RURAL AND REMOTE FRONTLINE HEALTH WORKERS RETENTION STRATEGY

(2021 - 2026)

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LIST OF ACRONYMS

AMW	Auxiliary Midwife
ANC	Ante-Natal Care
BHS	Basic Health Staff
BCG	Bacille Calmette-Guerin (TB vaccine)
CHW	Community Health Worker
CBHW	Community Based Health Workers
CPD	Continuing Profession Development
CPE	Continuing Professional Education
CSO	Civil Society Organization
DHRH	Department of Human Resources for Health
DMS	Department of Medical Services
DP	Dual Practice
DPH	Department of Public Health
DPT	Diphtheria, Pertussis (whooping cough), and Tetanus vaccine
EHO	Ethnic Health Organization
EPHS	Essential Package of Health Services
FGD	Focus Group Discussion
GAVI	Global Alliance for Vaccines and Immunization
GP	General Practitioner
HA	Health Assistant
HMIS	Health Management Information System
HRH	Human Resources for Health
HRIS	Human Resources for Health Information Sytem
HTR	Hard to Reach Areas
HWF	Health Workforce
ITHP	Inclusive Township Health Plan

IPE	Inter Professional Education
LHV	Lady Health Visitor
MHAA	Myanmar Health Assistant Association
MMA	Myanmar Medical Association
MNMA	Myanmar Nurse and Midwife Association
MPHW	Multi-Purpose Health Worker
MOHS	Ministry of Health and Sports
MOLIP	Ministry of Labor, Immigration and Population
MOPFI	Ministry of Planning, Finance and Industry
NHC	National Health Committee
NHP	National Health Plan
NHWA	National Health Workforce Account
PHC	Primary Health Care
PHS	Public Health Supervisor
SBA	Skill Birth Attendant
SOPS	Standard Operating Procedures
SMO	Station Medical Officer
THA	Township Health Assistant
THN	Township Health Nurse
TMO	Township Medical Officer
TT1 &2	Tetanus Toxoid 1 and 2
UHC	Universal Health Coverage
WHO	World Health Organization

FOREWORD

The Myanmar National Health Plan 2017-21 (NHP) identified human resources for health (HRH) as one of four pillars of UHC in Myanmar. In particular, the NHP highlights the acute need to recruit and retain well-trained health professionals to provide quality health services in rural and remote areas, where an estimated 70 percent of the population resides. According to the Rural Retention Case Study published in 2019 by Tin et. al., 50% vacancy of medical doctors was noted in states of Kachin, Kayah, Kayin, Chin, Shan North and Shan East and Rakhine. Similar trend was observed among other essential cadres who provide integrated primary care services.

In response, the Cross- Departmental Technical Working Group was tasked in 2019 to formulate a five year Rural and Remote Frontline Health Workers Retention Strategy that will underpin the roll-out of Universal Health Coverage (UHC).

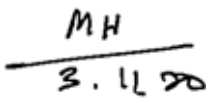
I am pleased to present the Rural retention strategic direction for 2021-2025. The strategy provides an overall direction to increase availability and quality of frontline health workforce in rural and remote areas.

This strategic document is the cumulation of extensive data analysis and consultation conducted over a one-year period (2019-2020). With the support of the World Health Organization and the Access to Health Fund, the Cross-Departmental Technical Working Group for Rural Retention coordinated six meetings and workshops involving many policy makers, program managers, and health professionals at national and subnational levels.

The purpose of the consultations was aimed to 1) document and build on what has been accomplished; 2) assess the feasibility of various options to strengthen retention of health workforce; and 3) prioritize and sequence the interventions.

The strategy is aligned with the National Health Plan 2017-2021, which was based on the overarching Universal Health Coverage strategy, and the Human Resources for Health Strategic Plan. Furthermore, the strategic directions outlined in the document will be incorporated in the next National Health Plan as well as the Human Resources for Health Strategic plan. To ensure fidelity to strategy, implementation will be closely monitored by the Central Human Resources for Health Coordination Unit (CHRH-CU) and relevant departments.

I want to thank the CHRH-CU working group for ensuring that the need of the population living in rural and remote areas is met, and that all people in Myanmar will be able to access quality essential health services.



Myint Htwe

Union Minister for Health and Sports, Myanmar

ACKNOWLEDGEMENTS

The development of the Rural and Remote Frontline Health Workers Retention Strategy (2021-2026) 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	Chair
2	Deputy Director General (Civil Servant Affairs), Department of Medical Service	Member
3	Dr. Kyaw Shwe, Deputy Director General (Civil Servant Affairs), Department of Human Resources for Health	Member
4	Dr. Myint Myint Than, Deputy Director General (Public Health) Department of Public Health	Member
5	Dr. Kyaw Khine Oo, Director (Civil Servant Affairs) Department of Human Resources for Health	Member
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8	Dr. G Seng Taung, Director (Planning) Department of Public Health	Secretary
9	Dr. Win Yee Mon, Director (Planning) Department of Medical Service	Joint Secretary – 1
10	Dr. Aye Mya Aung, Director (Human Resources Management-2) Department of Human Resources for Health	Joint Secretary – 2

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, Faculties 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.

EXECUTIVE SUMMARY

Introduction

The recent publication of a National Health Plan and Human Resources for Health Strategy have highlighted many of the challenges and gaps in the health system that is limiting the capacity of the country to reach universal health coverage goals. The most significant gap relates to the lack of availability of a skilled frontline health workforce, especially in rural and remote areas including the ethnic States and border regions. These gaps relate to a shortfall in production numbers and equitable distribution of skilled health staff and the incorrect mix of staff to provide the essential package of health services. Workforce motivation is also a critical issue, with this strategy outlining how inadequate remuneration, housing, security, educational and professional career development opportunities contributes to low retention and high vacancy rates for frontline staff. In order to facilitate the required health workforce reforms in education and incentives, gaps in human resource governance also need to be addressed, especially with regards to development of human resource management and planning capacity at central and Regional/State levels of the system.

Given that improved retention of the rural and remote health workforce is critical to the attainment of universal health coverage goals, this front-line health workforce retention strategy aims to identify and implement main strategic actions to improve recruitment and retention of front-line health workers in hard to reach areas in Myanmar. The detailed strategic actions were a result of national consultations undertaken with central level planners and policy makers, Regional and State representatives and Township Medical Officers in late 2019 and early 2020. The strategy is also an outcome of the Human Resources for Health Strategy and Health Workforce Review conducted in 2018 and 2019.

Strategic Framework and Actions

This document is divided into three main sections of situation analysis, strategic framework and detailed strategic actions for education, incentives and governance. Section 4 of this strategy proposes detailed actions for each main strategy, as well as identifying expected outputs of implementation of each action. The strategic framework figure provides an overview of each strategic area, and a summary of the main strategic actions. Cross-cutting themes are identified and demonstrate the feasibility of working across strategic areas to adopt an integrated policy and planning approach to improving rural retention.

Policy and regulation will need to be developed across all three strategic areas, generally in the areas of policies, regulations, standards or standard operating procedures (SOPs) for education, governance, and bundled incentives.

Plans and budgets will be required for educational developments, expanded human resource management in States and Regions, and preparation for retention packages for rural staff.

Institutional capability will need to be expanded at Central and State / Regional levels to plan, manage and implement human resource reforms including rural retention strategies.

Human resource research programs will also be required across all three strategic areas to assess motivation levels and training and living condition needs of rural frontline staff, as well as support evaluation of the rural retention strategy.

Conclusions and next steps

Implementation of a rural and remote frontline health worker retention strategy is a necessary condition for the attainment of the National Health Plan UHC targets. Successful implementation will require a commitment to reform across three strategic areas of human resource governance, education and development of bundled incentive packages for frontline staff. Initial steps should include defining and developing the incentives package (based on the actions identified in this strategy), and preparing human resource management plans, budgets and procedures centrally and in States and Regions to oversee implementation and evaluation of this strategy.

BACKGROUND

The National Health Plan (NHP) in Myanmar 2017-2021 identified as its main objective provision of an essential package of health services to the whole population of Myanmar by 2030. (Ministry of Health and Sports, 2017) A necessary condition for attaining this goal is ensuring equitable distribution and retention of frontline health staff with the required skills to provide basic primary care services in all States and Regions. Towards this end, Ministry of Health and Sports developed the Human Resources for Health Strategy 2018 – 2021, and a Central Human Resources for Health Coordination Unit to spearhead, coordinate, and monitor HRH planning. (Ministry of Health and Sports, 2018)

As part of the HRH strategy and the CHRH-CU mandate, this strategy paper builds on literature review on rural retention and focuses on mechanisms to recruit and retain front-line health workforce in hard to reach areas in Myanmar.

The main sources for this strategy are the above-mentioned national plans and strategies, a National Review of Human Resources (Ministry of Health and Sports, 2019), a recently completed Case study on frontline health workers in Myanmar (World Health Organization & Ministry of Health and Sports, 2019), and reviews of international evidence on retention of front-line health workers. (Ministry of Health and Sports, 2018)

A series of national consultations with central and sub national planners and health managers were conducted to 1) contextualize WHO regional recommendations for rural retention to the Myanmar context and 2) identify and prioritize strategic actions of this retention strategy.

