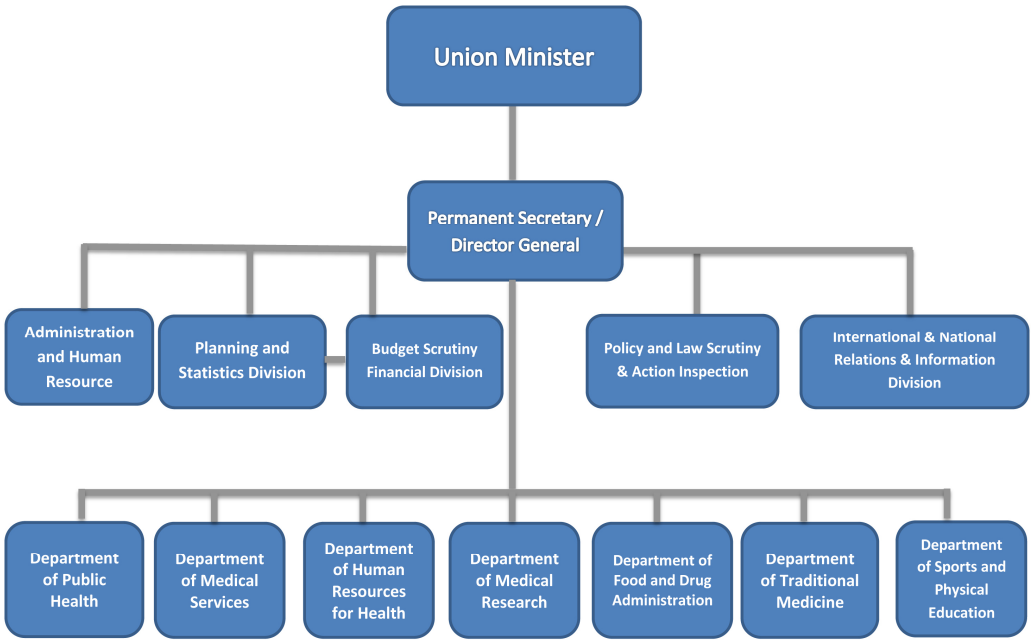
At the Township level, CME for BHS is usually conducted at the end of the month when all BHS come in for their salary payments. Currently, CME programmes are project oriented and not uniformly conducted nationwide. Township CME programmes are conducted by Township Medical Officers (TMOs) and senior BHS in Township Health Departments, without formal medical education training, appropriate training aids and resources. Previously, JICA funded a five-year project on "Strengthening Capacity of Training Teams for Basic Health Staff" (2009 - 2013) where teaching aids and standardized training handbooks for BHS were developed. A training information system was set up at State/Regional levels to support this training system but came to an end when the funding stopped. Thus, updating of such aids, handbooks and information systems are required in order to revitalize CME training at sub-national level.

Career Progression: The opportunity for career development is limited in some cadres, such as Pharmacist and Paramedics, where they could be promoted only to the Technical Officer level. There is also lack of clarity around roles and responsibilities, insufficient posts for promotion and poor utilization of post-training skills.

5. Governance

5.1. Policy and Planning: The current National Health Plan (2017-2021) was developed by Steering and Working Committees in collaboration with stakeholders from MoHS, other Ministries and non-MoHS groups, including EHOs, CSOs, NGOs and the private sector. Annual operation plans (AOP) for the current NHP period are being facilitated and monitored by the NHP Implementation Monitoring Unit (NIMU) of the Minister's office. In these AOPs, HRH is identified as one of the four main pillars for the development of NHP 2018-21.

Figure 3. Ministry of Health and Sports: Departmental Structure and Responsibilities.



As in Figure 3 above, the MoHS is headed by a Union Minister with seven departments, each responsible for different aspects of health care and with varying responsibilities in relation to HRH.

1. Department of Human Resources for Health – responsible for the production of health workers, development and implementation of HRH policy, strategic plans and information systems.

2. Department of Medical Services – responsible for the provision of health services and deployment of health workers at State, Region and Township health facilities.

3. Department of Public Health – responsible for the provision of health services and deployment of health workers at the community level.

4. Department of Medical Research – responsible for conducting medical research and providing evidence-based data for policy making.

5. Department of Food and Drug Administration – responsible for quality assurance of food and drugs.

6. Department of Traditional Medicine – responsible for the development of Myanmar traditional medicine.

7. Department of Sports and Physical Education – responsible for the development of sports and physical education for Myanmar.

Planning, management and production of HRH requires intensive coordination at both policy and operational levels. Within the MoHS, the Department of HRH is responsible for the production of the health workforce, but graduates are variously deployed by the Department of Medical Service, the Department of Public Health and others. In the absence of a focal unit/department in the MoHS to coordinate all aspects of HRH, planning, production, management and deployment are not sufficiently aligned, which reduces the efficiency and effectiveness of health workforce development and deployment.

5.2. Regulation: Currently only doctors, nurses, dental surgeons and traditional medical practitioners are required to be registered and licensed to practice. For medical practitioners, the **Myanmar Medical Council** (MMC) Law (revised in 2015) defines their medical duties and rights. The MMC is responsible for registration and licensing of generalist, specialist and foreign medical practitioners; for control of professional practice and conduct through supervisory bodies and for setting standards and professional practice guidelines.

Nurses and midwives are regulated by the State Law and Order Restoration Council Law Relating to Nurses and Midwives (amended 2015). The Act defines, in general terms, nursing and midwifery duties and rights. The **Myanmar Nurse and Midwife Council Act** (MNMC) was endorsed in May 2015, establishing the MNMC as the responsible body for registration and licensing of nurses and midwives; for control of professional practice and conduct through supervisory bodies; for setting standards and guidelines of professional practice for nursing and midwifery education and practice. Registration of nurses is achieved by provision of evidence of graduation from an approved training school. Once registered, nurses are required to renew their license every two years.

5.3 Various HRH Information Systems: Lack of a central HRH database makes tracking turnover and retention of all cadres extremely difficult. Separate MoHS departments have developed and utilize their own HRH databases. With the aim of creating a national HR database, where data from all departments can be updated, stored and utilized for planning and management purposes, the MoHS is in the process of developing the HR Information System (HRIS). Systematic tracking of village based health workers serving in the community as CHW, AMW and others is still lacking.

6. Financing

6.1 General Health Financing Context

Historically, Myanmar has had low rates of public investment in the health sector, and very high out of pocket expenditures on health by the population. This being the case, investment in public health education and remuneration has also been stagnant, and contributed to health system challenges of low rates of retention of the health workforce in rural and remote areas, low levels of social protection, and underfunding of health service operations. Recent political and development reforms, including enactment of a new constitution, has resulted in expansion of both national government, non-MoHS and development partner investment in social sectors and in health care specifically in Myanmar in recent years. This therefore provides a timely opportunity to rebuild the health care workforce in Myanmar. This observation is reinforced by the trends in health care expenditures nationally, which illustrate increased percent of national budget allocated to health, increased development partner financing, and some decrease in out of pocket expenditures on health care. The National Health Plan points that, as a share of Total Health Expenditure (THE), the government investment in health has increased from 10% of THE in 2005 to 24% in 2015.

6.2. Remuneration: Data on health worker remuneration levels in 2017 are not available. While it may be expected that specialist medical practitioners earn higher remuneration compared with other health workers including BHS and allied health staff, all health workers receive a basic salary - there are no formal incentive payments, performance-based payments or other allowances although some pilot schemes have trialed. Further, based on 2012 figures there appears to be little salary progression e.g. for nurses, midwives and township health nurses earning the same salary. No data was available for how health worker salaries compare to other public servants such as teachers or police officers. Salaries are set by the Ministry of Planning and Finance and all health workers receive wages in cash at the end of the month.

6.3. Costs of Training: The cost of training all cadres of HRH – for both pre- and in-service training - is currently borne almost exclusively by the government using public resources. There is now discussion to reduce this almost 100% subsidy by implementing some realistic cost-sharing through an increase in student fee.

7. Summary: main issues and challenges in HRH.

Human resources for health is one of four critical pillars of the NHP 2017-21 to strengthen health systems for effective delivery of the UHC EPHS. Evidence discussed in this situation analysis section highlights issues and challenges that may be grouped under three headings as below. Also, these are then reflected in the Objectives of the Policy Statement in Part 2 and in the structure of the following sections on the HRH Strategy:

1. Planning
2. Quality
3. Governance and Financing

7.1. Planning

(a) Research, information & planning. Need to establish central electronic HRH information systems to enable HRH policy formulation and operational decision making, including the deployment of staff in the private sector.

(b) Workforce classifications. Need to clarify functional responsibilities, scope of services, required competencies and supervision arrangements in different settings, which is likely to involve reviews of job descriptions, competencies and career pathways.

(c) Workforce numbers. Need to review norms concerning optimal staffing mix at different facility levels. Need to scale up of BHS production numbers in support of the Basic Package of Universal Coverage of EPHS by 2021.

(d) Workforce recruitment. Need to review workforce recruitment quotas which currently fail to respond to the overall health service needs, but in particular the needs of rural/ remote/special area health services. Need to reform recruitment procedures to streamline among agencies and to delegate authority for the recruitment of some cadres to the States and Regions.

