THE ASIAN COLLECTIVE FOR HEALTH SYSTEMS

Human Resources for Health:

Strengthening Competence and Compassion

Regional Workshop Report; Held on July 3-4, 2025 in Colombo, Sri Lanka;

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Table of Contents

THE ASIAN COLLECTIVE FOR HEALTH SYSTEMS

List of Abbreviations

AETCOM	Attitude, Ethics, Communication
ANAAA	National Agency for Assessment and Accreditation
ASEAN	Association of Southeast Asian Nations
ASHA	Accredited Social Health Activist
BHMIS	Bhutan Health Management Information System
BMDC	Bangladesh Medical and Dental Council
BNMC	Bangladesh Nursing and Midwifery Council
CHV	Community Health Volunteer
CHWs	Community Health Workers
CME	Continuing Medical Education
CPD	Continuing Professional Development
DGHS	Directorate General of Health Services
DHIS2	District Health Information System, Version 2
FCHV	Female Community Health Volunteer
HRH	Human Resources for Health
HRIS	Human Resources Information System
iGOT	Integrated government online training platform
KGUMSB	Khesar Gyalpo University of Medical Sciences of Bhutan
LMIC	Low and Middle Income Countries
MHPC	Medical and Health Professional Council
MIS	Management Information System
NMC	National Medical Commission
NMNC	National Nursing and Midwifery Commission
NCDs	Non Communicable Diseases
NGO	Non-governmental Organization
PBRI	Pra Baromarachachanom Institute
PRC	Professional Regulation Commission
PSF	Programa Saúde na Família (Family Health Promoters)
SDGs	Sustainable Development Goals
SMS	Short Message Service
TACHS	The Asian Collective for Health Systems
UHC	Universal Health Coverage
WHO	World Health Organization
WHO SEARO	World Health Organization South-East Asia Region

1. Introduction

Human Resources for Health (HRH) are central to strengthening health systems, and their roles are evolving in response to demographic shifts, health shocks, and growing service demands. A workshop, jointly hosted by The Asian Collective for Health Systems (TACHS) and World Health Organization South-East Asia Region (WHO SEARO) in Colombo, Sri Lanka, emphasized the importance of developing competence and compassion within the workforce, moving beyond numbers to cultivate adaptable, resilient, and multidisciplinary teams. The workshop had representation from 12 country governments in the South and South East Asian region, along with several non-government organisations and think tanks. A list of participants is provided in the Appendix.

Country reflections on successes and challenges related to the health workforce emphasized issues such as equitable distribution of the workforce, their retention, and continuous professional development, underscoring that HRH development requires collaboration across government, academia, civil society, and international partners. At the same time, participants stressed the importance of institutional approaches to quality and accountability, with governments playing a stewardship role in setting priorities, mobilizing resources, and embedding structured mechanisms for monitoring and transparency. Quality was framed not only as technical excellence but also as responsiveness to community needs, while accountability was seen as a shared responsibility across institutions and professionals. Together, these discussions point to an HRH agenda that is both people-centered and system-driven, aiming to build trust, resilience, and equity in health systems.

The following section discusses country-specific responses to emerging capacity needs, followed by institutional approaches to quality and accountability.

2. HRH Capacity Building in Response to Evolving Needs

The global health landscape is in constant flux, shaped by dynamic demographic shifts, the escalating burden of chronic and non-communicable diseases, the undeniable impacts of climate change, and the lingering effects of global health crises like pandemics. These multifaceted pressures demand a continuous evolution in the capacity of HRH. Across South and Southeast Asia, various nations are adopting diverse institutional approaches to bolster their health workforces, striving for resilience, equity, and responsiveness in the face of these emergent and evolving needs. The following outlines country-specific strategies, innovations, and current challenges, as identified in the discussions held in Colombo from July 3rd to July 4th, 2025.

Bangladesh: Bangladesh confronts a significant HRH deficit, with a shortfall of over 60,000 doctors and 140,000 nurses. This gap is compounded by severe rural-urban disparities, where a disproportionate 70% of doctors are concentrated in urban centers, leaving rural areas underserved. Compounding these issues are training gaps, characterized by outdated curricula and a limited focus on patient-centered care, and accountability issues stemming from weak

regulation and low community trust. A particular challenge noted in the past involved a rapid proliferation of nursing colleges, raising concerns about their quality and even their existence, which prompted the use of geomapping for institutional verification[2][4][5][6][7].

In response, the Directorate General of Health Services (DGHS) under the Ministry of Health and Family Welfare (MOHFW) is actively engaged in institutional reforms. A key initiative includes the 2025–2030 HRH Strategy, which explicitly targets a 10% increase in doctors serving in rural areas to mitigate existing disparities. Capacity building efforts are leveraging technology extensively. Bangladesh utilizes a comprehensive Human Resources Information System (HRIS) for more effective workforce planning and to enhance accountability. Telemedicine is deployed not only for service delivery in remote and rural areas but also as a tool for training healthcare professionals, thereby extending educational reach and ensuring continuous professional development. The country employs a public hotline (16263) and robust data management systems like District Health Information System, version 2 (DHIS2) and Open MIS to improve health information flow and system efficiency. Intersectoral collaboration is another cornerstone, with non-governmental organizations (NGOs) playing a vital role in training over 20,000 Community Health Workers (CHWs), playing a critical role in grassroots healthcare delivery. To combat rural-urban imbalances and improve retention, solutions proposed include incentives for rural service, such as financial benefits and clear career progression pathways. There is a recognized need for continued curriculum modernization and expansion of pre-service and in-service education in medical colleges, alongside scaling up simulation-based and continuing professional development (CPD) to enhance the clinical competence of the workforce[2][4][5][6][7].