This strategy is divided into the following chapters:

1. Situation Analysis
2. Rural Retention Strategic Framework and Strategic Actions

The strategy concludes with a prioritization of interventions and estimated cost to implement the Rural Retention Strategy.

SITUATION ANALYSIS

Recent reviews and national planning exercises in Myanmar have highlighted barriers and opportunities for improving rural retention of the health workforce, as well as health systems strategic directions for health workforce development.

The following situation analysis on human resources for health intends to summarize barriers, opportunities and policy directions, with a view to informing strategic directions and priority operational actions for improving retention of the health workforce in rural and remote areas of the country.

National Planning Directions for Retention of the Health Workforce

Strategic directions for human resource planning generally, and retention of a frontline health workforce more specifically, are set out in two recently published national documents – the National Health Plan 2017-2021 and the Human Resource for Health Strategy 2018-2021.

National Health Plan: The main objective of the National Health Plan (NHP) is to extend access to the population a basic essential package of health services (EPHS) by 2021, and a more comprehensive package by 2030. There is a strong focus on equitable placement and retention of Basic Health Staff (BHS) as a key mechanism to deliver the integrated Essential Package of Health Services (EPHS). (Ministry of Health and Sports, 2017)

In support of this direction, the National Health Plan calls for appropriate delegation of human resource management to the State/Region level. In addition, a decentralized governance strategy, the NHP 2017-21 recommends implementation of a package of educational, financial and non- financial incentives for front-line health workers including local recruitment, financial allowances, more flexible education strategies (distance learning and certificate courses) and improved professional pathways and cultural competency. (Ministry of Health and Sports, 2017) These human resources specific strategies would be reinforced by wider health systems developments to ensure adequacy of infrastructure, equipment and essential medicines, transport and operational financing.

Human Resources Strategic Plan: The current human resource plan in Myanmar – the Human Resources for Health strategy 2018-2021 -- identifies the following strategic areas: planning, quality, governance and finance.

As part of the planning strategy, MOHS highlights a need to address: workforce shortages, inappropriate balance and mix, and inequitable distribution between States/Regions.

Rural Health: The challenge of strengthening the health workforce is particularly stark in rural and remote areas.

Several interventions have been undertaken in Myanmar to address issues affecting rural retention. They include locating schools of nursing and medical education outside major urban centers, local recruitment strategies, continuing professional training and providing double salary for BHS working in hard to reach areas for two years during 2013-14 and later continue with lesser amount for hardship allowance. However, the impact of these strategies has been constrained by other obstacles including weak health infrastructure in rural and remote areas, poor housing and infrastructure, on-going conflict in some areas, limited engagement with the community, high levels of stress, inadequate incentives, and lack of supervision support. (Ministry of Health and Sports, 2018)

It should be noted that while shortage of qualified front-line worker is a pressing issue in remote and rural areas, recruitment and retention of frontline health staff working in border, urban poor and conflict affected areas have also been a challenge.

Strategic actions to address retention include acquiring evidence on motivational factors effecting retention, developing and disseminating standard operating procedures for HRH management, including recruitment, retention, professional development, performance appraisal, supportive supervision, remuneration and special allowances, preparing budgets for retention packages to support UHC, and giving priority for publicly-funded post-graduate training positions and opportunities for BHS, especially for those from underserved areas, states, regions, and townships.

CURRENT FRONTLINE RETENTION CHALLENGES AND OPPORTUNITIES IN MYANMAR

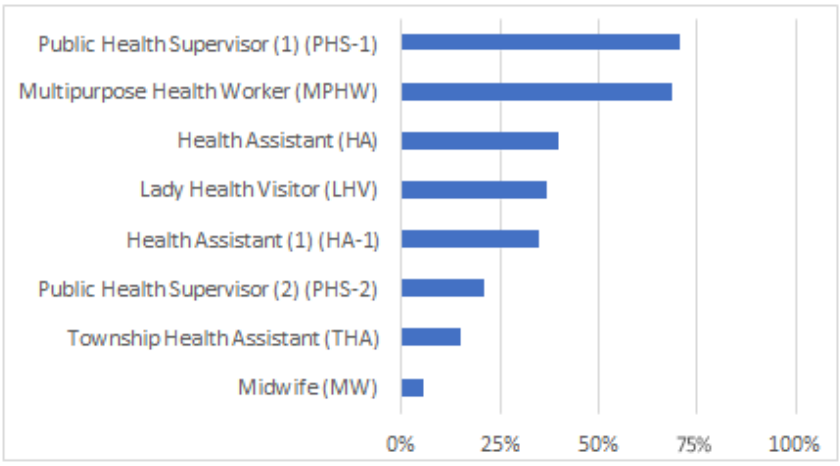
Basic Health Staff at the primary level of care are the main workforce categories in rural and remote areas, and as such will have the highest impact on achievement of UHC coverage and equity goals. Basic health staff are responsible for provision of primary care (and hence the EPHS) in rural health units, sub rural health units and in communities across the country.

Categories of BHS in Myanmar include:

- Township Medical Officer
- Station Medical Officer
- Nurses (Sister, Staff Nurse, Trained Nurse, Township Health Nurse)
- Health Assistant (HA, HA1, Township Health Assistant - THA)
- Public Health Supervisors (1 and 2, two categories)
- Lady Health Visitor (LHV)
- Midwives and
- Multipurpose Health Workers (MPHW) (lowest level of health worker, very few in number, which is almost obsolete and no more production.)

Figure 1 below illustrates the percentage of unfilled sanctioned posts (vacancies) across by professional category. MPHW, although vacancy is high, the original number is very few, and there is no more production of this health worker, mostly substituted by PHS2. Another category having high vacancy was PHS1, and this category have not been recruited for some time in the past, as there were plans for them to be replaced in Station Hospitals by trained nurses during (1988–2013), that was directed by senior officials from the Ministry of National Planning and Economic Development (MNPED). In reality, PHS-1 was appointed for public health work in the Station Hospitals to oversee the Sub RHC under them. After some years, the need for a PHS-1 at the SH was proposed to the MNPED and, in 2013, PHS-1 posts were created in the organizational set-up of all Station Hospitals. (Case study on Rural Retention). This data confirms that national staffing mix, distribution and numbers of national data is likely to be a vast underestimate of the real needs for health access in rural and remote areas. This being the case, rural health workforce retention strategy will need to maintain a strong focus on collection and analysis of sub national human resource data.

Figure 1: Percentage vacancy basic health staff



Source: Department of Public Health, 2019 as reported in HRH Review, WHO

Availability: A main challenge for HR planning in Myanmar is to produce and retain a health workforce in adequate numbers. According to a 2018 Human Resource situation analysis, in order for Myanmar to reach the WHO SDG health targets, the normative guideline suggests that the number of health staff (doctors, nurses and midwives) would need to increase from 77,612 in 2014 (ratio of 14/10,000) to 260,340 by 2030 (ratio of 44/10,000).

Distribution: Myanmar is largely a rural country. While only 30% of the total population are living in urban areas, 50% of health workforce are based in these urban locations. There are wide variations in professional to staff ratios between rural/remote locations and major urban centers. Doctor to population ratios range from .38 per 1000 in Rakhine, to 3.48 and 5.13 per 1000 population in Mandalay and Yangon respectively. The border ethnic States have significantly lower medical professional to population ratios, with States such as Shan, Karen, and Kachin all having medical professional to population ratios below 2 per 10,000. The distribution of midwives and nurses is more even, with 12 of the 15 States and Regions reported having midwife to population ratios that range from 2.06 to 3.51 per 10,000 populations.

Mix: Along with both distribution and numbers, achieving the appropriate mix of knowledge and skills in a primary health care team is also an essential human resource planning requirement to ensure coverage and equity. This is especially the case in rural and remote areas, where geographic distances or other social or physical barriers will restrict capability for referral to higher levels of care. Access to an essential health care package in the NHP also demonstrates that a wide set of team skills in medicine, public health and midwifery will need to be available in PHC teams to achieve universal coverage.