(e) Workforce distribution. Need for revised and strengthened HRH deployment criteria and mechanisms – to ensure equity in posting, transfer and retention for underserved areas including rural/ remote, border, urban poor and conflict affected areas.

(f) Workforce Retention. Need for a comprehensive retention policy addressing issues of workload, supervision, incentives, workplace safety, CPE and benefits.

(g) Non-MoHS health workforce. Need to review the contribution of non-MoHS workforce and garner this for the national UHC effort including public-private partnerships.

(h) Workforce migration & mobility. Need to understand HRH in the context of new labour market context of Myanmar.

7.2. Quality

(a) Education and training. Need to address deficiencies in the quality of education and training of health workers, particularly regarding the adequacy of faculty, teaching resources and clinical exposure in order to strengthen professional, practical and clinical skills.

(b) Career development. Need to develop policy and strategies to ensure competency in leadership, management and delivery of person-centred care and embed these in pre-service, in-service and CPE curricula and training modules.

(c) Registration system. Need to establish a systematic regulatory framework with ***common standards*** applicable to all practitioners/provides including non-MoHS to ensure: i) adherence to institutional quality standards, and b) competence of health personnel to provide quality services.

This framework should address:

1. PRE-SERVICE – student selection, programme accreditation, licensing requirements.
2. IN-SERVICE – registration and CPE, quality assurance, ***standards for ethical conduct*** and ***gender and ethnic inclusivity*** including procedures for addressing misconduct/exclusion, ***performance appraisal*** and systems for protecting health worker health and safety.

7.3. Governance and Financing

(a) Leadership. Need for a coordinating unit or similar mechanism within MoHS for continuity and sustainability of the HRH effort including:

1. harmonised guidance for ***roles and function*** of health workers needed for UHC
2. overall oversight including ***regulation*** and ***accountability*** as well as issues related to ***occupational health and safety*** and ***industrial relations***.
3. other ***labour market*** related actions needed for HRH beyond the health sector notably international migration and mobility
4. production, recruitment, deployment and performance of MoHS workers

(b) Finance.

1. Need for a package of ***remuneration and special allowances*** that is consistent with standards of the Union Civil Service Board especially for rural retention.
2. Need to consider appropriate financing planning for both magnitude and nature of functions (roles and responsibilities) needed for UHC across cadres, facility levels and Centre versus States/Regions as well as between State/Regions.
3. Need to strengthen the capacity for ***budget*** proposal development, implementation and monitoring (i.e. health financing).

Part 2. POLICY STATEMENT: HUMAN RESOURCES FOR HEALTH 2018-2026

1. Background

The objective of the Myanmar National Health Plan 2017-2021 (NHP) is to extend the basic package of essential health services to the entire population and towards a longer-term goal of achieving universal health coverage (UHC), defined as all people having access to needed health services of quality without experiencing financial hardship. The purpose of the HRH Policy 2018-2026 is to set a high-level guide to policy development aimed at ensuring universal availability, accessibility, acceptability, and quality of the health workforce in support the NHP, towards improving health, social and economic development outcomes. The Policy articulates a long-term Vision and Mission, as well as three Policy Objectives corresponding to the three HRH Strategic Areas of: Planning, Quality, and Governance & Financing. This Policy informs the HRH Strategy 2018-2021.

2. Vision

The Vision of the HRH Policy is:

An adequate, competent and productive health workforce that is responsive to changing health needs within an effective, efficient and equitable health system.

3. Mission

The Mission of the MoHS and its main partners in realising this Vision is to:

Grow, foster and support an adequate, competent and productive health workforce through establishing and enhancing human resources for health planning, production, distribution and regulation systems.

4. Guiding Principles

The Guiding Principles that underpin the HRH Policy are:

1. *Responsiveness to the **priority health needs** of the population*
2. *Sustainability in moving towards the attainment of **universal health coverage***
3. *Embeddedness in the priorities set by the **Sustainable Development Goals***
5. *Responsiveness to the **socio-economic and cultural context** of the country*
6. *Sensitivity to issues of **equity**, particularly from the perspective of gender and the needs of people living in remote and hard-to-reach areas*
7. *Cognisance of the need to **protect and promote diversity** within the workforce*
8. *Consistency with **best evidence**, with reference to the Association of South East Asian Nations (ASEAN) and global health policy*

9. *Flexibility in adapting to **changing circumstances***
10. *Development, implementation and revision informed by **wide consultation** within and outside the health sector.*

5. Policy Objectives

Policy Objective 1. Human Resource Planning - To specify the adequate production numbers, mix and distribution of staff required to achieve the medium to long term objectives for universal health coverage as specified in the *National Health Plan 2017-2021*.

To achieve this Policy Objective the Ministry of Health and Sports (MoHS) will **classify the health workforce according to professional disciplines, level of education attained and the functional responsibilities of staff** in the reformed health system. Such functional responsibilities will reflect the long term strategic objectives of the National Health Plan, particularly with regards to attainment of universal cover (with equity) for an essential health care package in a progressively decentralised health care system.

The MoHS, in support of the NHP goal for universal coverage with equity, commits to put in place measures to gradually (beyond the period of the 2018-21 HRH Strategy) **expand workforce production numbers and distribution** towards achieving the WHO target in all Townships of 4.45 physicians, nurses and midwives per 1,000 population. The MoHS also commits to setting norms and standards for ensuring the correct numbers of staff and skills mix, particularly in rural and remote areas.

In support of the NHP objective for universal coverage for a basic package of essential health services by 2021 (EPHS), the MoHS commits to a **policy and strategic emphasis on development of health workforce capacity for primary health care** focusing on frontline workers especially Basic Health Staff (BHS) inclusive of all healthcare providers working in primary care services in Urban Health Centres, Maternal and Child Health Centres, Township Health Centers, Rural Health Centers (RHCs) and sub-Rural Health Centers (sRHCs)).

In support of this policy direction, the MoHS commits to improve the quality of human resources production, planning, deployment and monitoring through the establishment of **a national human resource unit** and a data base of registered and licensed health professionals and quality health services in both the public and private sectors. Further, in line with the National Health Plan, commits to a 5-yearly planning and monitoring cycle to inform and enable the deployment of adequate workforce numbers with the required skill mix in areas of need.

Policy Objective 2. Quality of Human Resources – To develop and implement systems of education, regulation and performance management that ensure standards of quality care that correspond to the health needs of the population and the goal of universal health coverage.

To achieve this Policy Objective the MoHS, in collaboration with health professional councils, will ensure that the councils have the capacity and mandate for ensuring quality training programmes and for **registering and licensing all health professionals** for practice in both public and private sectors.

The MoHS commits to development and operation of **National Accreditation Systems** of all training institutions and continuing training programs, and will ensure a strategic focus for training by alignment of curricula content, job descriptions, and the required competencies linked to the implementation of the essential package of health services (EPHS).

In support of human resource **recruitment, deployment, distribution and retention** that enables universal coverage of an essential health care package**, t**he MoHS will ensure that priority for publicly-funded post-graduate training positions and opportunities will be given to BHS who have served the rural communities, or who are local people from the under-served areas, states, regions, and townships.

In support of the goal for ensuring effective **management of the performance of the health care workforce**, the MoHS, in collaboration with professional councils, commits to developing and operating systems for career pathways, performance appraisal, a Code of Ethical Conduct, as well as instituting measures to ensure the cultural and gender acceptability of health care services.

Policy Objective 3. Governance and Financing - To develop and implement a sustainable Human Resources for Health Management institutional framework, inclusive of the required regulatory, information and planning guidelines and tools for quality HRH management. Further, the Policy commits to securing adequate resource mobilization to support equitable deployment of Human Resources for Health in Myanmar.

To achieve this Policy Objective the MoHS commits to **strengthening the planning capacity of central institutions** through intersectoral coordination mechanisms and the establishment of a Central HR Unit to coordinate the large-scale effort to expand production numbers to meet national and international standards and to ensure equitable placement of health staff. As part of this institutional strengthening, the MoHS will assist in defining human resource management responsibilities at state and region levels consistent with the national decentralization agenda.

Human resource management policies, strategies and procedures will have a firm evidence basis drawing on information generated through workforce projections, registration and licensing databases, human resource research programs and tracking systems to monitor placement, distribution and skills mix at Township level. In so doing, human resource for health policies will be aligned to the National Health Plan goals of ensuring universal health coverage with equity.

In terms of **improved regulatory functions**, the MoHS and Professional Councils commits to development and monitoring of systems for registration and licensing of all professionals and of health facilities in both the public and private sectors.

In support of the national development trends toward decentralization and community participation, the MoHS commits to promoting **transparency and accountability for performance** at all levels of the system, which will include (but not be restricted to) development of systems to link planning and budgeting, the introduction of performance based management mechanisms, a focus on results, and the development, dissemination and use of a Patient Charter of Rights and Responsibilities and a Staff Code of Conduct.