Bhutan: Bhutan's HRH landscape is marked by unique challenges, including issues of attrition and retention, limited career progression opportunities for health professionals, and a notable dependency on a foreign-trained workforce. These factors contribute to a constrained capacity to meet evolving health demands, particularly in rural and difficult-to-access areas where adequate incentives for health workers are lacking[3].

In addressing these concerns, Bhutan is heavily focused on strengthening its domestic HRH production. A national emphasis is placed on improving the in-country training of healthcare professionals to reduce reliance on external sources. Capacity building includes establishing comprehensive in-service competency and professional development plans that are meticulously aligned with the country's broader five-year development plans. A robust curriculum validation process, overseen by the Khesar Gyalpo University of Medical Sciences of Bhutan (KGUMSB) and the Medical and Health Professional Council (MHPC), ensures that all in-country training programs – for both pre-service and in-service professionals – are relevant to Bhutan's specific health context and needs. This validation process scrutinizes the relevancy of program content, the qualifications of faculty, and the readiness of teaching hospitals and physical facilities. Strategically, Bhutan is undertaking significant reforms in workforce structure, including the reintroduction of the curriculum and the position of Clinical Officer, a role vital for extending healthcare services in primary settings. Additionally, the

creation of separate career pathways for health professionals aims to enhance retention by offering clearer opportunities for professional growth and advancement, thereby fostering a more stable and locally adaptable workforce capable of responding to the nation's evolving health priorities[3].

Timor-Leste: Timor-Leste faces a critical HRH shortage, with only about 25 health workers per 10,000 population, falling significantly short of the global standard of 44.5 per 10,000. This numerical deficit is compounded by an uneven distribution of HRH, leading to primary health facilities in remote areas often experiencing severe staff shortages. A key systemic challenge identified is that the existing curriculum for health professionals is often "not based on the need in the field," leading to a disconnect between training and practical healthcare demands[4][5].

To overcome these hurdles, Timor-Leste is strategically prioritizing curriculum contextualization as a cornerstone of its capacity-building efforts. In a notable example of South-South cooperation, Timor-Leste is collaborating with Sri Lanka to develop a curriculum that is specifically tailored to its unique disease burdens and health needs. This initiative aims to build indigenous capabilities within the country, thereby reducing the reliance on sending professionals abroad for general training that may not align with local realities. Furthermore, a crucial element of their strategy is the revitalization of Community Health Volunteer (CHV) cadres. These programs, previously known as Family Health Promoters (PSF), are being reformed with new guidelines and incentive frameworks. This revitalization aims to overcome past failures where the system struggled to deliver comprehensive primary healthcare services consistently. The piloting of these new CHV guidelines in five municipalities signifies a concerted effort to strengthen healthcare delivery directly at the community level, ensuring that health services are accessible and relevant to local populations and their evolving health requirements [4][5][6][7].

India: India's HRH capacity building is significantly influenced by the country's demographic transition and a rising burden of non-communicable diseases (NCDs), including conditions like obesity. This necessitates a shift in focus towards preventive and promotive care alongside curative services[1].

In response, India's health sector is adapting its training and service delivery models. There is an increased emphasis on addressing NCDs, which includes training health workers to conduct basic health parameter checks, such as weight and waste measurements, and providing public health advice on prevention. A significant stride in expanding HRH capacity and reach, especially in rural and underserved areas, involves leveraging digital technology. Some states are procuring digital devices for Accredited Social Health Activists (ASHA workers), while others are providing data plan reimbursements for their smartphones. This initiative empowers ASHA workers to utilize digital health platforms, facilitating data collection, health information dissemination, and more efficient service delivery at the grassroots level. During the COVID-19 pandemic, India further demonstrated its adaptive capacity by scaling up the integrated government online training platform (iGOT), which provided essential courses for

health professionals. This rapid deployment showcased the potential of online learning for agile HRH development in response to urgent health needs. Moreover, there is an evolving conceptualization of care towards "transformative care-compassion," with a growing emphasis on developing "non-technical skills" such as empathy, communication, and patient-centeredness among health professionals. The use of technology for oversight, like biometric attendance systems and dashboards, also contributes to improved accountability[1][2][4][6][7].

Sri Lanka: The discussions highlighted the nation's proactive engagement in enhancing the capabilities of its health workforce in response to general "emerging health needs"[6].

A prominent aspect of Sri Lanka's strategy is its active participation in South-South cooperation. This involves sending healthcare professionals to other countries, such as Thailand, for advanced training and knowledge exchange, thereby enhancing their specialized skills and broader capabilities. Furthermore, a significant emphasis is placed on embedding compassionate, people-centered care alongside clinical competence in health professional education and training. This reflects a commitment to developing a workforce that is not only technically proficient but also deeply empathetic. Innovative approaches are being explored to achieve this, including integrating "The Arts and Humanities" into the medical curriculum. This interdisciplinary approach aims to foster humaneness, critical thinking, and a deeper understanding of human experiences, thereby preparing health professionals for a more holistic and compassionate approach to patient care in a complex and evolving healthcare landscape. Sri Lanka also leverages institutional culture to support ethical and compassionate practice, although it seeks to expand the systematic use of digital/quantitative performance appraisal and grievance mechanisms[1][2][6][7].

Thailand: Thailand, despite achieving Universal Health Coverage (UHC) in 2002, continues to face challenges in prevention and health protection, coupled with some localized health workforce shortages. Crucially, Thailand explicitly acknowledges the impact of major global trends on its HRH, including demographic shifts, the rising burden of chronic diseases, climate-related health challenges, and the demands of post-pandemic recovery[7].