- Based on normative guidelines suggested by the World Health Organization, Myanmar would need an estimated six, four and two fold increase in production of midwives, nurses and doctors respectively over the next 10 years. (Ministry of Health and Sports , 2019)

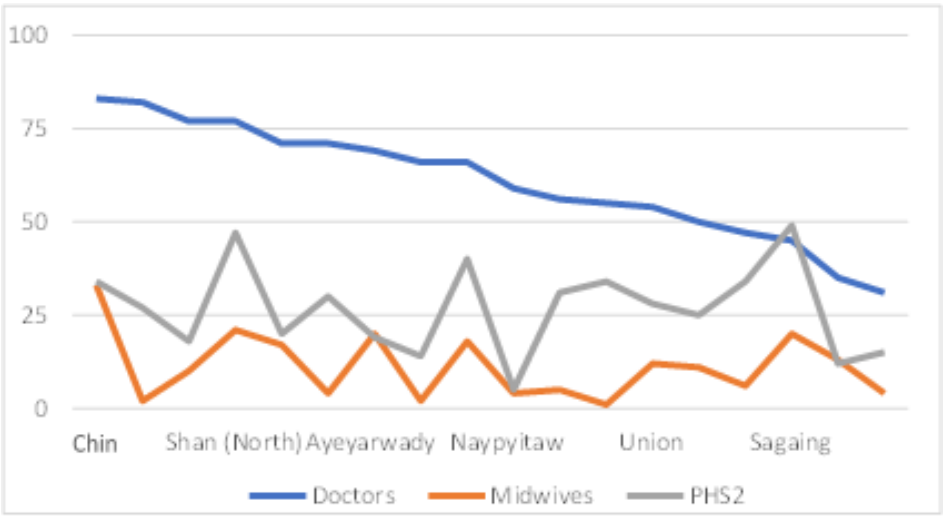
- Findings from a pilot study based on the WHO Workload Indicators of Staffing Needs (WISN) framework conducted in 2019 further suggests that the 1) current workloads assigned to staff do not reflect the health needs of the population and 2) the types of health professionals deployed at townships should be revisited; in some townships there are surplus of nurses and physicians, while in other townships there are severe shortage. Furthermore, make the best use of the resources, MOHS at the national and subnational levels should consider task shifting. And finally, across the four townships, administrative tasks take up a significant amount of work in almost all cadres in general and midwives in particular. For further details of the study, please refer to the document. (Ministry of Health and Sports, 2019)

Recruitment, Placement and Attrition: One of the factors contributing to inadequate distribution, numbers and mix in rural and remote areas are high rates of attrition. The National Review of Human Resources for Health found that "basic health staff and voluntary health workers have higher rates of workforce instability and turnover compared to medical doctors." (Ministry of Health and Sports, 2019)

Furthermore, data suggest that there is significant loss of health practitioners of all categories from the public sector from graduation. Of the 6521 graduates in 2018 (all health professional categories), 60% entered public and private practice, 10% changed profession and 30% did not enter public services. (Ministry of Health and Sports, 2018) That fact that 40% of graduates are lost to the public system post-graduation is a missed opportunity for rural placement and expansion of universal cover, a problem which is exacerbated by high rates of attrition and insufficient opportunities for local recruitment and placement. In the focus group discussion and in-depth interviews conducted as part of the HRH review, frontline workers and with state health director expressed low remuneration as one of the causes of low retention in rural and remote/hardship areas. (Ministry of Health and Sports, 2019)

A recent study found that the underlying causes of attrition rates of doctors were low remuneration, long working hours and heavy workload, and "unfavorable" work environment. For this reason, voluntary rates of attrition (resignation or absenteeism) are higher than involuntary rates of attrition (death or retirement). (Yu Mon Saw, 2019) Vacancies occur across the country for all categories of staff. As the figure below demonstrates, these vacancies are acute for medical officers in rural and remote areas.

Figure 2: Vacancies of Sanctioned Posts by State and Region 2018



This acute shortage of staff for rural PHC has been partly addressed in the Myanmar through the introduction of community-based health worker programs which includes community health workers and Auxiliary Midwives, a new category of volunteer health worker established to improve availability of essential health services. The roles and responsibilities of CBHWs are variable across the country, although policy is currently being developed to standardize and institutionalize roles and functions. (Ministry of Health and Sports, 2018)

Given that the human resource review estimated that it may take up to 20 years to produce primary care staff numbers that match population health needs, community health workers are likely to be central to the rural and remote health strategy for at least the next 20 years.

Ethnicity : Ethnicity is an important issue in Myanmar with respect to retention in rural and remote areas, given that it is these areas that often have the lowest health care access and the lowest density of health care workers. Part of these low-density problems relate to low local recruitment rates. In 2019 less than 1 percent of medical students (0.8%) were recruited from special administrative zones in 2018, and just 5.3% were recruited from areas classified as social or geographically hard to reach (n = 62). (World Health Organization & Ministry of Health and Sports, 2019) Although staff vacancy rates remain higher in these locations, there are prospects for improvements in retention given recent developments in communication technologies and peace building in some States.

Linguistic and cultural diversity in Myanmar means partnerships with EHOs, models of community participation and management, local recruitment and cultural competency programs are likely to be higher order human resource management strategies in these areas. The case study on human resources in 2019 indicated that the government has implemented a program of ethnic quotas for medical intakes in in some ethnic areas (Naga, Danu, Pa-O, Palaung, Kokant, Wa), but efforts to date have been insufficient to sustain growth in local recruitment.

(World Health Organization & Ministry of Health and Sports, 2019) As suggested in the National Human Resources for Health Strategy, this reinforces the need for researching and strategizing motivational factors that promote local recruitment in ethnic areas, as well as other areas of the country where retention or access is low (e.g. conflict affected areas or urban poor areas). The links between recruitment and retention is also recognized in strategy 1.5.3. of the Human Resources for Health Strategic Plan 2018-2021, which recommends adopting policies to "substantially increase the recruitment of students from areas with workforce shortages and from ethnic and vulnerable communities." (World Health Organization & Ministry of Health and Sports, 2019) The strategy also recommends addressing cultural and linguistic barriers to patient- provider communication in the ethnic minority areas.

EDUCATION AND RURAL RETENTION

Rural Enrolment and Retention:

The links between local recruitment and retention have been well documented internationally and evidence suggests a strong association. (Ministry of Health and Sports, 2018) The Human Resources for Health Review in Myanmar, 2018 found that out of the total proposed intake of around 1000 medical students per year, during 2018 and 2019, there was around 5 % -10% of students recruited from remote hard to reach regions. (Ministry of Health and Sports, 2019) One other case study of rural retention in Myanmar found that most medical students are recruited from the two largest urban regions of Yangon and Mandalay (79%). Only 21% of medical students are recruited from all States/Regions apart from Yangon and Mandalay, and 5.2% from social or geographically hard to reach areas. (World Health Organization & Ministry of Health and Sports, 2019)

For the nursing and midwifery schools, investments starting in 1993 to establish at least one nursing and one midwifery schools (often they are located in the same campus) in each State and Region improved local recruitment and retention. This is confirmed by the findings of the case study on rural retention in Myanmar. While 79% of the medical students were enrolled at the two main urban medical schools, only 9.5% of students in the Bachelor of Nursing Science (Generic) & 3-year Nursing Diploma were enrolled in the University of Nursing in Yangon and Mandalay, with the remainder (90.5 percent) enrolled in the 25 Nursing Schools and 22 Midwifery Schools dispersed across the States and Regions.[1]

Having the local training process in place, the Ministry and Local S/R governments should put in place mechanisms to increase local recruitment and placement. Furthermore, the government and associations should provide regional training opportunities as a medium to long term intervention for rural retention of the health workforce.

This was highlighted in consultations undertaken nationally on retention in 2019, which outlined a requirement for policy, regulatory and standard operational procedures regarding selection criteria, rural quotas, professional and financial support, and additional undergraduate educational supports for rural origin students of all health professions. (CHRH-CU Rural Retention Consultation, 2019)

Education Reforms and Retention:

The Human Resources for Health Review found that the quality of medical education is compromised by large sized classes over 100 students, and didactic teaching methodologies. Most of the students are dependent on private tuitions from which students to be financially viable. (Ministry of Health and Sports, 2019)

1 There are currently no tracking mechanisms to see if graduates remain in the States and Regions where they are trained, which indicates the need for establishment of adequate tracking mechanisms to determine impact of rural recruitment and education on retention

To improve quality of medical education, several reforms were initiated in 2018. They include curriculum reform using outcome-based approach and emphasis on quality control and patient centered safely. Other reforms include courses on collaborative learning and inter-professional education to support more of a team-based approach in primary health care. While no formal evaluation has been conducted; discussions with students and faculties suggest that these reforms were welcomed.

Clinical Rotation and Retention:

A consideration in implementing rural retention strategy is exposing undergraduate students to rural health work in order to 1) attract these students to work in the rural workforce post-graduation and 2) to teach students of the special, multidisciplinary skills needed to serve the rural and hard to reach population.

Myanmar health and education systems have implemented several measures in this regard. All medical students are required to undertake 3 weeks of field training, and student nurses have a community health curriculum which requires 6-8 weeks in the community each year. Similar arrangements for field experience are available for PHS1, midwives and health assistants. (World Health Organization & Ministry of Health and Sports, 2019)

Compulsory services post-graduation:

Rotation can also refer to movement of staff from urban to rural areas on a temporary basis. Sometimes this is referred to as "compulsory service" (refer to section on Regulation on Compulsory Rural Services in the Governance section). The case study on Frontline Health Workers in Myanmar made the important observation that rotation is not only important for promoting retention, it is also a way for developing community health knowledge and skills for BHS staff. (World Health Organization & Ministry of Health and Sports, 2019)

Although there is no evaluation evidence from Myanmar confirming the positive impact of rural rotation on rural retention, international reviews from the Philippines, Thailand, Australia and New Zealand have all confirmed that compulsory undergraduate exposure has improved placement or retention in rural areas post-graduation. (World Health Organization & Ministry of Health and Sports, 2019)

Several strategies have been recommended to apply rotation strategies in the Myanmar context. For instance, The National Review on Human Resources recommended development of a "Core Team of Frontline workers" which would rotate through remote and rural areas, an intervention of which would be backed up by a bundle of financial and non-financial incentives.