The National Health Plan target of achieving universal coverage of a basic package of essential health services (EPHS) by 2021 is an ambitious development goal that will require rapid scale-up of health workforce numbers and their distribution. In support of this goal, the MoHS commits, in collaboration with the central human resource unit, to ensure through its strategic and operational budgeting cycles that an **adequate volume of resources is mobilised** for the production, deployment, and retention of the required number of staff in the public sector. Further, in the changed economic context of the country, it would be relevant to anticipate and balance labour market considerations in public health workforce decisions.

Equity in services cover will be enabled by designation of special allowances, and design of local recruitment and retention strategies, to ensure placement of an adequate health workforce in underserved areas, such as conflict affected areas, rural and remote locations and services for the urban poor.

6. Policy Implementation Timeframe

The HRH Policy will guide policy activity over the nine-year period from 2018 to 2026. During this time, a review will be undertaken before 2021 of the HRH Strategy 2018-2021, and a new HRH Strategy developed as necessary according to progress made and in line with the objectives of the next *National Health Plan 2022-2026.*

Part 3. HRH STRATEGIES

The following Strategies are structured under three Strategic Areas: Planning, Quality, and Governance & Financing. Strategic Actions that seek to operationalise the Strategies are in Part 4 below.

1. PLANNING

POLICY OBJECTIVE*: **To specify the adequate production numbers, mix and distribution of staff required to achieve the medium to long term objectives for universal health coverage as specified in the National Health Plan 2017-2021**.*

Research, information and planning

Strategy 1.1: ***Create and maintain coordinated research, health information and planning systems that support timely and robust health workforce planning and implementation.***

Expected Outcome/s:

Robust, adequately resourced and coordinated systems of health workforce planning and implementation.

Workforce classifications

Strategy 1.2: ***Determine the categories of health personnel needed to meet the National Health Plan objectives for universal health coverage, based on the World Health Organization International Classification of Health Workers, including support staff categories required in a decentralised system.*** (See Appendix 1)

Expected Outcome/s: Workforce classifications that support phased introduction of universal health coverage.

Strategy 1.3: ***Determine a feasible mix of skills required to perform basic essential package of health services using a team approach within a primary health care context.***

Expected outcome/s: An affordable and sustainable mix of health workforce skills for primary health care that reflects service utilization and population needs, and the effective use of limited resources.

Workforce numbers

Strategy 1.4: ***Determine health workforce production requirements to meet current and projected health system needs consistent with the National Health Plan goal and targets for universal health coverage with equity.***

Expected outcome/s: Adequate numbers of health personnel to deliver on universal health coverage goals.

Workforce recruitment

Strategy 1.5: ***Establish processes for recruitment of health workers aligned with health system goals and specific needs.***

Expected outcome/s: Recruitment processes that facilitate the functioning of an effective, efficient and equitably distributed health workforce.

Workforce distribution

Strategy 1.6: ***Design and implement strategies for improving the distribution of human resources for health, particularly in rural and remote areas, among vulnerable communities and in areas which are rapidly urbanizing.***

Expected outcome/s: A health workforce distribution that enables access of all populations to a well-managed essential package of health services.

Workforce retention

Strategy 1.7. ***Determine the factors that will retain health staff in the service.***

Expected outcome/s: An understanding of issues that assist in the development of retention strategies.

Public-private partnerships

Strategy 1.8: ***Design and implement procedures to regulate HRH working in public/private partnership structures.***

Expected outcome/s: A mixed system of integrated public and private health services delivering consistent quality health care to the whole population.

Workforce migration and mobility

Strategy 1.9: ***Regulate the health workforce labour market including reducing the negative impact of health worker outflows, supporting return of qualified staff and inflow of practitioners from other countries.***

Expected outcome/s: A system of workforce migration and mobility that strengthens the Myanmar health workforce.

2. QUALITY

POLICY OBJECTIVE: ***To develop and implement systems of education, regulation and performance management that ensure standards of quality care that correspond to the health needs of the population and the goal of universal health coverage.***

Education and training

Strategy 2.1: ***Strengthen and support educational and training systems to improve their capacity to produce a health workforce that is skilled, knowledgeable, competent and capable of achieving NHP health goals.***

Expected outcome/s: Educational and training systems that produce sufficient health workers with an appropriate mix and level of skills to deliver health system goals.

Career development

Strategy 2.2: ***Establish career pathways and criteria that enable competent and skilled staff to advance in their professional discipline and career development incentives that reward high performing staff working in underserved areas.***

Expected outcome/s: An appropriately skilled and incentivized health workforce that is capable of delivering on health system goals.

Registration systems

Strategy 2.3: ***Strengthen systems of health professions registration and licensing of appropriately skilled and competent health workers to ensure the maintenance and provision of national standards of health care.***

Expected outcome/s: Efficient, relevant and responsive professional registration systems that produce, define and regulate the roles and standards of the future health workforce.

Ethics and codes of conduct

Strategy 2.4: ***Create codes of ethical conduct and operating procedures to guide health worker practice and behaviour and to protect patients' rights.***

Expected outcome/s: A system of ethically consistent codes and operating procedures guiding all aspects of health worker behaviour.

Performance appraisal

Strategy 2.5: ***Develop systems and processes to assess and improve HRH performance and to foster a culture of continual improvement.***

Expected outcome/s: A continually improving health system that rewards and promotes excellence.

Gender and cultural acceptability

Strategy 2.6: ***Promote gender equity and ethnic and cultural inclusivity.***

Expected outcome/s: Mainstreaming of gender policy and ethnic health frameworks into health planning and management processes.

Common HRH standards across public and non-government/private sectors

Strategy 2.7. ***Regulate the quality of HRH standards and practices in non-government and private sector health care provider organisations.***

Expected outcomes/s: Common systems of monitoring, evaluation and supervision such that standards are consistent across the public, private, NGOs and EHOs sectors.

3. GOVERNANCE AND FINANCING

POLICY OBJECTIVE: ***To develop and implement a sustainable Human Resources for Health Management institutional framework, inclusive of the required regulatory, information and planning guidelines and tools for quality HRH management; and to secure adequate resource mobilization to support decentralised Human Resources for Health management and leadership in Myanmar.***

Leadership

Strategy 3.1: ***Ensure strong, coordinated health workforce governance and leadership capable of responding to health system information and population health needs***

Expected outcome/s: A health system led by adequately trained leaders and managers working through effective governance frameworks.

Regulation

Strategy 3.2: ***Create a regulatory architecture that supports the strategic actions detailed in this HRH Strategy.***

Expected outcome/s: Robust yet flexible systems of government regulation that supports a safe and effective health workforce.

Accountability

Strategy 3.3: ***Initiate and maintain accountabilities that deliver equitable access to high quality health services.***

Expected outcome/s: Organizational cultures that support continual improvement and accountability for performance.

Roles and functions

Strategy 3.4: ***Clarify roles, functions and scope of practice for all HRH to deliver the basic package of essential health services.***

Expected outcome/s: A coherent and accountable health workforce capable of meeting organisational and population health needs.

Occupational health and safety

Strategy 3.5: ***Develop, publish, disseminate and implement policies and procedures to protect the health and safety of the health workforce***

Expected outcome/s: A workforce environment that protects the health, safety and wellbeing of the health workforce.

Industrial relations

Strategy 3.6: ***Develop systems to manage and respond to industrial relations demands and/or disputes***

Expected outcome/s: A system capable of responding to industrial relations demands and/or disputes.

Remuneration

Strategy 3.7: ***Deliver a feasible and flexible package of public sector health workforce remuneration and non-monetary recognition of high performing VBHW.***

Expected outcome/s: Remuneration arrangements and systems that attract and retain human resources for health in the public sector and at for Village Basic Health Workers.

Special allowances

Strategy 3.8: ***Deliver a feasible, equitable and transparent system of special allowances for selected health workers.***

Expected outcome/s: Special allowance arrangements and systems that recognize unique practice situations and that reward performance.

HRH financing and budgeting

3.9: ***Prepare budgets for the planning, production, distribution, retention and CPD of the required numbers and mix of staff to attain universal health coverage in the context of wider labour market considerations.***

Expected outcome/s: An appropriately financed human resources for health infrastructure and health workforce capable of supporting health system goals.