Their strategy involves a fundamental shift from hospital-based, high-technology care to community-based, high-touch care, effectively decentralizing services and making them more accessible. This transition is heavily supported by the integration of advanced technology, including telemedicine, Augmented Reality (AR), and Artificial Intelligence (AI), which facilitate remote care, diagnostics, and training. This technological embrace directly addresses the need for a more distributed, efficient, and technologically adept workforce capable of reaching diverse populations. Educational reforms are central to this transformation, spearheaded by the Pra Baromarachachanom Institute (PBRI), which focuses on modernizing health workforce education. A cornerstone of these reforms is community-integrated learning, a unique model where medical students dedicate a significant portion of their study (one year out of six) to learning and working directly in community settings. This practical immersion fosters interdisciplinary skills, collaboration across nine health professions, communication,

empathy, and transformational leadership, equipping future professionals with the competencies required for a complex and evolving health environment. Thailand also strengthens its community health workforce by establishing clear career paths for over 1.2 million healthcare volunteers, offering them financial incentives (approximately $40/month) and opportunities for advancement[4][5][7].

Philippines[8]: The Philippines is both a major supplier of nurses to the world and a country struggling with domestic shortages. To address this paradox, the government and training institutions have prioritized continuing professional development (CPD), competency-based curricula, and licensing reforms to maintain global competitiveness while strengthening local care delivery. More recently, emphasis has shifted to disaster risk management and climate-resilient skills for community health workers, recognizing the country's high exposure to typhoons and floods. Pilot programs train rural health workers in emergency response, psychosocial support, and continuity of chronic care during crises. Scholarship schemes and return-service obligations are used to retain professionals in underserved areas, though migration incentives remain strong.

Vietnam[8]: The most pressing workforce challenge is the aging population, with over 14% of the population already above 60 years old. The government has responded by embedding geriatric medicine, elderly nursing, and chronic disease management into training curricula. Partnerships with Japan and other countries have introduced eldercare programs benchmarked to international standards, and specialized geriatric departments are being established at provincial hospitals. Community-based eldercare training models are also emerging, equipping grassroots staff and volunteers to support home-based and day-care services. Beyond geriatrics, broader skill-building efforts include digital health training, preventive health promotion, and interprofessional education to prepare for multi-morbidities and complex care needs.

Nepal[8]: Nepal's celebrated Female Community Health Volunteer (FCHV) program has been the backbone of service delivery for decades. Today, capacity building efforts are focused on expanding their competencies beyond maternal and child health to include chronic disease screening, mental health awareness, and climate-related risk communication. Training modules now emphasize emergency preparedness, as recurrent floods and landslides disrupt access to care. Parallel investments are being made in digital health platforms, enabling FCHVs to record patient data, receive supervision, and extend their reach into remote mountain communities. For physicians and nurses, mandatory community postings and strengthened accreditation standards aim to ensure a broader skill base and equitable distribution.

Maldives[8]: In the Maldives, the geographical dispersion of small island populations creates distinct HRH challenges. The heavy reliance on expatriates has prompted the government to develop scholarship and training pathways for Maldivian students in medicine, nursing, and allied health fields. Regional partnerships with South Asian and Association of Southeast Asian Nations (ASEAN) institutions aim to build specialist capacity while reducing dependence on foreign workers. Given its acute climate vulnerability, HRH training includes disaster response,

environmental health, and mental health care linked to displacement and livelihood loss. Community health cadres are also being upskilled to handle health issues related to saltwater intrusion and ensure continuity of care across scattered islands.

To encapsulate, most of the countries are facing a dual challenge of HRH shortage at the country level and rural-urban disparities in terms of the distribution of the workforce. Several countries have a lot of dependency on foreign graduates/foreign trained workforce. Despite taking measures in terms of financial incentives and career progression pathways, rural retention of the workforce is a great challenge for most countries in South and Southeast Asia. Besides, outdated curriculum and gaps in medical training pose a challenge to address evolving needs.

Since the focus of the workshop was on HRH strengthening, there was a great emphasis on harnessing technology to address gaps in both distribution and skill building. South-South cooperation is considered a lever for addressing gaps in the distribution and skills of the health workforce. Further, modernization of health workforce education, community integrated learning, and building an institutional culture to support ethical and compassionate practice were at the core of the discussion.

3. Institutional Approach to Quality and Accountability

Ensuring the quality and accountability of HRH is pivotal to achieving resilient, equitable, and responsive health systems. The complex challenges faced by health systems in South and South-East Asia call for a health workforce that is not only clinically competent but also people centered, resilient, and ethically grounded. In the backdrop of emerging health needs, the disparities of HRH quality and accountability can vary both within and across countries. These variations raise important questions about the role of institutional capacity and policy frameworks to ensure quality and accountability in the health workforce [2][4][6].

The ensuing discussion draws on the experiences of Bangladesh, Bhutan, Timor-Leste, India, Sri Lanka, Thailand, the Philippines, Vietnam, Nepal, and the Maldives to further explore mechanisms and challenges related to HRH quality and accountability across diverse health system landscapes[1][2][3][4][5][6][7].

Bangladesh[2]: Bangladesh has focused on strengthening clinical competence primarily through curriculum modernization in medical colleges, expansion of pre-service and in-service education, and scaling up simulation-based and continuous professional development (CPD). The Bangladesh Medical and Dental Council (BMDC) and Bangladesh Nursing and Midwifery Council (BNMC) regularly review curricula and accreditation standards. Human Resource Information System (HRIS) supports tracking of health worker education and deployment. Training for community health workers (CHWs) embeds empathy, communication, and patient rights. However, practical in-service quality initiatives for non-academic institutions and community cadres are more limited[2][4][5][7].