Rural Health Content in Health Professional Curricula:

The assumption underlying inclusion of rural health topics in the curriculum is that enhanced competencies of health workers will increase initial recruitment, job satisfaction and retention. ii In Myanmar, the case study on Frontline health workers indicates that some steps have been taken regrading inclusion of rural health content. The case study found that the curricula for the nurses, midwives, Health Assistants, LHV and public health supervisor mostly reflect the rural health issues, and medical studies includes Preventive and Social Medicine, which includes topics relevant to rural health. A post graduate course for Family Medicine has also been developed for general practitioners working in rural areas. This course was upgraded from Diploma in GP which was previously given to General Practitioners who are working in both urban and rural areas to get updated medical information. This latter course does not contain topics specific to rural practice. However, the case study observed that improved competencies should increase job satisfaction of GPs working in rural areas, and so therefore should have an impact on retention. As discussed in the previous section, clinical rotation is also a way in which

rural health topics can be integrated into undergraduate and post graduate education. The emphasis on task shifting for the expanded delivery of the EPHS also has implications for education content for frontline health workers, to ensure that (a) PHC providers have the balance of knowledge and skills to ensure the essential package of services can be universally provided in a team environment, and (b) that some PHC functions can be delegated to PHC community health workers or other frontline category.

Continuing Professional Development and Inter Professional Education: Proposed reforms to continuing education should facilitate retention, when it is considered that improved competencies, supervisory support and workforce orientation has the potential to increase workforce motivation. The case study on frontline health workers found that most continuing education programs are program based and implemented through programmatic silos. Some continuing training is conducted during monthly meetings at Township level (linked to CME). The courses of CPD by MMA and MNMA conducted so far are mostly structured and standardized, however, to date CPD is not linked to the Credit point system. Plans are in place to link CPDs to licensure.

The MNMA and MHAA have been supporting their own professionals in capacity building and improving the professionalism. (World Health Organization & Ministry of Health and Sports, 2019) Overall, the linkages between continuing training participation and career pathways are quite limited, although the MOHS does provide additional recognition for those who have served in rural/ hard-to-reach areas for candidates in the postgraduate entrance exams. Given that the directions outlined in the NHP suggest a need for a more team based approach for delivery of the EPHS, the concept and practice of inter professional education is of particular relevance for rural retention and for retention of front line workers more generally. The current Human Resources for Health Strategy describes several strategies to improve CPD programs, all of which should have some impact on retention of front-line health workers. The MOHS commits to giving priority for post- graduate training positions and opportunities to BHS who have served in rural communities, or who are local people from underserved areas, states, regions, and townships. There are also calls to link CPD programs to CPE / CME points (career pathways), performance appraisal and years of experience. Strategic Action 2.2.3 recommends that specific performance-based career pathways should be developed for health professionals who provide services for underserved groups. To support recruitment and retention of community-based health workers (CBHWs) there should be common standards of training and a pathway for entering professional cadre. Finally, the establishment of a central Continuing Education (CE) database will enable planners to monitor whether staff from underserved areas are being exposed to adequate types and numbers of professional development opportunities.

FINANCIAL AND NON-FINANCIAL INCENTIVES FOR HEALTH PROFESSIONALS

According to the Human Resources for Health Strategy, despite implementation of various pilot strategies, there are no formal incentive payments, performance-based payments or other allowances, and no evidence of salary progression for BHS in recent years.

Entry:

Of the 6521 graduates in Myanmar in 2018, 60% enters public and private practice, 10% change profession and 30% do not enter public services at all. (Ministry of Health and Sports, 2019) This data underscores that placement and retention of health staff in the public sector is a major policy and planning challenge.

But the question remains as to how health professionals will be incentivized to work and remain in rural or remote locations. Experience nationally and internationally demonstrates that a combination of financial and non-financial incentives should be "bundled" to achieve maximum impact on rates of retention. (Ministry of Health and Sports, 2018) The national consultations on rural retention concluded similarly for a strategy of bundled financial and non-financial incentives. In line with experience internationally, the consultations in 2019 recommended a financial package including additional salary, and travel and accommodation allowances. (CHRH-CU Rural Retention Consultation, 2019)

Financial Incentives:

According to interviews conducted with senior officials, front line health workers posted in hard to reach townships receives additional (double) payments in 2013-2014. (Ministry of Health and Sports, 2018) However, based on feedback from providers regarding the incentives, the additional payments were enough to motivate and retain staff who already work in these locations, however it is insufficient to attract new staff to these locations.

While the incentive payments have been reduced after a year or two, there remains some additional allowances for staff working in hard to reach area. Additional payments for services can also be accessed through various international projects and national programs which support training per-diems and travel allowances such as EHSAP project by the World Bank and GAVI HSS. (World Health Organization & Ministry of Health and Sports, 2019)

The Human Resources for Health Strategy recommends several actions to improve remuneration so as to improve retention. (Ministry of Health and Sports, 2018). It should be noted that this has been a difficult area to move forward as MOHS have limited budget. Nevertheless, the following recommendations are important to consider:

- Flexible policy options on remuneration to support retention that MOHS liaise with the Ministry of Labor, Immigration and Population (MOLIP) and Ministry of Planning, Finance and Industry (MOPFI) to advocate to develop or revise remuneration packages for public sector health workers. This should include specific criteria such as performance related payments and hard to reach area remuneration packages. Standardized remuneration and allowances package for VBHW (both monetary and non-monetary) should also be developed, which is important consideration given high attrition rates form this cadre.
- "Special allowances" for health workers in remote and conflict-affected areas or among vulnerable communities.

Non-Financial Incentives:

In its framework for rural retention, the World Health Organization recognizes that adequate living conditions are essential to attract and retain staff in hard to reach areas. Some improvements have been made in recent years through health sector investments in staff housing. Between the years 2016 and 2019, 1,125 health facilities and staff housing have been renovated or constructed, still a lot is needed to be renovated or new construction. The Human Resources for Health Strategy states that housing for BHS should be included in Township Health Plans. Living conditions link to wider concepts of a safe and supportive working environment. This means ensuring adequate supervisory and community support for health workers, adequate health systems operational support for essential medicines, equipment and health outreach and measures to ensure the security of the health workforce, especially those working in isolated or conflict effected areas.

The National Review of Human Resources for Health found that there were no laws or regulations on protecting the security of the health workforce. (Ministry of Health and Sports, 2019) Aligned with these findings, the national Human Resources for Health Strategy recommends the development of policies and procedures to protect the health and safety of the health workforce (Strategy 3.5). Strategic Action 3.5.2 recommends Strategic Action 3.5.2 audits of occupational health and safety enforcement systems, especially in "conflict-affected areas, humanitarian emergency situations and areas of high and stressful workloads." (Ministry of Health and Sports, 2018)

Availability of essential medicines, and equipment is likely to significantly increase the motivation of the health workforce as such support contributes to improved health system performance and working environments. One study suggests that provision of adequate outreach support significantly improved health coverage in hard to reach Townships in Myanmar. By comparing the achievements of first 20 townships in 2013 to 2010 (prior to the program) the evaluation team noted a significant improvement in some MCH service coverage: out of 20 townships, 19 demonstrated increased coverage of antenatal care, 15 showed increased SBA coverage, 11 demonstrated increased TT2 and BCG coverage. The secondary data analysis showed that outreach services to hard-to-reach communities four times a year boosts ANC, SBA, TT2, DPT3 and BCG coverage. Without these outreach services, people residing in hard-to-reach villages would not gain access to these services. (MoHS, IHPP Thailand, GAVI, 2014)

Opportunities for career development and links to professional networks are important considerations for retention, given that social and professional isolation are important professional risks that need to be managed. The National Review on Human Resources for Health found that deployment plans for staff need to be linked to professionals' aspirations, desire for specialization and a related opportunity to choose their own career development path. (Ministry of Health and Sports, 2018)

The Human Resources for Health Strategy 2018-2021 recommends establishing 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. The main action recommended to support this strategy is development of additional performance-based career pathways specifically for health professionals serving under-served population groups, ethnic minorities and stigmatized groups. This include post graduate trainees and enhancing capability of VBHWs to train, work to standards and enter a professional cadre.

The National Consultations on retention have recommended supporting the development of professional networks including rural health professional associations so as to improve the morale and status of rural providers. (CHRH-CU Rural Retention Consultation, 2019) This aligns with international experience in this area, where rural professional associations have been utilized to oversee development of standards, engage in continuing education, and advocate for resources for rural and remote health. The National Consultations also recommend the improvement of less formal and local area based communications, including facilitating networks to encourage exchanges among rural health professionals, including exchange visits EHO and BHS in conflict areas.