Part 4. STRATEGIC ACTIONS

STRATEGIC AREA 1. PLANNING ***Policy Objective: To specify the adequate production numbers, mix and distribution of staff required to achieve the medium to long term objectives for universal health coverage as specified in the National Health Plan 2017-2021.***			
Domain	**STRATEGIC ACTION**	**CENTRAL HRH UNIT IN COLLABORATION WITH**	**COMMENCEMENT TARGETS**
INFORMATION & PLANNING	***Strategy 1.1: Create and maintain coordinated research, health information and planning systems that support timely and robust health workforce planning and implementation.***		
	Strategic Action 1.1.1: Establish a Central Human Resources for Health Unit (HRHU) under the Minister's Office, including representatives from all departments, with clear terms of reference and capacity to coordinate all aspects of HRH, including: • Mobilizing human and financial resources and political commitment to support the health sector to attain universal health coverage with equity. • Promoting and strengthening inter-sectoral coordination and networking for management of HRH, including consulting jointly within MoHS departments, other ministries (including UCSB, MoPF, MoE) and other relevant stakeholders, such as parliamentarians, donors, DPs, EHOS, CSOs, NGOs and the private sector for HRH planning and quality improvement purposes. • Leading effective evidence-informed planning, management and monitoring of human resources and policy implementation.	DHRH, DPH, DMS	Q1 2018
	Strategic Action 1.1.2: Align HRHU mechanisms with the National Health Plan implementation including the development of annual operational plans for HRH.	DHRH, DPH, DMS, NIMU	Q1 2018
	Strategic Action 1.1.3: Develop and maintain an integrated information system on health personnel, and strengthen mechanisms for national human resources data collection, reporting and analysis to inform policy and enable effective management of HRH.	DPH (Planning, DAAS),	Q4 2018

	Strategic Action 1.1.4. Establish baseline indicators for inclusion in Annual Operational Plans and against which to evaluate the implementation of this HRH Strategy . Such as: • The percent of Townships that have staff numbers that meets national standard. • The percent of Townships that have staff mix of midwife to PHSII that meets national standard. • The annual production of new BHS staff to match forecasted needs in this planning period.	NIMU	
	Strategic Action 1.1.5: Conduct, disseminate and use research findings on acceptability, availability, accessibility and quality of human resources for health for health planning.	UPH, DMR	Q4 2018
	Strategic Action 1.1.6: Develop and disseminate standard operating procedures for HRH management including recruitment, retention, professional development, performance appraisal, supportive supervision, remuneration and special allowances, and other related procedures.	NIMU	Q1 2018
	Strategic Action 1.1.7: Explore the feasibility of linking the centralized payroll system with the centralized human resources information system (HRIS).	DPH (Planning)	Q1 2018
	Strategic Action 1.1.8: Phased in a unique identity (ID) to facilitate HR planning and management.	DPH (Planning)	Q1 2018
	Strategic Action 1.1.9: Develop a plan for decentralised HR management. • Facilitate decentralized planning, budgeting, monitoring and evaluation consistent with the *National Health Plan 2017 – 2021.* • Support S/R and townships to take up HR functions and authorities in accordance with decentralization.	NIMU, MoHS,	Q1 2018
	Strategic Action 1.1.10: Include the activities of VBHW in the Health Information System.	NIMU	Q1 2018

WORKFORCE CLASSIFICATIONS	***Strategy 1.2: Determine the categories of health personnel needed to meet the National Health Plan objectives for universal health coverage, based on the World Health Organization International Classification of Health Workers, including support staff categories required in a decentralised system.***		
	Strategic Action 1.2.1: Update the classifications of health cadres, including those external to the MoHS, using the health worker classifications developed by WHO (see Appendix 1) adapted as needed for the Myanmar specific country context. • Update job descriptions to reflect the competencies of different cadres e.g. for BHS and VBHW to provide basic EPHS in alignment with NHP (2017 – 2021) • Create career opportunities for all cadres at all levels including for VBHWs.	MoHS Training Section, NIMU	Q1 2018
	Strategic Action 1.2.2: Determine the appropriate balance of categories of staff for the differing levels of care to ensure appropriate skill-mix and the efficient use of human resources, with reference to local contexts.	MoHS	Q3 2018
	Strategic Action 1.2.3: Assess the need for and initiate the training of support staff necessary to address health system priorities at Township, State and Regional levels, in particular for ICT, health planning and financial management, and for monitoring and evaluation in a decentralised system.	State and Region MoHS	Q3 2018
	Strategic Action 1.2.4: Expand supportive supervision to all HRH cadres including VBHWs to ensure their competencies complement those of government health personnel and that they are integrated into local health systems.	Program Managers and State ad Region from MoHS	Q 4 2021
	Strategic Action 1.2.5: Strengthen the collaboration with Private sector/EHO to ensure the service provision/implementation at local level	S/R Health Directors, MoHS	Q 4 2021
	Strategy 1.3: Determine a feasible mix of skills required to perform basic essential package of health services using a team approach within a primary health care context.		
	Strategic Action 1.3.1: Establish an HRH database that enables monitoring and reporting of the distribution and mix of HRH, staff-to-population ratios at Township, State and Regional levels that assists HR deployment to keep pace with demographic changes and population health needs.	TWG and DPH (Planning)	Q4 2018
	Strategic Action 1.3.2: Identify support for multi-skilling and the potential for task-shifting among categories of staff to overcome staff shortages as needed.	State and Regional training teams	Q1 2018

	Strategic Action 1.3.3: Foster team-based models of care that include delegated functions and supervision models, especially in areas where there are health workforce shortages.	DPH, DMS, S/R MoHS	Q1 2018
	Strategic Action 1.3.4: Regular review and update of training manual of BHS and develop manuals for VBHW to overcome service deficiencies with an emphasis on integrated primary health care services and life-saving skills.	DPH, MoHS, NIMU	Q1 2018
	Strategic Action: 1.3.5: Promote and resource the use of mobile teams of skilled staff to provide scheduled clinics in facilities which are in need of technical competence or capacity in specific areas.	DPH	Q2 2018
	Strategic Action 1.3.6: Improve, standardise and resource referral systems from community to facility level.	MoHS	2019-20
WORKFORCE NUMBERS	***Strategy 1.4: Determine health workforce production requirements to meet current and projected health system needs consistent with the National Health Plan goal and targets for universal health coverage with equity.***		
	Strategic Action: 1.4.1: Project the numbers of each cadre required to achieve the NHP target of delivering the basic package of Essential Health Service by 2021 and increase production annually.	DHRH/DPH	Q1 2018
	Strategic Action 1.4.2: Monitor and update annually the skill mix required at each level of service.	MoHS	Q1 2019
	Strategic Action 1.4.3: Align production with the projected needs for health workers	DHRH	Q4 2018
WORKFORCE RECRUITMENT	***Strategy 1.5: Establish processes for recruitment of health workforce aligned with health system goals and specific needs.***		
	Strategic Action 1.5.1: Publish and disseminated Standard Operating Procedures for recruitment and orientation of new health workforce	NIMU	Q3 2019
	Strategic Action 1.5.2: Plan to recruit graduates only from quality assured institutions, to ensure that staff are selected based on the core competencies identified for each cadre and posting.	DHRH, Professional councils	Q1 2021
	Strategic Action 1.5.3. Adopt policies to substantially increase the recruitment of students from areas with workforce shortages and from ethnic and vulnerable communities to address health workforce inequities as measured by HRH to population ratios across townships, states and regions.	DHRH	Q3 2018

WORFORCE DISTRIBUTION	***Strategy 1.6: Design and implement strategies for improving the distribution of human resources for health, particularly in rural and remote areas, among vulnerable communities and in areas which are rapidly urbanizing.***		
	Strategic Action 1.6.1: Investigate the development and implementation of targeted initiatives to enhance health workforce availability in underserved areas.	MoHS and S/R	Q1 2018
	Strategic Action 1.6.2: Extend midwifery and PHS II coverage at sub-health centres by increasing deployment of midwives and by other means to reduce heavy workloads of midwives in rural areas.	DPH	Q1 2018
WORKFORCE RETENTION	***Strategy 1.7. Determine the factors that will retain health staff in the service.***		
	Strategic Action 1.7.1: Acquire evidence on motivational factors that would retain health workforce in the health system. (e.g. routine data collection, exit interview and reviewing existing literature)	Relevant research departments and institutes	Q2 2018
	Strategic Action 1.7.2: Address the issues revealed by gathered evidence with actions to reduce numbers of staff leaving service.	MoHS	Q1 2019
	Strategic Action 1.7.3. Integrate into HRH planning the re-contracting of competent and needed health professionals beyond their retirement age.	DMS, DPH, DHRH	Q1 2018
PUBLIC-PRIVATE PARTNERSHIPS	***Strategy 1.8: Design and implement procedures to regulate HRH working in public/private partnership structures.***		
	Strategic Action 1.8.1: Create regulations for HRH staff working in public /private partnership service structures.	MoHS, Professional Councils	Q1 2019
	Strategic Action 1.8.2: Create regulations for HRH practice consistent with purchaser provider arrangements.	NIMU, MoHS	Determined by progress on these arrangements.
WORKFORCE MIGRATION AND MOBILITY	***Strategy 1.9: Regulate the health workforce labour market including reducing the negative impact of health worker outflows, supporting return of qualified staff and inflow of practitioners from other countries.***		
	Strategic Action 1.9.1: Develop a baseline report on the rate of health worker migration out of Myanmar.	MoHS	Q4 2018
	Strategic Action 1.9.2: Enforce systems of temporary registration for foreign nationals consistent with the Association of South East Asian Nations (ASEAN) policy on regional HRH mobility.	MoHS. Professional Councils	Q1 2018

	Strategic Action 1.9.3. Regulate the employment and/or practice of foreign trained practitioners including traditional medicine practitioners.	MoHS	Q2 2018
	Strategic Action 1.9.4: Intensify efforts to support the return of qualified staff who have obtained further qualifications abroad.	MoHS	Q1 2018
	Strategic Action 1.9.5: Promote a model of professional mobility that is consistent with the ASEAN policy on regional integration and with the WHO Code of Practice on the International Recruitment of Health Personnel.	MoHS	Q1 2018