Bangladesh has made substantial progress in HRH management. Digitalization has transformed HRH monitoring (national HRIS, digital attendance, and community SMS feedback). Community engagement and rapid reporting are now embedded in HRH management. There is increasing formalization of grievance redress mechanisms and expanded avenues for patient feedback[1][2][4][5][6][7].

Accountability of the health workforce is reinforced through digital HRIS for workforce monitoring, biometrics, dashboards, citizen charters, and formal grievance redressal. Community health committees and feedback mechanisms (such as SMS-based systems in community clinics) bring local oversight to service delivery, backed by quarterly review committees[1][2][4][5][6][7].

Despite innovations and reforms, challenges remain, including outdated/inconsistent training—especially in rural/under-resourced areas, underregulation of the private sector, limited in-service capacity-building, and gaps in alignment of training with real-world community and patient needs. An inadequate number of teachers and physical infrastructure adversely impact the quality of medical education. Inappropriate skill mix affects quality of service delivery[4][5][7].

Regulatory enforcement is patchy; the private sector is underregulated; and community engagement, while institutionally advanced, is limited by literacy barriers, insufficient follow-up, and committee training. Supervision and performance management lack depth and equity in application. Centralization limits local accountability[2][4][5][6][7].

Strategies and Mechanisms for Quality in Bangladesh

• Intersectoral Collaboration: Non-governmental organizations (NGOs) are actively involved in training Community Health Workers (CHWs), with 20,000 CHWs having been trained. The private sector also contributes by aiding referrals.

• Local Initiatives: District Health Boards have been established and piloted in 10 districts since 2024 to coordinate clinic staffing and management at a localized level.

• Role of Technology: Bangladesh utilizes technology for HRH management and service delivery. A Human Resources Information System (HRIS) is in place for workforce planning and accountability. Telemedicine is used for training and delivering services in rural areas, complemented by a dedicated hotline (16263). The country also employs DHIS2 and Open MIS systems.

Bhutan[3]: In Bhutan, the Medical and Health Professionals Council (MHPC) mandates competency and professional development as a licensing requirement (30 CME credits). All in-service and pre-service programs must be validated for curriculum relevancy and faculty qualification through collaboration between the KGUMSB (Khesar Gyalpo University of Medical Sciences of Bhutan) and MHPC, ensuring ongoing alignment with the country's evolving needs. Government-funded residency and specialisation programs, as well as program validation processes, reinforce a systemically planned approach to HRH quality[3].

Regular curriculum validation, a system of mandatory and government-funded CME, and deliberate policy alignment with national health strategies have institutionally advanced HRH quality[1][2][4][6][7].

Mandatory CME participation and curriculum validation link directly to professional registration and ongoing licensure. BHMIS supports HRH monitoring, and pilot digital grievance redress and health worker performance scorecards are in use. District health offices, in partnership with community workers, are tasked with accountable delivery[1][2][4][5][7]. Implementation of pilot digital grievance mechanisms and improved use of workforce data show momentum toward modernized accountability[1][2][4][6][7].

Alongside the momentum, there have been limitations. Supervision unevenness at decentralized levels, limitations of domestic specialized training capacity, and continued reliance on foreign training for some cadres remain barriers. There are still gaps in the practical use of HRH data for real-time intervention. Accountability mechanisms like grievance redress and individualized staff feedback are still evolving. District-level unevenness and lack of formal legal recourse for HRH disputes persist. Attrition, career progression frustrations, and limited institute autonomy are noted [2][4][6].

Timor-Leste[4][5]: The National Agency for Assessment and Accreditation (ANAAA) oversees quality by accrediting all higher education and pre-service health institutions, with criteria on curriculum, faculty licensure, infrastructure, and laboratory capacity. The Ministry of Health defines standard job descriptions and practice expectations, but academic program quality is still evolving. Performance reviews exist as formal processes for health workers, but are generally management-focused rather than deeply engaged with clinical competencies.

There has been progress in formalizing performance appraisal linked to incentives and piloting CHV revitalization under new standards and incentive plans. Timor-Leste has prioritized developing its HRH by localizing educational curricula. Partnership with Sri Lanka and other countries for academic quality assurance is a positive example of regional innovation[4][5][6].

Annual performance assessments against set criteria (discipline, professionalism, punctuality, etc.) are linked to grade and salary but are usually generic. ANAAA ensures institutional (academic) accountability through program accreditation. Community accountability is fostered with revitalized CHV schemes—now operating under standardized guidelines[2][4][5][6][7].

Alongside the progress in Timor-Leste, challenges continue. Performance assessments are often generic, lacking clinical focus or developmental support. Academic quality is undermined by faculty licensing gaps, misalignment with field needs, and siloed curriculum development between health and education ministries. The performance review process is often a "box-ticking" exercise, with weak links to capacity building or clinical standards. Lack of functional HR information systems, poor feedback loops, inconsistent supervision, and drops in CHV motivation/retention (linked to inconsistent incentives and institutional support) are persistent challenges.

Timor-Leste: Tailoring Education for Local Needs

Timor-Leste has prioritized developing its HRH by localizing educational curricula. A notable advancement is the collaboration with Professor Indica from Sri Lanka, who conducted a situation analysis to understand Timor-Leste's specific disease burdens. This South-South cooperation aims to create a curriculum more aligned with local needs, fostering home-grown capabilities rather than exclusively sending students abroad for training. This approach is a concrete example of strengthening educational quality through contextualization.