Public recognition is a strategy applied by the MOHS and internationally to identify and reward outstanding performances in rural health. Although there is no evaluative evidence to determine the impact of such award systems on retention, such systems in all probability raise the profile of rural health in national and international public health discourse.

GOVERNANCE:

The National Review of Human Resources for Health in Myanmar observed that "an entirely free labor market will never lead to a well-distributed health workforce." The roles of governing, professional and civil institutions are therefore critical for developing and enforcing standards, procedures and regulations, to ensure adequate distribution and retention of a quality health workforce

Registration, Licensing and Accreditation: In recent years there have been important developments in improved regulation of educational programs, teaching institutions and quality of care. The Myanmar Medical Council is an independent body for registration and licensing and in 2016 formed the Myanmar Medical Council Accreditation Committee (MMCAC), whose task is to accredit medical education programs/institutions. National Standards and Guidelines for accreditation were developed in 2018 and are planned to be operationalized in 2020.

Similarly, the Myanmar Nurse and Midwife Council is responsible for regulation, registration, and licensing of nurses and midwives in Myanmar, with registered nurses and midwives being required to renew their license every two years. In 2016, as per the revised Myanmar Nurse and Midwife Council Law-2015, the MNMC has formed the Accreditation Committee – Myanmar Nurse and Midwife Council (AC-MNMC), whose task is to accredit nursing and midwifery educational programmes.

Other health professional groups such as Dental and Traditional Medicine practitioners also have license to practice. The development of registration, licensing and accreditation processes, which are currently under development in the area of medical, midwifery and nursing, should provide important opportunities for policy makers, planners and the associations to sharpen the focus in professional education and human resource planning on the needs of rural and remote health practitioners.

Policy Rural and Remote Scope of Practice: Rural and remote health practice presents unique challenges for delivery of health care, that arguably require development and application of a unique set of skills. Remoteness from wider health systems support, the need to implement programs across a large geographical area, the requirement for inter professional teamwork and community collaborations, the capacity to provide services in a cross cultural or conflict affected situation, and a heavy reliance on outreach services means that rural health practitioners are required to develop a specific set of skills to manage and provide services in such challenging contexts.

The scope of practice in a rural and remote setting is therefore not just limited to development of competencies to implement the EPHS. This was recognized in national consultations at the MOHS in October 2019, where participants identified the need to consider development of a new cadre of health professional (rural doctors as mentioned by participants) that would be devoted to rural and remote health practices. Job descriptions would also need to be adapted to the context of rural and remote health for all cadre of staff, to consider the special context, and related roles and functions in rural areas in universal provision of the EPHS.

Regulation on Compulsory Rural Services: The current policy on compulsory service is that agreements (bonds) are made with all graduates (through DOPH and DOMS) that at least 3 years of service must be provided in the public sector on completion of training. This applies to all categories of Basic Health Staff and nurses. Given that most of the posts for BHS are in the rural areas, this is one means by which to place staff in rural areas. (World Health Organization & Ministry of Health and Sports, 2019) Similarly, the National Review on Human Resources for Health recommended that the systems of compulsory rural service for all graduates for 3 years (as currently operates in Thailand) would be a strategy that would improve equity of health care in rural areas. National consultations on strategic actions recommended that, in line with a system of compulsory placement in rural areas, post- graduation, a system of financial and non-financial supports must be in place to promote retention of staff after the completion of the compulsory service. Management interventions to support retention and post completion of compulsory

service include establishment of professional support networks including through rural professional health associations, EHOs and CSOs, and ensuring accountabilities are clear with regards to the role of local administrations providing support for retention initiatives. Another model proposed by stakeholders for retaining staff through regulation is "Regulation on Subsidized Education for Return of Service." This involves provision of stipends to nurses, midwives and HAs throughout the training period, or provision of scholarships for the outstanding students, and stipends for the poor, which are currently provided through the Ministry of Education, in return for compulsory services in rural areas. (World Health Organization & Ministry of Health and Sports, 2019) There are also close links between local recruitment strategies and retention. In order to reinforce these linkages, stakeholders are proposing regulations for 5 years of mandatory service for students recruited from "special regions." (CHRH-CU Rural Retention Consultation, 2019)

Human Resource Management for Rural Retention:

Correcting human resource imbalances, preparing staff for placement, and then retaining them in those locations, will require major long- term developments in both health systems strengthening and human resource management, including gradual decentralization of planning and management. Data collection and analysis, human resource planning, allocating human resources according to need and pre-deployment training and supervision are roles that are likely to be taken on by Regional, State and Township health management in the medium to long term.

Local Recruitment and Retention: Throughout the literature (planning and strategy documents, human resource and wider literature reviews, case studies) the links between local recruitment and retention is strongly emphasized. Experience from Thailand has demonstrated that when local recruitment practices are linked with rural curriculum, provincial based medical and nursing training, and rural clinical rotations, significant improvements can be made to rates of rural placement and retention. The Human Resources for Health Strategy states that recruitment procedures need to be reviewed, so that priority is given to rural areas and to achieving "ethnic balance." This may require the delegation of some recruitment authority to States and Regions. This could also include local recruitment in "specialized areas" such as conflict affected zones or peri-urban settlement areas. Specific actions recommended in the Human Resources for Health Strategy (2018-2021) include developing and disseminating standard operating procedures for HRH management, publishing standard operating procedures for recruitment and orientation of new health workers, and "adopting policies to substantially increase the recruitment of students from areas with workforce shortages and from ethnic and vulnerable communities."

Several main themes emerge from this discussion that have implications for retention strategy:

1. Local Recruitment is a necessary condition for improving retention of front-line health workers in rural areas and other specialized areas
2. To translate local recruitment into policy and practice, delegations of authority to States and Regions are required to implement local recruitment programs
3. Policies and standard operating procedures on local recruitment need to be developed to reinforce a policy of local recruitment.

RURAL RETENTION STRATEGY

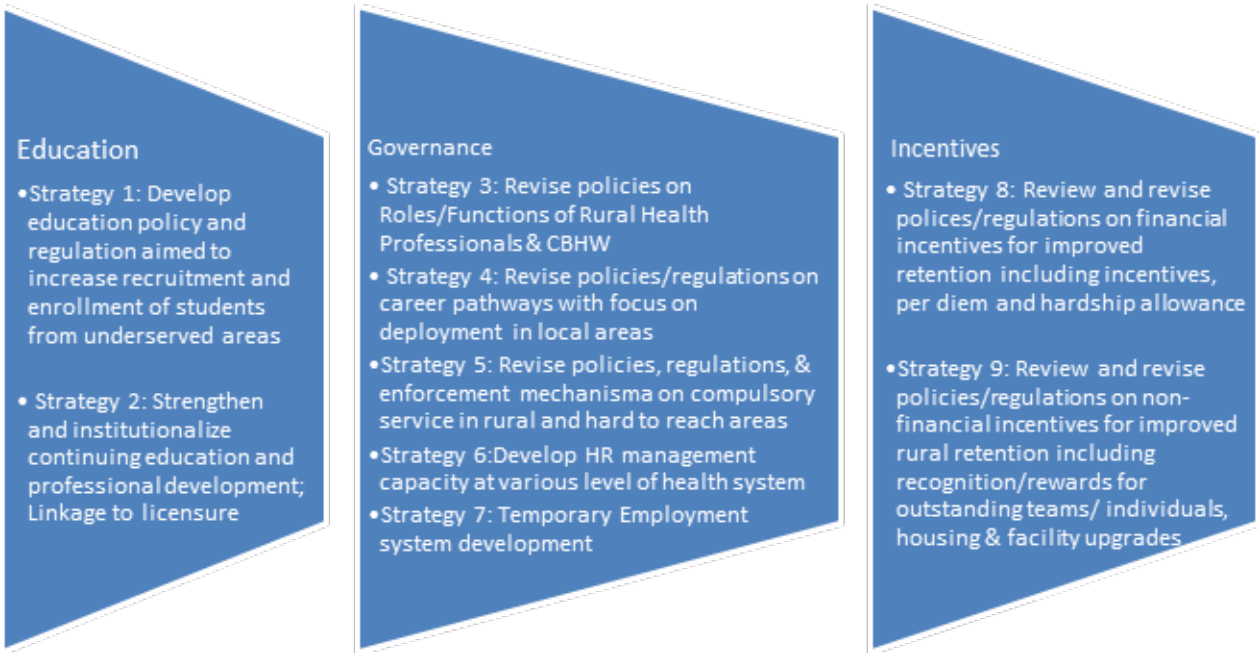
Strategic Framework

The aim of the rural retention strategy is to ensure adequate placement and retention of rural health staff (from Township to below) to support the overall MOHS NHP goals of universal coverage of the essential package of health services. This aim will be achieved through implementation of the retention strategy across three broad strategic areas of education, incentives and governance.

Figure 3 below outlines three strategic areas – education, governance and incentives. Each of these strategic areas include a set of strategic actions, of which there are nine in total, phased out over a 5 -year period.

In addition to the strategic areas and actions, certain themes have emerged from the consultations which cut across the three strategic areas of education, governance and incentives. These include policy & regulation, (2) human resource planning & budgeting, (3) institutional development for human resource management, and (4) human resource & health systems research.