STRATEGIC AREA 2. QUALITY ***Policy Objective: To develop and implement systems of education, regulation and performance management ensuring standards of quality care that correspond to the health needs of the population and the goal of universal health coverage.***			
	STRATEGIC ACTIONS	***CENTRAL HRH UNIT IN COLLABORATION WITH***	***COMMENCEMENT TARGETS***
EDUCATION AND TRAINING	***Strategy 2.1: Strengthen and support educational and training systems to improve their capacity to produce a health workforce that is skilled, knowledgeable, competent and capable of achieving NHP health goals.***		
	Strategic Action 2.1.1: Establish and use national systems of institutional assessment and accreditation criteria for doctors, nursing and midwifery training institutions and programs in both the public and private sectors (and later for NGOs and EHOs).	Professional councils, DHRH	Q3 2017
	Strategic Action 2.1.2: Establish criteria, monitor and report on student intake numbers to all health professions courses to align student intakes (accounting for rates of attrition) with forecasted HRH needs.	MoHS	Q4 2019
	Strategic Action 2.1.3: Periodically review and update under-graduate and post-graduate curricula, to ensure educational content, processes and outcomes match changing population health needs and health system requirements.	DHRH	Q3 2017
	Strategic Action 2.1.4: Implement methods to ensure all students have sufficient clinical exposure during training, such as establishing additional skills labs at selected medical, nursing and midwifery schools.	DHRH, DPH	Q3 2017
	Strategic Action 2.1.5: Conduct continuing professional education (CPE) to align curriculum content, required competencies and job descriptions with the implementation of the essential package of health services.	DPH, DHRH, DMS	Q1 2018
	Strategic Action 2.1.6: Develop standardised cadre-specific teaching and learning materials and CPE processes to include reference and links to complementary health team roles.	DMS, DPH	Q2 2018
	Strategic Action 2.1.7: Establish a central Continuing Education (CE) database linked to the centralized HRH database, to monitor and report on the individuals, numbers and locations of staff trained in order to inform programme roll-out and action towards increasing overall workforce competence and coverage.	DHRH, DPH, DMS, Professional Associations	Q3 2019

	Strategic Action 2.1.8: Establish Regional/State Training Units to coordinate decentralized implementation of CE for training all categories of health cadres including VBHW.	DPH, DMS	Q3 2018
	Strategic Action 2.1.9: Support educational institutions to develop strategic and costed operational plans with agreed institutional objectives, including consideration of: • Strengthening faculty capacity; • Improving learning environments, facilities, equipment and materials; • Improving clinical exposure and the ratio of preceptor to students in hospitals and other health settings; • Access to patients willing to allow student clinical learning; • Development of skills labs for skills practice.	DHRH, DMS, DPH	Q1 2018
CAREER DEVELOPMENT	***Strategy 2.2: Establish career pathways and criteria that enable competent and skilled staff to advance in their professional discipline and career development incentives that reward high performing staff working in underserved areas.***		
	Strategic Action 2.2.1: Develop the criteria that reflect the competencies and skills required for advancement in a professional discipline; (CPE points, performance appraisal, years of experience).	DMS, DPH, DHRH	Q1 2019
	Strategic Action 2.2.2: Articulate performance-based career pathways for each professional category that document promotional steps and selection criteria to enable advancement in a profession or discipline.	MoHS	Q3 2018
	Strategic Action 2.2.3: Articulate additional performance-based career pathways specifically for health professionals serving under-served population groups (e.g. ethnic minorities and stigmatised groups) to support the NHP goal for UHC with equity.	DMS, DPH, DHRH	Q1 2019
	Strategic Action 2.2.4: Give priority access to publicly-funded postgraduate training opportunities to staff serving in or recruited from underserved areas.	DMS, DPH, DHRH	Q1 2019
	Strategic Action 2.2.5: Identify common standards for VBHW to access training including for entering professional cadres.	DPH, DHRH	Q4 2018

REGISTRATION SYSTEMS	***Strategy 2.3: Strengthen systems of health professions registration and licensing of appropriately skilled and competent HRH to ensure the maintenance and provision of national standards of health care.***		
	Strategic Action 2.3.1: Reinforce health professional councils' mandates, roles and capacities to register all health professionals in both public and private sectors, and to: • Set requirements for entry/re-entry into a profession • Determine standards of practice • Investigate complaints against health professionals and instigate disciplinary measures when necessary • Provide advice to government on matters relevant to health professions • Set standards and processes for accreditation review, and approval of programmes for graduate registration and licensing according to National Accreditation and Quality Assurance Committee (NAQAC) and Professional Councils	MoHS, professional councils	Q1 2018
	Strategic Action 2.3.2: Strengthen central registry of health professionals registered with and licenced by professional councils; and require all registered health professionals to apply for renewal of license-to-practice within prescribed timelines.	Professional Councils, MoHS	Q3 2020
	Strategic Action 2.3.3: Strengthen linkages between professional councils and international stakeholders (e.g. ASEAN, World Federation of Medical Education, and other regional professional bodies).	Professional Councils	Q1 2018
	Strategic Action 2.3.4. Conduct a locational mapping exercise and register of VBHW to facilitate rationalisation of cadres, referral systems and local training.	DPH including State/Region, DHRH, NIMU	Q1 2019
ETHICS AND CODES OF CONDUCT	***Strategy 2.4: Create codes of ethical conduct and operating procedures to guide HRH practice and behaviour and to protect patients' rights.***		
	Strategic Area 2.4.1: Review, revise and develop the national Code of Ethical Conduct consistent with the *Global Code of Conduct for Healthcare Professionals.*	MOHS, Professional Councils	Q4 2019
	Strategic Area 2.4.2: Consult with stakeholders, develop, publish and disseminate a *Charter of Patients' Rights and Responsibilities* in health care provision.	MOHS, Professional Councils	Q4 2019

	Strategic Area 2.4.3: Establish and implement standard operating procedures for reporting malpractice and adverse events and for responding according to the law.	MOHS, Professional Councils, Attorney General	Q4 2019
PERFORMANCE APPRAISAL	***Strategy 2.5: Develop systems and processes to assess and improve HRH performance and to foster a culture of continual improvement.***		
	Strategic Area 2.5.1: Establish systems for regular periodic performance appraisal of all HRH, including feedback by staff on the conditions and facilities that limit their professional performance.	MoHS and all departments	Q1 2020
	Strategic Area 2.5.2: Revise where necessary the standard operating procedures and guidelines for supportive supervision, monitoring and performance evaluation, to foster a culture of performance appraisal and improvement throughout the health system.	MoHS and all departments	Q2 2019
GENDER AND CULTURAL ACCEPTABILITY	***Strategy 2.6: Promote gender equity and ethnic and cultural inclusivity.***		
	Strategic Area 2.6.1: Assess, develop, disseminate and implement a gender policy for the health sector, which considers: • Integrating gender mainstreaming principles into planning and implementation of service delivery, recruitment and promotion of health staff. • Securing resources to address gender issues limiting the equitable provision of reproductive, maternal, neonatal, child and adolescent health services. • Promoting gender parity in health decision-making within families and communities. • Developing guidelines for the prevention and reporting of sexual and gender -based violence.	MOHS (lead department will be DPH)	Q 1, 2018
	Strategic Area 2.6.2: Develop, publish, disseminate and implement an *Ethnic Human Resources for Health Strategy*, which establishes: • A program of needs-based planning to ensure equitable resource allocation to remote and conflict-affected regions. • An ethnic HRH strategy that prioritises training and public-sector employment quotas for ethnic populations. • A partnership strategy to ensure ethnic health organisations are adequately consulted and represented in health service delivery decision-making in their regions.	DPH, DMS, DHRH,	Q1 2018

HRH STANDARDS IN PPP	**Strategy 2.7. Regulate the quality of HRH standards and practices in private sector health care provider organisations.**		
	Strategic Action 2.7.1. Regulate the quality of private sector health care providers by common systems of monitoring, evaluation and supervision such that standards are consistent across the public, private, NGOs and EHOs sectors.	MoHS, private sector, EHO and Professional Councils	Q3 2019
	Strategic Action 2.7.2: Explore procedural mechanisms for improving patient referral, service collaboration and information exchange between the private and public sectors and between VBHW and TMOs.	MoHS, private sector, EHO	Q3 2019
	Strategic Action 2.7.3: Regulate dual practice by monitoring and enforcing public sector attendance and working hours for public sector employees.	MoHS, private sector, EHO	Q3 2019
	STRATEGIC AREA 3. GOVERNANCE & FINANCING ***Policy Objective: To develop and implement a Human Resources for Health Management institutional framework, inclusive of the required regulatory, information and planning guidelines and tools for quality HRH management; and to secure adequate resource mobilization to support decentralised Human Resources for Health management and leadership in Myanmar.***		
	STRATEGIC ACTIONS	***CENTRAL HRH UNIT IN COLLABORATION WITH***	***COMMENCEMENT TARGETS***
LEADERSHIP	***Strategy 3.1: Ensure strong, coordinated health workforce governance and leadership capable of responding to health system information and population health needs.***		
	Strategic Action 3.1.1: Identify human resource for health leadership and management responsibilities at state, regional and township levels consistent with the decentralization agenda, and document these in Terms of Reference and job descriptions.	DPH, DMS	Q2 2018
	Strategic Action 3.1.2: Strengthen human resources management capacity at all levels to effectively manage delegated human resource functions, through training, complemented by ongoing structured mentoring and regular period supportive supervision.	MoHS	Q1 2018
	Strategic Action 3.1.3: Strengthened soft skilled training in an integrated manner in all pre-service training	DHRH	Q1 2018