India[1]: India operates under the National Medical Commission (NMC), which has instituted comprehensive, competency-based curricula, notably AETCOM modules (Attitude, Ethics, Communication), early clinical exposure, and assessment reforms. India's innovation includes reflective practice, peer/team mentoring, periodic CPD, and digital dashboards for self-declaration and performance. The ASHA program further institutionalizes practical, community-level capacity-building[1][2][4][5][7].

India's rapid switch to competency-based and compassionate curricula, AETCOM roll-out, and digital attendance/self-declaration have advanced quality. The integration of team mentoring and participatory governance (ASHAs) aligns with modern quality and accountability standards; ongoing curricular reforms have gained momentum[1][2][4][6][7].

Accountability mechanisms include biometric attendance, digital dashboards, and increased community oversight (via ASHAs). Regulatory and academic boards monitor compliance through periodic self-evaluation and audits. However, on-the-ground observability and systematic individual-level assessment remain limited, particularly outside large academic centres[1][2][4][5][6][7].

There have been strong reforms, but uniform implementation of regulatory and curricular reforms is often challenged by diversity among institutions/states and weak governance in non-academic and rural sectors. In-service professional development remains inconsistent, especially for community and non-clinical cadres[4][5][7]. In addition, maintaining quality post-

service remained a challenge. Observability and individual accountability on the ground remain weak, particularly outside large academic institutions. Private sector regulation and rural accountability lag, and systematic adoption of objective assessment in HRH is not universal[2][4][6].

India: Comprehensive Regulation and Digital Transformation[8]

India has established a robust regulatory framework under the National Medical Commission (NMC) to ensure the quality and accountability of its medical professionals and education. The NMC oversees 780 medical colleges with a significant annual intake of undergraduate students.

Significant advancements include the focus on institutional accountability through initiatives like linking faculty salaries to attendance in government colleges to ensure effective teaching. The National Nursing and Midwifery Commission (NMNC) Act 2023 is set to bring reforms to nursing education, further ensuring quality at the institutional level. A national system for rating institutions based on the quality of education they provide is also being implemented, serving as a key accountability mechanism.

India has also embraced digitalization. During the COVID-19 pandemic, the integrated government online training (iGOT) platform was updated with numerous courses for health professionals, promoting continuous learning. Despite these advancements, challenges remain in the effective implementation of policies and translating recommendations into practice.

Sri Lanka[6]: Sri Lanka is a regional leader in embedding people-centered care through its Department of Medical Humanities at the University of Colombo. Training focuses on empathy, ethics, communication, and professionalism, amplified by assessment in narrative medicine and the arts. University-community partnerships and medical humanities are systematized, and specialist colleges drive professionalism and humane care in practice settings[4][5][6][7][8].

Sri Lanka's institutionalization of medical humanities, promotion of narrative and reflective assessments, and the use of global health humanities networks to drive continuous professionalism represent regional leadership for quality and value-based training[6].

Accountability is driven by narrative self-reflection, professionalism assessment, health humanities networks, and the activities of professional colleges (storytelling, "We care" humane care programs). While robust at the level of values and professional peer review, digital/system-level accountability structures are less emphasized[1][2][4][6][7].

Scaling innovations in medical humanities and humane care beyond leading universities poses a challenge, as does integrating a new curricula system-wide. Building faculty capacity for humanistic teaching and aligning field practice with educational reforms remain ongoing

needs. While institutional culture supports ethical and compassionate practice, there is less systematic use of digital/quantitative performance appraisal or grievance mechanisms; extending robust accountability beyond centers of excellence is a key area needing attention[1][2][4][6][7].

For quality assurance, Sri Lankan medical graduates undergo rigorous checks when applying for specialties, often requiring a mandatory one-year training in overseas centers of excellence (e.g., UK, Australia, Canada), involving competitive examinations. This external validation helps ensure the competence of their advanced workforce. However, the documents do not explicitly detail internal follow-ups on research quality within Sri Lanka.

Thailand[7]: Thailand uses a National HRH Commission for policy and coordination. Professional councils strictly regulate licensure and require mandatory CPD. Curriculum reforms emphasize community-based, interdisciplinary, and empathy-driven care (including rural orientation). Medical and nursing schools outside Bangkok are oriented toward rural needs; career and leadership pathways are developed at the institutional level[4][5][7].

Thailand has embedded public accountability in UHC governance, established rural practice requirements, and developed career and leadership frameworks. Interdisciplinary, community-based curriculum and robust community health volunteer programs are advances for both quality and accountability[2][4][5][6][7].

Strong HRH data units support routine reporting and benchmarking. Public hearings, grievance channels (helplines), mandatory service reviews, and household-oriented primary health volunteers ensure community accountability. Universal Coverage Scheme governance places citizen voice centrally, with mandatory public hearings and transparency for grievance handling[2][4][5][6][7].

Despite having robust mechanisms, gaps persist in harmonizing national policies and local implementation, team-based workforce planning, and adapting training to address the growing burden of NCDs and an aging population. Data system integration is an area for improvement. Achieving consistent enforcement across regions, integrating public and private sector accountability, and sustaining performance improvement at the subnational level remain challenges. Workforce data integration for decision-making and evolving needs demand continued adaptation[2][4][6].

Thailand: Universal Health Coverage and Community-Integrated Care[8]

Thailand stands out with its achievement of Universal Health Coverage (UHC) in 2002, demonstrating a foundational commitment to healthcare accessibility and quality. The country is transitioning from hospital-centric, high-technology care to community-based, high-touch care, integrating modern tools like telemedicine, AR, and AI.