Figure 3 Strategic Framework on Rural Retention Strategy



Cross Cutting Themes: (1) Policy and Regulation (2) Planning and Budgeting (3) Institutional Development for HRM (4) Operational Research and better routine data collection /analysis

STRATEGIC AREA 1: EDUCATION

The education strategic priorities contain actions that focus on undergraduate, post graduate, and continuing education of all health professions. Knowledge about rural health practice and frontline PHC will be imbedded in the learnings that a health professional will receive throughout his/her career through: mandatory rural health clinical rotations, including rural health topics in undergraduate courses as well as post graduate education, and by prioritizing recruitment of rural residents into health professional training.

To enable these activities to take place, educational policies and regulations will need to be revised, and the capacity of States and Regions to implement such policies and regulations will need to be developed. Main strategies for improved retention through education are as follows:

STRATEGY 1
Develop education policy and regulation aimed to increase recruitment and enrollment of students from underserved areas that includes selection, support and placement after graduation

STRATEGY 2
Strengthen and institutionalize continuing education and professional development; Linkage to licensure

STRATEGIC AREA 2: GOVERNANCE

Governance strategic priorities relate to development of policies, regulations and procedures relevant to rural health, such as defining scope of practice, rural health career pathways, and compulsory service. It also involves collecting central and State/Regional human resource information to define needs, and then apply this knowledge to human resources planning. Leadership and expanded capacity for human resource management at each level of the system is becoming increasingly important, given wider government strategy on decentralization and the MOHS commitment to universal health coverage. Main strategies for retention through governance are as follows:

STRATEGY 3
Revise Policies on Roles and Functions of Rural Health Professional and Community Based Health Workers.

STRATEGY 4
Revise policies and regulations on career pathways (i.e., placements, rotations, promotions, and professional support) with a focus on deployment in the local areas

STRATEGY 5
Revise policies, regulations, and enforcement mechanisms on compulsory service in rural and hard to reach areas.

STRATEGY 6
Develop human resource management capacity at various levels of the health system (i.e., information systems, standard operating procedures, planning and monitoring, supporting, problem solving and financing, gender and cultural awareness.

STRATEGY 7
Develop a system that will allow for temporary deployment and/or public private partnerships with non-government sector. This is critical to fill the gap in rural and hard to reach areas that are in dire need of front-line health workers.

STRATEGIC AREA 3: BUNDLED INCENTIVES (FINANCIAL AND NON-FINANCIAL)

In line with findings internationally and from national consultations, the strategic area of incentives incorporates strategic actions relating to both financial and non-financial incentives for rural placement and retention. Non-financial incentives will require investments in both health systems operations and infrastructure, as well as managerial and professional support. There is therefore a strong overlap between incentives and the strategic actions in education and governance strategic areas. This confirms the observation that there is no single "magic bullet" solution to resolve the problem of health workforce retention, but that in contrast, a "bundled" set of policy and strategy options should be applied in order to achieve maximum impact. Main strategies for retention through incentives are as follows:

STRATEGY 8
Review and revise policies and regulations on financial incentives for improved retention including incentives, per diem, and hardship allowance.

STRATEGY 9
Review and revise policies and regulations on non- financial incentives for improved retention including recognition/rewards for outstanding teams and individuals, housing, and facility and housing upgrades (if applicable).

CROSS CUTTING THEMES

This last-mentioned strategic area highlights the intersection of "Bundled Incentives" strategies with reforms in the areas of education and in governance in order to support improved retention of a frontline health workforce. As is even more evident in the detailed strategic actions that follow (see section 4), there are themes and actions that cut across the three strategic areas, which indicates that overall leadership of the strategy will be required to ensure that collaborative efforts are applied to work towards common objectives.

Policy and regulation will need to be developed across all three strategic areas, generally in the areas of policies, standards or standard operating procedures (SOPs). Examples include governance, where policies will need to be developed to define new cadre and the scope of practice of both new and current cadres. Education policies and regulation will be needed for retention of faculty members as well as development of CBHW training standards. Incentives policies will be required on post graduate education of staff in hard to reach areas and on career-based pathways for Basic Health Staff. The fact that incentives are "bundled" demonstrates that policy and regulations will also need to be "bundled" to support the overall retention effort.

Planning and Budgeting is also a cross cutting theme across strategic areas. Plans and budgets will be required for establishment of education specialty departments and expanded human resource management functions in States and Regions. Budgets will need to planned and allocated for retention packages for rural and remote health staff, including for construction and renovation of staff accommodation.

Institutional capability will need to be developed in order to implement developed policies and operating procedures on human resource management, especially given the trends towards decentralization in Myanmar. Strengthening of the Central HRH Coordinating Unit (CHRH-CU), establishment of State/Regional Training Units and CME systems, establishing a central human resource and continuing education information system, revision of organizational charts and job descriptions and planning for decentralized human resource management all assumes development of managerial capability at Central, State/Regional and Township levels.

Research also cuts across strategic areas, with proposed actions in this area including research on workforce motivation, research on innovative methods to deliver CME (e-health, distance learning), curriculum review and revision to include rural health and cultural competence, and overall evaluation of the retention strategy.

Gender Both gender and ethnic inclusivity have been identified in the Human Resource Strategy as a priority area for health workforce strengthening. The Myanmar health workforce is 75% female. Almost all the nursing staff are female and over 50% of the medical practitioners are also female. Another important gender perspective is that the majority of EPHS service contacts in a primary care setting are likely to be for women's and children's health services. These gender perspectives have important implications for rural and remote retention strategy, especially with regards to the security and accommodations needs of staff as well as the safety of clients in remote areas, especially for those sub national areas with a history of conflict. According to the National Review of Human Resources, there are not yet standard procedures structures for addressing gender equality, gender-based violence and gender mainstreaming in planning for HRH management. (Ministry of Health and Sports, 2019)

Conflict sensitivity: Given that front line health workers, especially in conflict affected areas, are at increased security risk, more attention could be given to gender-based issues to address retention. This is recognized in the Human Resources for Health Plan 2018-2021, which indicates that standards for ethical conduct and gender and ethnic inclusivity should be developed. Human Resources Health 2018-2021 Strategy recommends mainstreaming of gender and ethnic health into health management, planning and implementation of service delivery, recruitment and promotion of health staff. (Ministry of Health and Sports, 2018)

PRIORITIZATION AND NEXT STEPS

Annex 1 shows the preliminary prioritization of implementation of Rural Retention strategies and activities identified by the stakeholders through the series of consecutive workshops on Rural Retention in 2019. Based upon the Rural Retention strategies of Frontline Health Workers identified, the technical group revised the strategies and selected the seven strategies (2 for Education, 3 for Governance and 2 for Incentives) out of nine as shown in the main document.

Annex 2 below provides a total compilation of the key intervention areas and activities highlighted by stakeholders through an inclusive consultation workshops conducted in 2019. During the fourth workshop, the stakeholders reviewed progress to date in each of the three areas, and recommended areas to focus on finalizing the coming years (2021-2026).

Final prioritization workshop was conducted on 30th September 2020 to ensure that activities suggested are 1) feasible 2) cost-effective, and 3) aligned with other strategic priorities of the Ministry.

Annex 3 shows the findings from the voting of 5 prioritized strategies by a total of 40 participants voted via Google Form from the 30th September-workshop as well as participants from States/Regions through sending email. The final prioritized list is as follows:

Prioritized Strategies and Activities for National Rural Retention Strategy (2020-2025)

1. Financial incentive- Area level based bundled incentive packages developed. Travel, housing allowance, meter bill etc; 34/40 (85%)
2. Strengthen ongoing HRH Information System (HRIS) and Forecasting 33/40(83%)
3. Develop student selection criteria and Special student selection policy 32/40 (80%)

4. Policies and mechanisms ensuring local recruits to be stationed at corresponding local rural areas after graduation/ rotation/ promotion 30/40 (75%)

5. Develop SOP, rules and regulations upon Temporary Employment/ Outsourcing/ contracting-out for HRH and recruitment and orientation of new health workers 27 (68%)

All five prioritized activities are essential for the rural retention of health workforce in the future.

With this prioritization, CHRHCU could lead the activities to be implemented in the next five years, hand-in-hand with the States/Regional HRH Units formed and many other Stakeholders. This does not mean the other issues such as strengthening institutionalizing CPE or rewards/recognition of health workforce as non-financial incentives will not be carried out, but CHRHCU would pay attention to the first five prioritized issues then later would tackle the others or if have opportunity windows will be able to implement.

Under the four units of CHRHCU, HRH Management and Rural Retention Unit (Unit 3) and Policy and Planning Unit (Unit 1) have to work together to obtain the Financial Incentive for the frontline health workers in negotiations and collaboration with the officials from the Ministry of Planning, Finance and Industry (MOPFI), the Auditor General Office and other stakeholders concerned. They have to start from exploring evidence-based search for existing hardship allowances practiced in the hard-to-reach areas, by desk reviewing documents, decree and order for those allowances, how payment have been made, any calculation for weightage, etc. These will be the basis for further discussions and decisions for provision of any kind of incentives for the frontline health workers.