REGULATION	***Strategy 3.2: Create a regulatory architecture that supports the strategic actions detailed in this HRH Strategy .***		
	Strategic Action 3.2.1: Consult with relevant legal authorities to review this HRH Strategy to create or revise legislation and regulations to authorise Strategies and Actions in line with the decentralisation of administrative functions, the accreditation of educational institutions, programs and facilities and the licensing of health practitioners.	MoHS, Professional Councils and Union Attorney General's Office	Q1 2018
	Strategic Action 3.2.2: Ensure that regulations are in place to support the health workforce in line with International Health Regulations on the development, prevention, preparedness, response and recovery phases of emergency health situations.	DPH, DMS	Q1 2018
ACCOUNTABILITY	***Strategy 3.3: Initiate and maintain accountabilities that deliver equitable access to high quality health services.***		
	Strategic Action 3.3.1 - To develop effective, efficient and convenient communication channel among different stakeholders	MoHS	
	Strategic Action 3.3.2: Promote accountability for performance, through the introduction of annual operational planning systems that require reporting against agreed service quality and equity targets.	MoHS	Q1 2018
ROLES AND FUNCTIONS	***Strategy 3.4: Clarify roles, functions and scope of practice for all HRH to deliver the basic package of essential health services.***		
	Strategic Action 3.4.1: Ensure that HRH operational planning processes and job descriptions reflect HRH requirements to deliver the Basic Package of Essential Health Services for each level of service as defined in the *National Health Plan*.	TWG	Q4 2018
	Strategic Action 3.4.2: Update organisational charts and job descriptions consistent with the overall strategic definitions of roles and functions as defined in the *National Health Plan* and other relevant and endorsed strategic documents.	TWG	Q4 2018
	Strategic Action 3.4.3. Develop guidelines for the functions of the proposed State/Region and Township Health Working Groups.	DPH, DMS, NIMU	Q1 2018
	Strategic Action 3.4.4: Consider the potential benefits in HRH production, research and educational standards of increased autonomy in the HRH education sector.	MoHS	Q1 2020

OCCUPATIONAL HEALTH AND SAFETY	***Strategy 3.5: Develop, publish, disseminate and implement policies and procedures to protect the health and safety of the health workforce.***		
	Strategic Action 3.5.1: Review and revise policies and procedures regarding the health and safety of all health workers.	MoHS	Q4 2018
	Strategic Action 3.5.2: Conduct periodic audits of the effectiveness of occupational health and safety enforcement systems and institute corrective actions where necessary, with particular emphasis on conflict-affected areas, humanitarian emergency situations and areas of high and stressful workloads.	MoHS	Q4 2018
	Strategic Action 3.5.3: Ensure a safe work environment through appropriate regulation for both daily interactions as well as health risks.	MoHS	Q1 2018
INDUSTRIAL RELATIONS	***Strategy 3.6: Develop systems to manage and respond to industrial relations demands and/or disputes.***		
	Strategic Action 3.6.1: With the support of legal advice design and implement standard operating procedures for the solution of industrial disputes.	MoHS, Union Attorney General's Office, Private sector	Q2 2019
REMUNERATION	***Strategy 3.7: Deliver a feasible and flexible package of public sector health workforce remuneration and non-monetary recognition of high performing VBHW.***		
	Strategic Action 3.7.1: Liaise with Ministry of Labour, Immigration and Population and MoPF to advocate for revised remuneration packages for public sector health workers including considering performance and other criteria e.g. hard to reach areas.	MoHS	Q2 2018
	Strategic Action 3.7.2: Where existing remuneration is insufficient to retain HRH, create flexible policy options to explore and access additional sources of remuneration to attract and retain health workers in hardship postings.	MoHS and Philanthropic organizations	Q2 2018
	Strategic Action 3.7.3. Develop a standardized remuneration and allowances package for VBHW (both monetary and non-monetary).	MoHS	Q2 2018
SPECIAL ALLOWANCES	***Strategy 3.8: Deliver a feasible, equitable and transparent system of special allowances for selected health workforce.***		
	Strategic Action 3.8.1: Assess and recommend special allowances for health workers in remote and conflict-affected areas or among vulnerable communities, and for other health workforce categories as determined through policy consultation and discussion. – OK as per overarching Strategic Action.	MoHS, MoPF, State/Regional Government	Q2 2018

	Strategic Action 3.8.2: Explore the possibility of introducing systems of performance-based payments and non-monetary benefits for aspects of public service in alignment with the health financing strategy.	MoHS	Q2 2018
FINANCING AND BUDGETING	***3.9. Prepare budgets for the planning, production, distribution and retention of the required numbers and mix of staff to attain universal health coverage.***		
	Strategic Action 3.9.1: Develop Costed Annual Operation Plan for HRH in line with the national budgeting cycle and NHP	MOHS, MoPF	Q1, 2018
	Strategic Action 3.9.2: Improve evidence for health funding requirements for HRH and strengthen advocacy with central government agencies involved in resource allocation.	MoHS, MoPF	Q1 2018
	Strategic Action 3.9.3: Mobilise resources through engagement with donors to support UHC strategy development and implementation.	MoHS	Q1 2018
	Strategic Action 3.9.4: Identify additional resources needed for increased regulatory and other functions at the state and regional levels and make a case to secure these in a sustainable manner.	MoHS	Q1 2018

Part 5. MONITORING AND EVALUATION FRAMEWORK

The Monitoring and Evaluation (M&E) Framework in Part 5 (a) is linked to the Strategic Actions and Targets detailed in PART 4. (Refer to PART 4 for a complete description of Actions summarised below.) To monitor progress on achieving Targets select the appropriate Monitoring Code (1-5) by Planning Year.

As such, the Framework does not include targets and indicators associated with outputs or outcomes – this shall require agreement between implementing stakeholders and consistency with the final HRH-related NHP targets and indicators. And, back-up from the development of HRIS for requisite information and data. As guidance, in Part 5 (b), the HRH related Sustainable Development Goals (SDGs) have been detailed as well as Milestones towards the SDG as in the WHO G*lobal Strategy on Human Resources for Health*: *Workforce 2030;* and, in Part (c), 14 agreed indicators to monitor progress on the Decade of HRH in the WHO South-East Asia Region have been (MoHS Myanmar participated in associated consultations and they include indicators related to the Global HRH Milestones).

Finally, it is important to note the role of operational research as a key component of evaluation especially with respect to review and revision of actions and even the Strategy itself.

MONITORING PROGRESS ON STRATEGIC ACTIONS (Part 5 (a))

STRATEGIC AREA 1. PLANNING

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
1.1. *Create and maintain coordinated research, health information and planning systems that support timely and robust health workforce planning and implementation.*	1.1.1. Establish a Central Human Resources for Health Unit (HRHU)							
	1.1.2. Align HRHU mechanisms with the National Health Plan including annual operational plans for HRH.							
	1.1.3. Develop and maintain an integrated information system on health personnel, and strengthen mechanisms for national human resources data collection, reporting and analysis to inform policy and enable effective management of HRH							
	1.1.4. Establish baseline indicators for inclusion in Annual Operational Plans and against which to evaluate the implementation of this HRH Strategy							
	1.1.5. Conduct, disseminate and use research findings on acceptability, availability,							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
	accessibility and quality of human resources for health for health planning							
	1.1.6. Develop and disseminate standard operating procedures for HRH management							
	1.1.7. Explore the feasibility of linking the centralized payroll system with the centralized human resources information system (HRIS)							
	1.1.8. Phased in a unique identity (ID) to facilitate HR planning and management							
	1.1.9. Develop a plan for decentralised HR management. planning, budgeting, monitoring and evaluation consistent with *NHP 2017 – 2021.*							
	1.1.10: Include the activities of VBHW in the Health Information System.							
1.2. *Determine the categories of health personnel needed to meet the National*	1.2.1. Update the classifications of health cadres including those external to the MoHS, using the health worker classifications developed by							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
Health Plan objectives for universal health coverage and support staff required in a decentralised system.	WHO adapted as needed for the Myanmar specific country context.							
	1.2.2. Determine the appropriate balance of categories of staff for the differing types of health facilities.							
	1.2.3. Assess the need for and initiate the recruitment of support staff necessary to address health system priorities at Township, State and Regional levels							
	1.2.4. Expand supportive supervision to all HRH cadres including EHOs and VBHWs to ensure their competencies complement those of government health personnel and they are integrated into local health systems.							
	1.2.5. Strengthen the collaboration with Private sector/EHO to ensure the service provision/implementation at local level							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
1.3. *Determine a feasible mix of skills required to perform basic essential package of health services using a team approach within a primary health care context.*	1.3.1. Establish an HRH database that enables monitoring the distribution and mix of HRH, staff-to-population ratios at Township, State and Regional levels							
	1.3.2. Identify possibilities for multi-skilling and the potential for task-shifting							
	1.3.3. Foster team-based models of care that include delegated functions and supervision models.							
	1.3.4. Regular review and update of training manuals of BHS and VBHW							
	1.3.5. Promote and resource the use of mobile teams of skilled staff.							
	1.3.6. Improve, standardise and resource referral systems from community to facility level.							
1.4. *Determine health workforce production requirements to meet current and projected*	1.4.1. Project the numbers of each cadre required to achieve the NHP target of delivering the basic package of Essential Health Service by 2021 and increase production annually.	What % of townships / RHCs have numbers according to nat.std						