Educational reforms are central to Thailand's quality improvements. The Pra Baromarachachanom Institute (PBRI) modernizes health workforce education through community-integrated learning, where medical students spend a significant portion of their training in community settings. This approach cultivates essential skills like interdisciplinary collaboration, communication, and empathy. Thailand also fosters collaboration across nine health professions and involves local communities in health promotion. The establishment of career paths, including financial incentives, for over 1.2 million healthcare volunteers further strengthens the community health workforce. A compulsory service requirement for medical graduates reinforces their commitment to public health.

Philippines[8]: The Philippines has one of the more established HRH regulatory systems in the region. The Professional Regulation Commission (PRC), through professional boards such as nursing and medicine, regulates licensing, accreditation, and continuing professional development (CPD). Accreditation of medical and nursing schools enforces minimum standards for pre-service quality. In-service quality is monitored through facility supervision and local government oversight, as health service delivery is decentralized.

The country has integrated CPD as a mandatory requirement for license renewal, aligning domestic standards with international benchmarks. This supports both domestic quality assurance and global recognition of Filipino nurses and doctors. More recently, disaster preparedness and climate resilience modules have been incorporated into professional standards, ensuring that HRH are trained to deliver safe care during frequent typhoons and floods.

The Philippines has built accountability mechanisms through its Professional Regulation Commission and professional boards, which enforce licensing and professional standards. Local government units also play a supervisory role in public service delivery, while facility-level performance evaluations provide some oversight of health worker conduct. Progress has been made in linking CPD requirements to licensing, strengthening professional accountability, and framing health workers' roles within disaster resilience, which holds providers to new expectations during emergencies.

The Philippines has demonstrated a forward-looking approach to quality, but challenges remain. Enforcement of quality standards is uneven, especially in rural and private sectors where oversight is limited. Migration of health workers, a longstanding feature of the

Philippine health system, also weakens domestic quality assurance by disrupting continuity of care and draining skilled personnel. Despite progress, accountability challenges persist. Oversight is weaker in rural and private sectors, where shortages are greatest. Migration further complicates accountability, as many health workers do not fulfill return-service obligations. During disasters, accountability is often weakest, as service breakdowns leave communities without recourse to grievance mechanisms or institutional redress.

Vietnam[8]: Vietnam's commitment to quality in HRH is anchored in its national legislation. The Law on the Elderly (2009) and the National Program for Elderly Care (2020) establish standards for geriatric training and service delivery, while the Ministry of Health regulates accreditation of medical and nursing institutions. Specialized geriatric hospitals and departments at the provincial level provide benchmarks for eldercare services. In recent years, progress has been evident in the integration of geriatrics and chronic disease management into health worker education, alongside the creation of specialized training programs. Community-based eldercare has also gained prominence, reflecting efforts to bring quality services closer to households.

Accountability in Vietnam is rooted in national laws that assign responsibilities to government bodies and health providers. Provincial health departments are tasked with compliance monitoring, while professional associations support peer accountability. Progress is evident in the government's efforts to strengthen the legal basis for accountability, clarifying mandates across central and provincial levels, and in extending accountability to emerging areas such as eldercare.

Even though Vietnam has made substantial progress in HRH quality, especially in geriatric care, quality enforcement remains fragmented across provinces, leading to uneven application of standards. Data on HRH capacity, especially in geriatrics, is incomplete, which hampers effective planning. The rapid expansion of private eldercare facilities adds another layer of complexity, as many operate outside stringent regulatory oversight, raising concerns about variable quality. Accountability of HRH remains fragmented. Provincial monitoring capacity is limited, which weakens the enforcement of central directives. The expansion of private eldercare services poses major challenges, as regulatory oversight is inadequate. Patients and families also have limited channels to raise grievances, leaving accountability incomplete from the perspective of service users.

Nepal[8]: Nepal's approach to HRH quality combines professional regulation and community-based service delivery. The Nepal Health Professional Council licenses health workers and accredits medical and nursing schools, ensuring a minimum standard of training. Standardized curricula and training packages have been introduced, particularly for community health workers such as Female Community Health Volunteers (FCHVs), who remain central to service delivery. Recent progress includes digital health tools being piloted for supervision and monitoring, offering opportunities to strengthen in-service quality even in remote areas.

Accreditation systems have also been reinforced, and interprofessional education is gaining ground in medical schools.

Despite these advances, in-service quality monitoring remains weak. FCHVs, though critical, are increasingly overburdened as their responsibilities expand without adequate institutional support, which risks a decline in service quality. Infrastructure gaps and shortages of specialized personnel further undermine quality, especially in rural and mountainous regions.

Nepal relies on a combination of professional councils, government supervision, and community structures for accountability. The Nepal Health Professional Council provides formal regulation through licensing, while provincial and district health offices supervise public facilities. Historically, FCHVs functioned as a grassroots accountability mechanism by linking communities to health services and ensuring responsiveness. Recent progress includes the use of digital tools for HRH supervision, which offer potential for stronger accountability through more transparent monitoring. Accreditation improvements also contribute to professional accountability.

Despite the progress, in-service quality monitoring remains weak. FCHVs, though critical, are increasingly overburdened as their responsibilities expand without adequate institutional support, which risks a decline in service quality. Infrastructure gaps and shortages of specialized personnel further undermine quality, especially in rural and mountainous regions. Dual practice among physicians undermines accountability to the public system, as doctors divide their time between public and private work. Patient grievance systems are weak or absent, leaving individuals with little recourse when care is substandard. Moreover, the accountability function of FCHVs has diminished as their responsibilities expand without sufficient institutional backing.