Data and Information Unit (Unit 2) has to start with the strengthening of ongoing HRH Information System (HRIS) and Forecasting of HRH as a whole. This has to be conducted in collaboration with S/R HRH-U, Councils (MMC, MNMC, MDC), Professional associations (MMA, MNMA, MHAA, Myanmar Pharmaceutical Association (MPA) and Myanmar Medical Technologists Association(MMTA)), in order to create official linkage between HRIS, HMIS and National Health Workforce Account (NHWA) by WHO and MOHS. Involvement of other stakeholders widely in forecasting of HRH will be able to cover wider planning and monitoring of HRH for the whole country beyond public sector, including private sector, EHOs and CSOs in future.

Unit 1(Policy and Planning Unit, CHRH-CU) together with Unit 3 (HRH Management and Rural Retention Unit, CHRH-CU) & Unit 4 (CPD and IPE Unit, will take care of developing special student selection criteria. Linking with this to allocate locally trained in their local areas after graduation, in their rotation and promotion.

All units have to explore means and ways to develop SOP, rules and regulations upon Temporary Employment/ Outsourcing/ contracting-out for HRH and recruitment and orientation of new health workers.

With COVID 19 crises, all of the above prioritized strategies for retaining rural health workforce are of utmost need for the MOHS.

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ANNEXES

ANNEX 1: PRIORITIZATION OF IMPLEMENTATION OF RURAL RETENTION STRATEGY

Based on discussions with stakeholders (see Annex 2): 7 priority areas have been identified. The following set of interventions had been further refined during the October 30, 2020 workshop based on feasibility, cost/resources, and importance.

Education								
Areas	Strategies	Interventions	Timeline			Responsible entity	Feasibility	Costing
			2021-2022	2023-2024	2025 -2026			
Education	1.Develop education policy and regulation aimed to increase recruitment and enrollment of students from underserved areas that includes selection, support and placement after graduation	Develop appropriate student selection criteria and special student entrance policy to increase intake of students from underserved areas by 15-20% for enrollment in medicine, nursing and allied health professions.	x	x	x	CHRHCU Sub-unit1 Policy and Planning and unit 3 HRM and RR Team DHRH, DoPH, DoMS	Yes	+ + +
	2. Strengthen and institutionalize continuing education and professional development; Linkage to licensure	Establish system to link CME to registration, accreditation and career development	x	x	x	Central CHRHCU S/R HRH-U, DHRH Training Institution, MMC, MNMC, MDC MMA, MNMA, MHAA, MPA, MMTA	Yes	+ + +

Governance								
Areas	Strategies	Interventions	Timeline			Responsible entity	Feasibility	Costing
			2021-2022	2023-2024	2025 -2026			
Gove-rnance	1.Develop Human Resource Management capacity at various levels of the health system including: • information systems, • standard operating procedures for key topics such as gender and cultural awareness • capacity to conduct needs-based planning (WISN tool, forecasting), monitoring and supporting implementation • problem solving	HRH Data: Strengthen ongoing Human Resource Information System (HRIS) that is aligned with DHIS2 and health facility registry to enable decision making. Data based should be managed by the CHRH-CU and a system should be developed to ensure data are up to date Information sharing amongst different Departments on HR for further collaborative planning of HR by both production and deployment sectors	x	x	x	Central CHRHCU, S/R HRH-U, Councils (MMC, MNMC, MDC), Professional bodies (MMA, MNMA, MHAA, MPA, MMTA) to create official linkage between HRIS, HMIS and National Health Workforce Account (NHWA) by WHO and MOHS	Yes	+ + +
	2. Develop and implement system for temporary employment (i.e., a 'contracting' out system with quality assurance)	Develop SOP, rules and regulations upon Temporary Employment/ Outsourcing/ contracting-out for HRH and recruitment and orientation of new health workers	x	x	x	CHRHCU S/R HRH-CU Teams Other related Ministries	Yes	+ + +
	3. Revise policies and regulations on career pathways (i.e., placements, rotations, promotions, and professional support) with a focus on deployment in the local areas	Policies and mechanisms ensuring local recruits to be stationed at corresponding local rural areas after graduation/rotation/ promotion	x	x	x	MOHS (CHRH -CU) Civil Servant Affairs Sections from DHRH, DOPH, DOMS, in collaboration with S/R Governments, S/RHD, Union Civil Service Board	Yes	+ + +

Financial and non-financial Incentives

Areas	Strategies	Interventions	Timeline			Responsible entity	Feasibility	Costing
			2021-2022	2023-2024	2025-2026			
Financial and Non-Financial incentives	1.Review and Revise policies and regulations on financial incentives to improve retention of Health workforce in rural and hard to reach areas including incentives, per diem, and hardship allowance.	Financial - Area level-based bundled Incentive packages developed -Travel, housing allowance, meter bill, etc	x	x	x	CHRH -CU, Sub -unit1 Policy Planning and Coordination and sub unit 2 Data and Information MOPF AG	Yes	+ + +
	2.Review and revise policies and regulations on non- financial incentives for improved retention	SOP for Performance Appraisal clubbed in with rewards/ recognition	x	x	x	MOHS-CHRH CU Sub Unit 1 and 3 & MOPF AG	Yes	+ + +

ANNEX 2: RECOMMENDATIONS BY STAKEHOLDERS FROM THE SERIES OF WORKSHOPS

EDUCATION	IMPLEMENTATION AND OVERSIGHT	OUTCOME
STRATEGY E 1: Develop education policy and regulation specifically for underserved areas that includes selection, support and placement after -graduation.		
E1.1. Develop appropriate student selection criteria and special student entrance policy to increase intake of students from underserved areas to enroll in medicine, nursing and allied health professionals	- MOHS DHRH in collaboration with S/R local governments, MOE, UCSB, to review and modify selection criteria based on local context. - There should be a focus on post-graduate licensure (in collaboration with councils) for students from special regions and EHO areas	- Selection criteria reviewed and revised to increase intake of students from underserved areas - Inclusion of MOE to strengthen basic education of students from hard and remote ethnic areas for further support of enrolling students in medicine, nursing and other allied subjects
E 1.2 Collaboration with Ministry of Education, strengthen basic education for students from rural areas who may need further support to enroll in medicine, nursing, and other allied health schools	Form Multi-sector working group. Central level to coordinate and advocate with Ministry of Education to identify outstanding students and provide them additional training in preparing for entry into medicine, nursing and other allied health schools	Strengthening basic education for students from rural areas who may need further support to enroll in medicine, nursing, and other allied health schools is being set.
E 1.3 Provide support for improving capacity for the students from special regions once students are enrolled in institutions	- Health institutions to establish student support center that will provide financial support/ stipend and facility for learning (i.e., library) - Academic support (i.e., special tuition) to be provided by faculty members - If feasible, S/R & local communities to provide support to ensure that students from special regions receive additional tutoring - If needed, schools to provide special language program for those students	Supporting system for improving capacity for the students from special regions once students are enrolled in medicine, nursing, and other allied health schools.

STRATEGY E 2: Develop the capacity of Educational Institutions to better meet the needs of the rural and remote health workforce		
E 2.1 Develop policy to recruit and retain faculty members in all cadres teaching at health professional schools and training institutes outside of major cities	- Review and update financial and other supportive environment - Transparent Policy for promotion and transfer should include specific duration (eg.2 yr or 3 yr) when faulty members has been posted at training institutions outside of major cities - Performance appraisal for faculty members including feedback from students - Central level to ensure all faculty members have the opportunity for fellowships and other non-financial rewards - Central and S/R/S to adapt models from other countries developing contracting mechanism for faculty members	- Reduced turnover rate of faculty members. - Updated, revised policy on promotion and transfer of faculty members - Updated/revised SOP on performance appraisal for faculty members for use in career ladder Updated/revised policy/ regulation on non- financial incentives for faculty members
	Implementation and oversight	Outcome
STRATEGY E 3: Undertake reviews and revision of curriculum, pre-service and continuing training systems to ensure they meet the needs of the rural and remote health workforce		
E 3.1 Design continuing education and professional development programmes that meet the needs of rural health workers and are accessible from where they live and work	- Communities to propose skill needs - All levels to arrange and organize CPD	- Continuous learning programme designed and developed - Rural Health content incorporated into outcome based integrated curriculum in medicine
E3.2 Establish system to link CME to registration, accreditation, and career development	- Central level, together with professional bodies develop system to link CME to registration, accreditation and career development	- CPD system improved Patient's outcome, safety and satisfaction are improved by CPE. - CME system developed that is linked to registration and career pathways