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
health system needs consistent with the National Health Plan goal and targets for universal health coverage with equity.	1.4.2. Monitor and update annually the skill mix required at each level of service.	What % of townships / RHCs have skill mix according to nat.std						
	1.4.3 Align production with the projected needs for health workers	Basic Health Staff (BHS) production capacity as a proportion of projected BHS need						
1.5. *Establish processes for recruitment of health workforce aligned with health system goals and specific needs.*	1.5.1. Publish and disseminated Standard Operating Procedures for recruitment and orientation of new health workers.							
	1.5.2. Plan to recruit graduates only from quality assured institutions, to ensure that staff are selected based on the core competencies identified for each cadre and posting							
	1.5.3. Adopt policies to substantially increase the recruitment of students from areas with workforce shortages and from ethnic and vulnerable communities.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
1.6. *Design and implement strategies for improving the distribution of human resources for health, particularly in rural and remote areas, among vulnerable communities and in areas which are rapidly urbanizing.*	1.6.1. Investigate the development and implementation of targeted initiatives to enhance health workforce availability in underserved areas							
	1.6.2 Extend midwifery and PHS II coverage at sub-health centres by increasing deployment of midwives and by other means to reduce heavy workloads of midwives in rural areas.							
1.7. Determine the factors that will retain health staff in the service.	1.7.1. Acquire evidence on motivational factors that would retain health workforce in the health system.							
	1.7.2. Address the issues revealed by gathered evidence with actions to reduce numbers of staff leaving service.							
	1.7.3. Integrate into HRH planning the re-contracting of competent and needed health professionals beyond their retirement age.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
1.8. *Design and implement procedures to regulate HRH working in public/private partnership structures.*	1.8.1. Create regulations for HRH staff working in public /private partnership service structures.							
	1.8.2. Create regulations for HRH practice consistent with purchaser provider arrangements.							
1.9. *Regulate labour market including the negative impact of health worker outflows, support return of qualified staff and inflow of practitioners from other countries.*	1.9.1. Develop a baseline report on the rate of health worker migration out of Myanmar.							
	1.9.2. Enforce systems of temporary registration for foreign nationals consistent with the Association of South East Asian Nations (ASEAN) policy on regional HRH mobility.							
	1.9.3. Regulate the employment and/or practice of foreign trained practitioners including traditional medicine practitioners.							
	1.9.4. Intensify efforts to support the return of qualified staff who have obtained further qualifications abroad.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
	1.9.5. Promote professional mobility consistent ASEAN policy on regional integration and with the WHO Code of Practice on the International Recruitment of Health Personnel.							

STRATEGIC AREA 2. QUALITY

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
2.1. *Strengthen and support educational and training systems to improve their capacity to produce a health workforce that is skilled, knowledgeable, competent and capable of achieving NHP health goals.*	2.1.1. Establish and use national systems of institutional assessment and accreditation criteria for doctors, nursing and midwifery training institutions and programs in both the public and private sectors.							
	2.1.2. Establish criteria, monitor and report on student intake numbers to all health professions courses to align student intakes (accounting for rates of attrition) with forecasted HRH needs.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
	2.1.3. Periodically review and update under-graduate and post-graduate curricula.							
	2.1.4. Implement methods to ensure all students have sufficient clinical exposure during training.							
	2.1.5. Conduct CPE to align curriculum content, required competencies and job descriptions with the implementation of the essential package of health services.							
	2.1.6. Develop standardised cadre-specific teaching and learning materials and CPE processes to include reference and links to complementary health team roles.							
	2.1.7. Establish a central Continuing Education (CE) database linked to the centralized HRH database, to monitor and report on the individuals, numbers and locations of staff trained in order to inform programme roll-out and action towards increasing overall workforce competence and coverage.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
	2.1.8. Establish Regional/State Training Units to coordinate decentralized implementation of CE for training all categories of health cadres including VBHW.							
	2.1.9 Support educational institutions to develop strategic and costed operational plans with agreed institutional objectives							
2.2. *Establish career pathways and criteria that enable competent and skilled staff to advance in their professional discipline and* career development incentives that reward high performing staff working in underserved areas.	2.2.1. Develop the criteria that reflect the competencies and skills required for advancement in a professional discipline.							
	2.2.2. Articulate performance-based career pathways for each professional category that document promotional steps and selection criteria to enable advancement in a profession or discipline.							
	2.2.3. Articulate additional performance-based career pathways specifically for health professionals serving under-served population groups (e.g. ethnic minorities and stigmatised groups) to support the NHP goal for UHC with equity.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
	2.2.4. Give priority access to publicly-funded postgraduate training opportunities to staff serving in or recruited from underserved areas							
	2.2.5: Identify common standards for VBHW to access training including for entering professional cadres.							
2.3. *Strengthen systems of health professions registration and licensing of appropriately skilled and competent HRH to ensure the maintenance and provision of national standards of health care.*	2.3.1. Reinforce health professional councils' mandates, roles and capacities to register all health professionals in both public and private sectors.							
	2.3.2. Strengthen central registry of health professionals registered with and licenced by professional councils; and require all registered health professionals to apply for renewal of license-to-practice within prescribed timelines.							
	2.3.3. Strengthen linkages between professional councils and international stakeholders.							
	2.3.4. Conduct a locational mapping exercise and register of VBHW to facilitate rationalisation of cadres, referral systems and local training.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
2.4. *Create codes of ethical conduct and operating procedures to guide HRH practice and behaviour and to protect patients' rights.*	2.4.1. Review, revise and develop the national Code of Ethical Conduct consistent with the *Global Code of Conduct for Healthcare Professionals.*							
	2.4.2. Consult with stakeholders, develop, publish and disseminate a *Charter of Patients' Rights and Responsibilities.*							
	2.4.3. Establish and implement standard operating procedures for reporting malpractice and adverse events and for responding according to the law.							
2.5. *Develop systems and processes to assess and improve HRH performance and to foster a culture of continual improvement.*	2.5.1. Establish systems for periodic performance appraisal, including feedback on the conditions that limit professional performance.							
	2.5.2. Revise where necessary the standard operating procedures and guidelines for supportive supervision, monitoring and performance evaluation, to foster a culture of performance appraisal and improvement throughout the health system.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
2.6. *Promote gender equity and ethnic and cultural inclusivity.*	2.6.1. Assess, develop, disseminate and implement a gender policy for the health sector.							
	2.6.2. Develop, publish, disseminate and implement an *Ethnic Human Resources for Health Strategy.*							
2.7. Regulate the quality of HRH standards and practices in private sector health care provider organisations.	2.7.1. Regulate the quality of private sector health care providers by common systems of monitoring, evaluation and supervision such that standards are consistent across the public, private, NGOs and EHOs sectors.							
	2.7.2: Explore procedural mechanisms for improving patient referral, service collaboration and information exchange between the private and public sectors and between VBHW and TMOs.							
	2.7.3: Regulate dual practice by monitoring and enforcing public sector attendance and working hours for public sector employees.							