Maldives[8]: The Maldives faces distinct challenges in ensuring HRH quality due to its small population, reliance on expatriate workers, and dispersed geography. Licensing requirements are in place for both local and expatriate health workers, while limited domestic training programs are accredited by the Ministry of Health. The country has made progress by establishing scholarship pathways and regional partnerships, which allow Maldivian students to train abroad and return with higher-quality skills. Disaster preparedness and environmental health have also been incorporated into HRH training, reflecting the nation's acute vulnerability to climate shocks.

In the Maldives, accountability mechanisms primarily exist through the Ministry of Health, which licenses expatriate workers and supervises public facilities. Facility-level monitoring provides some oversight, though capacity is constrained. Progress has been made in incrementally strengthening oversight of expatriates and in incorporating accountability into disaster-response roles for HRH, reflecting climate vulnerability.

Heavy reliance on expatriates leads to uneven standards, as providers come from diverse training backgrounds. Domestic training capacity is limited, which constrains the country's

ability to establish consistent quality standards. Moreover, small island facilities struggle to uphold quality due to high staff turnover and persistent resource shortages. Thus, the quality assurance framework remained fragile. HRH accountability remains fragile. High turnover among expatriates disrupts continuity, making sustained accountability difficult. Regulatory authorities exist but are under-resourced, limiting their effectiveness. Private providers often operate with minimal oversight, and the dispersed geography of the islands complicates supervision and grievance redress. In times of climate emergencies, these challenges are magnified, as transport and communication barriers prevent communities from holding providers accountable for lapses in care.

To summarize, quality is addressed through the establishment of regulatory bodies, legislation (as in the case of Vietnam), accreditation systems, and competency-based curricula across countries. Countries such as India, Bhutan, and Thailand have introduced structured reforms—mandatory CPD, curriculum validation, or humanistic training modules—that reinforce professional competence. Digital tools, particularly HRIS, telemedicine, and e-learning platforms, are becoming embedded in Bangladesh, India, and Nepal, while Sri Lanka has pioneered the integration of medical humanities, showcasing leadership in embedding empathy and professionalism. Regional partnerships, such as Timor-Leste's collaboration with Sri Lanka, also reflect innovation in tailoring education to local needs.

However, systemic weaknesses persist. Implementation and enforcement remain uneven, with rural areas, private providers, and non-academic cadres often underregulated or inadequately supported. Faculty shortages, inadequate infrastructure, and fragmented governance slow the uniform roll-out of reforms in countries such as Bangladesh, India, and Nepal. Overburdening of frontline workers like FCHVs in Nepal and CHWs in Bangladesh risks diluting service quality, while reliance on expatriates in the Maldives creates variability in standards. Even in stronger systems like Sri Lanka and Thailand, the challenge lies in scaling innovations system-wide and adapting curricula to meet new burdens such as NCDs and climate-related health risks. In short, while the architecture for quality assurance exists, the execution gap undermines consistency and resilience.

On accountability, countries have made progress in embedding digital monitoring, licensing frameworks, grievance redressal, and community feedback systems. Bangladesh and India stand out for biometric attendance and HRIS-linked dashboards, while Thailand has institutionalized community accountability through household health volunteers and public hearings under UHC governance. Bhutan and the Philippines enforce accountability by linking CPD and professional registration, and Vietnam has reinforced accountability through national laws and provincial mandates. Local innovations—SMS-based patient feedback in Bangladesh or digital grievance pilots in Bhutan—demonstrate experimentation toward participatory oversight.

Nonetheless, accountability structures remain fragile and uneven. Private sector regulation is weak across the region, leading to service variability and undermining equity. Community-

level accountability, though innovative, often struggles with limited literacy, inconsistent incentives, or geographic barriers—as seen with FCHVs in Nepal or CHVs in Timor-Leste. On ground observability and systematic individual level assessment often remain limited. Expatriate dependence in Maldives makes accountability transient, while migration in the Philippines weakens return-service obligations. Sri Lanka, while strong in professional peer-review and ethical culture, lacks systemic, digital accountability tools. Across contexts, the biggest weakness is that accountability often functions as a compliance exercise rather than a transformative mechanism—performance reviews are generic, grievance redress limited, and enforcement patchy, especially in remote or disaster-prone settings.

4. Conclusion

The comparative analysis of HRH systems in Bangladesh, Bhutan, Timor-Leste, India, Sri Lanka, Thailand, the Philippines, Vietnam, Nepal, and the Maldives reveals a dynamic landscape of innovations, institutional reforms, and persistent challenges. While each country presents unique pathways shaped by its context, a few common themes emerge: the growing centrality of community-based, people-centered care; the role of digital platforms in enhancing monitoring and training; and the need for continuous professional development aligned with evolving health system demands[1][2][3][4][5][6][7].

The challenge of health workforce shortfalls and distributional skews continues, despite recognition and attempts at addressing this. Most countries have adopted incentives for retention as well as strengthening career pathways. The shift from hospital based care to community based has been an added strategy to address the shortage of specialists in rural and hard to reach areas. The use of technology is emerging a popular strategy across countries to address capacity and equity in access, through improved trianing and enhanced assess. India's iGOT program, aimed at agile HRH development, and Thailand's use of AI for remote care and education are examples. A specific focus on addressing demographic shifts is visible in Vietnam through training, and infrastructure in the form of community based eldercare and specialsied geriatric departments.

Efforts to improve HRH quality are most successful when coupled with robust accountability mechanisms that include both institutional oversight and community participation. However, systemic disparities remain, particularly in rural areas, private sector regulation, and consistent policy implementation. Addressing these gaps will require stronger intersectoral collaboration, capacity-building at decentralized levels, and a commitment to translating policy frameworks into sustained practice[2][4][5][6][7].