E 3.3 Conduct research on innovative mechanisms to deliver CME program in rural areas (Distance Learning, etc)	- Central level to allocate grants to assess the delivery mechanisms and design for CME courses Regional level to conduct implementation research on new CME programs	- Research capacity is improved and can explore and solve the health-related problems - Number of research studies on CME developed and implemented - Understanding of CME delivered through various modalities improved.
Governance	Implementation and oversight	Outcome
STRATEGY G 1: Review and Revise Policies on Roles and Functions of Rural Health Professional and Community Based Health Workers		
G1.1 To support recruitment and retention of community-based health workers (CBHWs) there should be common standards of training and a pathway for entering professional cadre.	- Districts and townships make proposal for recruitment and retention - Central and S/R set the policy to develop training curriculum	- Policy/regulation on standards and professional pathway developed for CBHWs - Recruitment, retention and quality of community-based health workers are improved
G1.2 Introduce enhanced scope of practice for health professionals working in rural and remote areas (Task Shifting)	- Central level to develop policy on task shifting - S/R to implement accordingly	- Policy and guideline/ SOPs developed for enhanced scope of practice
G 1.3 Clarify roles, functions and scope of practice for all HRH to deliver the basic package of essential health services	- Central, with subnational inputs to build on the job description that was conducted in 2018. - Adjusted to fit the needs of the community by TMOs (and approved by S/R), clearly articulated to health staff, and tied to performance review.	- Scope of work/ roles of all HRH cadres defined to enhance service delivery of essential health services
G 1.4 Clarify roles, functions and scope of practice for all HRH to deliver the basic package of essential health services	Central, with subnational inputs to build on the job description that was conducted in 2018 and further define roles and responsibilities. This may be adjusted to fit the needs of the community by TMOs (and approved by S/R), clearly articulated to health staff, and tied to performance review.	- Scope of work/ roles of all HRH cadres defined to enhance service delivery of essential health services

STRATEGY G 2: Review and Revise policy and regulation on career pathways (placements, rotations, promotions, professional support)		
G 2.1 Develop policies and mechanisms to ensure local graduate students are stationed in corresponding local rural areas after graduation Review and revise policies and regulations on rotation and promotion	- Central level to develop policy - S/R to implement and ensure graduated students are stationed accordingly - Central level to develop a transparent system for rotation and promotion - S/R to implement (policy to action) - Ensure policy alignment of staff rotation and promotion with National Health Policy framework.	- policies and mechanisms to ensure graduate local students are stationed in their corresponding local rural areas after graduation has been developed - Policy reviewed and revised. - Policy implemented by S/R level up to AD level for rotation and up to Officer level for promotion. For Promotion, S/R will be responsible for the positions below Officer level.
STRATEGYG 3: Review and Revise policy and regulation on compulsory service		
G 3.1 Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives to increase recruitment and retention of health professionals in these areas	- Central level to ensure rotation after compulsory service requirements are met - Community, EHOs, CSOs, and CBOs to provide support for retention of health professionals in these areas - Compulsory service policy is defined at the pre-service educational level to improve service retention at the remote/ rural areas"	- Enforcement of regulations in place to ensure a enabling environment for HWF retention at the rural areas. - Improved health workforce retention at the rural/ remote areas. - Update policy to increase amount required for students to refund to government if not enter into service after training
STRATEGY G 4: Develop human resource management capacity at various levels of the health system (information systems, standard operating procedures, planning and monitoring, supporting, problem solving and financing, gender and cultural awareness)		
G 4.1 Strengthen ongoing Human Resource Information System (HRIS) that is aligned with DHIS2 for decision making and also managed by the Central Human Resources for Health Coordination Unit (CHRH-CU)	- Coordination and collaboration with Central, S/R, Councils (MMC, MNMC, MDC), and professional bodies (MMA, MNMA, MHAA, etc) to create official linkage between HRIS, HMIS and National Health Workforce Account (NHWA) by WHO and MOHS]	- CHRH-CU formed and functioning to provide stewardship of HRH management system.

G.4.2 Development of minimum standards for HRH management and planning and establish S/R level HRH-CU team to enhance HRH management at the S/R and below	Review of minimum standards of human resource numbers, and mix of staff (staff to population ratios, staff mix, staff distribution) by CHRH-CU - Define minimum standard for HRH at the sub-national level. Provide on-going capacity building activities to staff working at townships and below	Published minimum standards by CHRH-CU HRH-CU team established at S/R level
G 4.3 Develop and disseminate standard operating procedures for recruitment and orientation of new health workers.	- Develop SOPs for recruitment and orientation of new health workers. Planning sub-unit under the CHRH-CU will be responsible to lead the process for development and implementation of SOPs. - Compulsory service policy is defined at the pre-service educational level to improve service retention at the remote/ rural areas	- System in place for the effectiveness of recruitment and orientation of new health workers - Standard Operating procedures for recruitment and orientation of new health workers developed
Bundled incentives	**Implementation and oversight**	**Outcome**
STRATEGY BI 1: Review and revise policies and regulations on financial incentives for improved retention		
BI 1.1. Create Area level-based bundled incentives package should be developed (regional allowance by local government).	Region/State government planning committees to prepare budget for allowances (travel, housing, meter bill etc) Special considerations to be taken during humanitarian crisis (disaster or man-made)	- Policy and regulation on bundled incentives package for rural and remote health workforce developed - Remuneration package endorsed for health workers in remote and conflict affected areas - Reviewed/revised policy and regulation on travel, accommodation and day care allowances - Reviewed/revised policy and regulation on medical insurance

BI 1.3 Consider provision of standardized remuneration and allowances package for CBHW (both monetary and non- monetary)	Region/State government planning committees to prepare budget for allowances	- CBHW retention/ reduced attrition - Promote Task shifting - Promote satisfaction/ motivation - Merit-based/ Performance-based remuneration package created for CBHW
STRATEGY BI 2: Review and revise policies and regulations on non- financial incentives for improved retention		
BI 2.1 Create a safe and happy working environment through improved security as well as living and working conditions	All levels have a responsibility to improve work environments for health staff and "Staff Safety" Construction and renovation of health facilities and housing for staff	- Developed guidelines/ SOPs for work safety in conflict or remote area setting - Reviewed guidelines and SOP for Occupational Health & Safety - Secured accommodation provided for health workers
BI 2.2 Ensure transfer policy is transparent, known to all health workers, and enforced	Central level to update transfer policy for all cadre that is transparent and enforced	- Updated transfer policy in hands of all levels of HWF
BI 2.3 Performance Appraisal to be performed regularly with clubbed-in recognition/ reward measures for motivation	Central level is piloting the use of an appraisal system. After the pilot phase, central level to review, revise (if necessary) and expand Appraisal system standardized and transparent	- Guidelines/SOPs on appraisal standardized, published and disseminated - Recognition and rewards to be institutionalized - Promote Job satisfaction/ motivation
BI 2.4 Foster team spirit by establishing practice models of inter professional education and collaboration. This will enable praising and motivation of the whole team (instead of, or in addition to individuals).	Central to continue/enhance current system Regional/State/Local level involvement	• Promote team spirit • Promote inter-professional collaboration • Patient Safety • Promote Job satisfaction/ motivation • Publication and dissemination of best practice models of inter professional collaboration

BI 2.5 Develop mechanisms for accountability to safeguard both health staff as well as the patients and communities	Central to develop a system S/R, D, T, Primary to implement	- Guidelines/SOPs developed on accountability measures for both providers and patients
B1 2.6 Research and strategize motivational factors that promote or hinder local recruitment in ethnic areas	Central (Implementation Research Grants) State/Regional/local	- Promote Health Systems Research - Enhanced evidence-based Information, Data to Policy, Data for Decision Making - Increased number of research studies undertaken on health workforce issues in rural or remote areas

ANNEX 3: PRIORITIZATION OF FIVE FEASIBLE, WORKABLE RURAL RETENTION STRATEGIES IN COMING 5 YEARS

Out of the following already prioritized seven strategies it was asked to select mostly doable, feasible and affordable FIVE strategies by the participants using Google Form Link for Voting.

Retention Strategic Actions for Voting
Please vote 5 options out of the following strategies

- Education - Develop Student Selection Criteria and Special Student Entrance Policy
- Education - Strengthen and institutionalize Continuing Education and CPD, linkage to licensure
- Governance - Strengthen ongoing HRH information system (HRIS) and Forecasting
- Governance - Policies and mechanisms ensuring local recruits to be stationed at corresponding local rural areas
- Governance - Develop SOPs, Rules and Regulation upon Temporary Employment, Outsourcing, Contracting and Orientation of new health workers

- Incentive - Financial - Area level-based incentive packages developed (travel, housing allowance, etc)
- Incentive - SOP for performance appraisal clubbed in with rewards/recognition

Voting Results: Prioritized Strategies and Activities for National Rural Retention Strategy (2020-2025)

1. Financial incentive- Area level based bundled incentive packages developed. Travel, housing allowance, meter bill etc; 34/40 (85%)
2. Strengthen ongoing HRH Information System (HRIS) and Forecasting 33/40(83%)
3. Develop student selection criteria and Special student selection policy 32/40 (80%)
4. Policies and mechanisms ensuring local recruits to be stationed at corresponding local rural areas after graduation/rotation/promotion 30/40 (75%)
5. Develop SOP, rules and regulations upon Temporary Employment/Outsourcing/ contracting-out for HRH and recruitment and orientation of new health workers 27 (68%)

Figure 4: Prioritized Rural Retention Strategies for Implementation in next five years