STRATEGIC AREA 3. GOVERNANCE AND FINANCING

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
3.1. *Ensure strong, coordinated health workforce governance and leadership capable of responding to health system information and population health needs.*	3.1.1 Identify human resource for health leadership and management responsibilities at state, regional and township levels consistent with the decentralization agenda, and document these in Terms of Reference and job descriptions.							
	3.1.2. Strengthen human resources management capacity at all levels to effectively manage delegated human resource functions, through training, complemented by ongoing structured mentoring and regular period supportive supervision.							
	3.1.3: Strengthened soft skilled training in an integrated manner in all pre-service training							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
3.2. *Create a regulatory architecture that supports the strategic actions detailed in this HRH Strategy .*	3.2.1. Consult with relevant legal authorities to review this HRH Strategy to create or revise legislation and regulations to authorise Strategies and Actions.							
	3.2.2. Ensure that regulations are in place to support health workers in line with International Health Regulations.							
3.3. *Initiate and maintain accountabilities that deliver equitable access to high quality health services.*	3.3.1. To develop effective, efficient and convenient communication channel among different stakeholders							
	3.3.2: Promote accountability for performance, through the introduction of annual operational planning systems that require reporting against agreed service quality and equity targets.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
3.4. C*larify roles, functions and scope of practice for all HRH to deliver the basic package of essential health services.*	3.4.1. Ensure that HRH operational planning processes and job descriptions reflect HRH requirements to deliver the Basic Package of Essential Health Services							
	3.4.2. Update organisational charts and job descriptions consistent with the overall strategic definitions of roles and functions.							
	3.4.3. Develop guidelines for the functions of the proposed State/Region and Township Health Working Groups.							
	3.4.4: Consider the potential benefits in HRH production, research and educational standards of increased autonomy in the HRH education sector.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
3.5. *Develop, publish, disseminate and implement policies and procedures to protect the health and safety of the health workforce.*	3.5.1. Review and revise policies and procedures regarding the health and safety of all health workers.							
	3.5.2. Conduct periodic audits of the effectiveness of occupational health and safety enforcement systems and institute corrective actions where necessary.							
	3.5.3: Ensure a safe work environment through appropriate regulation for both daily interactions as well as health risks.							
3.6. *Develop systems to manage and respond to industrial relations demands and/or disputes.*	3.6.1. With the support of legal advice design and implement a standard operating procedure for the solution of industrial disputes.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
3.7. *Deliver a feasible and flexible package of public sector health workforce remuneration and non-monetary recognition of high performing VBHW.*	3.7.1. Liaise with Ministry of Labour, Immigration and Population and MoPF to advocate for revised remuneration packages for public sector health workers including considering performance and other criteria e.g. hard to reach areas.							
	3.7.2. Where existing remuneration is insufficient to retain health workers, create flexible policy options to explore and access additional sources of remuneration.							
	3.7.3. Develop a standardized remuneration and allowances package for VBHW (both monetary and non-monetary).							
3.8. *Deliver a feasible, equitable and transparent system of special*	3.8.1. Assess and recommend special allowances for health workers in remote and conflict-affected areas or among							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
allowances for selected health workforce.	vulnerable communities, and for other health workforce categories as determined through policy consultation and discussion.							
	3.8.2. Explore the possibility of introducing systems of performance-based payments and non-monetary benefits for aspects of public service in alignment with the health financing strategy.							
3.9. *Prepare budgets for the planning, production, distribution and retention of the required numbers and mix of staff to attain universal health coverage.*	3.9.1. Develop Costed Annual Operation Plan for HRH in line with the national budgeting cycle and NHP							
	3.9.2. Improve evidence for health funding requirements for HRH and strengthen advocacy with central government agencies involved in resource allocation.							

Strategy		Completion Target	Monitoring Codes (1-5) 1. Not Started, 2. Started (+ month), 3. On Target, 4. Deferred (to year), 5. Achieved					Comments/Evaluation
No.	**Action**		**2018**	**2019**	**2020**	**2021**	**(2022)**	
	3.9.3. Mobilise resources through engagement with donors to support UHC strategy development and implementation.							
	3.9.4 Identify additional resources needed for increased regulatory and other functions at the state and regional levels and make a case to secure these in a sustainable manner.							

Part 5(b) Goals, targets and indicators

1. Sustainable Development Goals (SDGs)

Goal 3. Ensure healthy lives and promote well-being for all at all ages	
Target 3.c Substantially increase health financing and **the recruitment, development, training and retention of the health workforce in developing countries**, especially in least developed countries and small island developing States	**Indicator 3.c.1** Health worker density and distribution

2. **Global Strategy on Human Resources for Health*:* Workforce 2030**

Objective 1. Optimize performance, quality and impact of the health workforce through evidence-informed policies on human resources for health, contributing to healthy lives and well-being, effective universal health coverage, resilience and strengthened health systems at all levels
Milestones:

1.1 By 2020, all countries will have established accreditation mechanisms for health training institutions.

1.2 By 2030, all countries will have made progress towards halving inequalities in access to a health worker.

1.3 By 2030, all countries will have made progress towards improving the course completion rates in medical, nursing and allied health professionals training institutions.

Objective 2. Align investment in human resources for health with the current and future needs of the population and health systems, taking account of labour market dynamics and education policies, to address shortages and improve distribution of health workers, so as to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth

Milestones:

2.1 By 2030, all countries will have made progress towards halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice on the International Recruitment of Health Personnel.

2.2 By 2030, all bilateral and multilateral agencies will have increased synergies in official development assistance for education, employment, gender and health, in support of national health employment and economic growth priorities.

2.3 By 2030, partners in the Sustainable Development Goals will have made progress to reduce barriers in access to health services by working to create, fill and sustain at least 10 million additional full-time jobs in health- and socialcare sectors to address the needs of underserved populations.

2.4 By 2030, partners in the UN Sustainable Development Goals will have made progress on Goal 3c to increase health financing and the recruitment, development, training and retention of health workforce.

Objective 3. Build the capacity of institutions at subnational, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on human resources for health

Milestones:

3.1 By 2020, all countries will have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda.

3.2 By 2020, all countries will have an HRH unit with responsibility to develop and monitor policies and plans.

3.3 By 2020, all countries will have regulatory mechanisms to promote patient safety and adequate oversight of the private sector

Part 5 (c) 14 agreed indicators to monitor progress on the Decade of HRH in the WHO South-East Asia Region

	NHWA Indicator	NHWA*
Health worker density and distribution		
1	Health worker density	1-01
2	Health worker density at subnational level	1-02
3	Health worker distribution by age group	1-03
4	Female health workforce	1-04
Health professional education		
5	Graduation rate from education and training programmes	2-07
6	Accreditation mechanisms for education and training institutions and their programmes	3-02
7	Continuing professional development	3-08
Retention of health workers		
8	Vacancy rate	5-07
9	Share of foreign-born health workers	1-07
10	Share of foreign-trained health workers	1-08
HRH Governance		
11	Mechanisms to coordinate and intersectoral health workforce agenda	9-01
12	Central health workforce unit	9-02
13	Health workforce planning processes	9-03
HRH information systems		
14	HRHIS for reporting on outputs from education and training institutions	10-04
	HRHIS for tracking the number of entrants to the labour market	10-05
	HRHIS for tracking the number of active stock on the labour market	10-06
	HRHIS for tracking the number of exits from the labour market	10-07
	HRHIS for producing the geocoded location of health facilities	10-08

* refers to NHWA handbook

Indicators that are in the Global HRH Strategy

Additional indicators identified for monitoring Decade of Strengthening HRH in SEAR

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Appendix 1. WHO Classification of Health Workers.

The classification of staff based on professional disciplines is clustered into four major areas, as follows:

a) Medical and Dental surgery staff.
b) Nurse, Midwives, Medical Assistant and Basic Health staff.
c) Paramedical and allied health staff.
d) Professional, managerial and support staff.

Medical and Dental categories of staff include:

a) Medical doctors with higher degree qualifications (PhD and Master's degree) in various fields including Science, Public Health and Hospital administration and management;
b) Medical specialists in areas approved by the MoHS according to service requirements;
c) Medical doctors/dental surgeons (Bachelor's degree); and
d) Dental assistants (Diploma).

Nursing, Midwifery and Medical Assistant staff include:

a) Nurses with graduate and higher degree qualifications (Bachelor Nurses and beyond);
b) Nursing Clinical Specialist determined by the MoHS according to service needs (such as, Surgical, Paediatric, Intensive Care, Community, Mental Health);
c) Registered Nurses (Diploma);
d) Lady Health Visitors (Certificate);
e) Registered Midwives (Diploma or Certificate);
f) Nurse aides; and
g) Health assistants (Bachelor's degree).

Paramedical staff include:

a) Pharmacists (Bachelor degree and higher);
b) Pharmacy Assistants;
c) Medical Laboratory Technologists (Bachelor degree and higher);
d) Laboratory Technician Assistants;
e) Dental Technicians;
f) Medical Imaging Technologists (Bachelor degree and higher);
g) Hygienists (middle level, higher Diploma and Bachelor's degree);
h) Physiotherapists (including Occupational and Speech Therapists);

i) Dieticians and Nutritionists;
j) Orthotists;
k) Opticians;
l) Audiologists;
m) Public Health Supervisors (PHS) I and II; AND
n) Medical Physicists (for radiation and nuclear medicine).

Health-related professional, managerial and support staff include:

a) Social scientists, epidemiologists, public health specialists, health economists, anthropologists, statisticians, and information technologists;
b) Medical Social Workers;
c) Biomedical Engineers;
d) Managerial, financial staff and accountants;
e) Hospital administration and management;
f) Technical staff and tradespeople (medical equipment maintenance, electricians, plumbers, carpenters, mechanists, logistics etc.);
g) Support staff (drivers, cleaners, etc.); and
h) Clerical staff.

The classification of the workforce according to level of education attained:

a) Post-graduate (including PhD, Master's degrees, and specialist training).
b) Graduate (Bachelor degrees).
c) Post-basic Diploma (Vocational high and mid-level professionals).
d) Diploma (Vocational low-level professionals).
e) No professional qualifications.

The classification of functional responsibilities includes:

a) Direct patient care.
b) Paramedical support services (such as, pharmacy and laboratory technical services).
c) Health promotion, disease prevention and public health.
d) Managerial, technical, and logistical support.