As health systems in the region adapt to post-pandemic realities and the increasing burden of chronic diseases, strengthening HRH quality and accountability must remain a strategic priority. Lessons from these countries underscore the importance of adaptive, inclusive, and data-informed approaches to building a resilient health workforce—one that is not only clinically competent, but also ethically grounded and socially responsive[2][4][6].

The strengthening of clinical competence through curriculum modernization and expansion of pre-service and in-service education, alongside simulation-based and continuous professional development are evident across the region to varying extent. The extent to which these have led to quality improvement in practice needs to be evaluated. Some of the key takeaways include:

1. Tackling Workforce Shortages and skewed distribution: Shortages are common across the region, with rural–urban disparities persisting despite financial incentives and other strategies. Countries need to go beyond pay-based solutions by investing in career growth, supportive working environments, housing, and community integration to retain staff in underserved areas.

2. Reducing Dependency on Foreign-Trained Workforce: Heavy reliance on expatriates or foreign-trained health workers undermines sustainability. Strengthening domestic training capacity and modernizing curricula are critical for long-term resilience.

3. Modernizing Medical Education and Training: Outdated curricula limit the workforce's ability to address evolving needs such as NCDs, climate-related risks, and digital health. Reforms such as competency-based curricula, CPD-linked licensing, and medical humanities modules can help balance technical competence with empathy and professionalism.

4. Harnessing Technology for Equity and Skills: Digital innovations—HRIS, telemedicine, e-learning platforms, biometric attendance, grievance dashboards—are transforming workforce management and monitoring. Scaling these tools can bridge rural gaps, track performance, and support continuous learning.

5. Strengthening Accountability Systems: Effective models include community accountability mechanisms (Thailand), digital feedback tools (Bangladesh, Bhutan), and legal frameworks (Vietnam). To move beyond "tick-box" compliance, countries must focus on transformative accountability where feedback leads to real improvements.

6. Leveraging Regional Cooperation: South-South collaboration (e.g., Timor-Leste with Sri Lanka) demonstrates the value of adapting regional innovations to local needs. Institutionalized knowledge-sharing platforms can accelerate adoption of successful reforms.

7. Embedding Compassion and Ethics in Health Systems: Strong systems (like Sri Lanka's peer-review culture) show the importance of ethics and compassion alongside technical skills. Building an institutional culture of empathy, integrity, and patient-centeredness strengthens trust and quality in healthcare.

8. Regulatory and structural reforms matter for quality: Vietnam shows the role of legislation in standardizing quality. India, Bhutan, and Thailand emphasize structured reforms such as mandatory CPD, validated curricula, and humanistic training—highlighting that competency frameworks are central to professional quality.

9. Embedding humanism and empathy improves professionalism: Sri Lanka's medical humanities integration offers a replicable model for strengthening empathy and professionalism among health workers.

10. Digital innovation drives reach and efficiency: Bangladesh, India, and Nepal are leveraging HRIS, telemedicine, and e-learning platforms, indicating that digital tools are powerful for overcoming training and monitoring gaps.

11. Regional collaboration helps adapt solutions: Timor-Leste's collaboration with Sri Lanka shows that regional partnerships can help tailor global practices to local contexts.

12. Systemic weaknesses hinder reforms: Faculty shortages, weak infrastructure, and fragmented governance (Bangladesh, India, Nepal) show that reforms need system-wide capacity building, not just policy changes. Rural and private providers often remain underregulated, leading to uneven quality. Even strong systems (Sri Lanka, Thailand) face challenges in scaling innovations and addressing new health burdens (NCDs, climate-related risks).

13. Learning: Building strong regulatory frameworks, scaling digital innovations, embedding humanistic approaches, and ensuring equitable rural-private coverage are crucial for improving healthcare quality.

14. Digital monitoring enhances oversight: Bangladesh and India's use of biometric attendance and HRIS dashboards strengthens provider accountability—showing the potential of digital systems.

15. Community engagement ensures inclusivity: Thailand institutionalizes community accountability (via health volunteers and public hearings), offering lessons for participatory governance under UHC. Bangladesh's SMS-based patient feedback and Bhutan's digital grievance pilots highlight innovation in bottom-up accountability.

16. Linking professional development with accountability works: Bhutan and the Philippines tie CPD to professional registration, and Vietnam enforces accountability through laws and provincial mandates, making quality a legal and professional obligation.

17. Weaknesses persist in private sector and remote areas: Private sector regulation is weak across the region, risking variability in service standards. Community-based accountability is limited by low literacy, poor incentives, and geographic barriers (Nepal, Timor-Leste).

18. Sustainability and systemic embedding remain challenges: Expatriate dependence (Maldives) and migration (Philippines) make accountability transient. Sri Lanka has strong peer-review culture, but is low on digital accountability tools. Accountability often functions as box-ticking compliance rather than a transformative mechanism.

19.Quality is mainly anchored in regulatory councils, commissions, universities, and accreditation agencies.

20.Accountability is advanced through digital HRIS systems, grievance redress platforms, community structures (ASHAs, FCHVs, CHVs, volunteers), and legal frameworks. Countries like India, Bangladesh, Bhutan, and Thailand show stronger institutionalization, while Maldives, Timor-Leste, and Nepal face challenges due to reliance on expatriates, overburdened cadres, or limited institutional capacity.

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4. Presentation by the Ministry of Health, Timor-Leste.
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6. Presentation by Dr. Saroj, Department of Clinical Medicine, University of Colombo, Sri Lanka.
7. Compilation of notes from breakout sessions by Dr. Sushil Chandra Baral, Herd International, Nepal.
8. Compiled Notes from Colombo Regional Workshop Discussion, 2025.

Appendix

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