A Synthesis and Systematic Review of Policies on Training and Deployment of Human Resources for Health in Rural Africa

Presenter: Dr. Gail Tomblin Murphy, Dalhousie University

Background:
The majority of African countries are enduring a health human resource (HHR) crisis, lacking sufficient personnel to deliver basic healthcare to their populations, especially those most vulnerable in rural areas. Maternal and child health (MCH) and HHR are prioritized in many health planning dialogues, Millennium Development Goal progress reports and post-2015 agendas. With resource constraints, country-level policy makers have a reduced capacity to review and synthesize available policy information and build evidence-based policies to effectively use scarce HRH. A systematic review of evidence on training and deployment policies for doctors, nurses and midwives for MCH in rural Africa was undertaken by the WHO/PAHO Collaborating Centre on Health Workforce Planning & Research, and partners the University of Zambia School of Medicine (UNZASoM) and an international Advisory Group (AG).

Objectives:

1) Systematically review African HHR deployment and training policies for rural MCH to inform the policy process.
2) Boost African HHR-research capacity by engaging UNZASoM student researchers.
3) Build strategic partnerships for knowledge exchange and future collaboration through AG involvement.

Methods:
A scoping review of 14 peer-reviewed literature databases was completed for all African countries with official languages of English, Portuguese or French. Non-peer reviewed literature and policy documents were obtained via systematic searches of selected international organization and ministry of health websites with additional documents provided directly by the AG and UNZASoM research team. Informed by an established policy analysis framework, an in-depth policy synthesis was conducted for a selected
subset of countries: Ethiopia, Ghana, Mali, Mozambique, Niger, Tanzania, Uganda and Zambia.

**Findings:**
There was an overall paucity of evidence on relevant policies. Although information on policy names and context was noted in other documents, there was little material available on their actual development, implementation, or impacts. The identified gaps between the evidence base and its use in policy and policy development and actual implementation suggest a need for improved regional capacity for HHR policy knowledge-transfer in order to effectively strengthen healthcare systems and efficiently plan for scarce HHR; thus connecting evidence, policy and service provision. Based on the synthesis, and validated by the AG, a number of cross-cutting political and socio-economic issues affecting HHR training and deployment policy were identified in the countries studied, such as fiscal and resource management, monitoring and evaluation, transparency, decentralization and political stability.

**Conclusions:**
The dissemination and expansion of this research, continued AG engagement, and collaboration with African policy-makers are critical mechanisms for addressing the identified issues and strengthening Africa’s capacity to advance rural MCH through optimally trained and deployed HHR.

**Take Home Messages:**

1) The identified gaps in the use of evidence in policy and between planning implementation in African HHR policy indicates a need for a cultural shift and increased alignment throughout the policy process.

2) The importance of collaborative partnerships, between and among countries and agencies, to inform knowledge development and exchange for the advancement of evidence-based HHR policy and planning for rural MCH post-2015.

3) The review unveiled a plethora of innovative strategies for tackling MCH and rural health inequalities through the use of novel cadres of health workers, demanding further research.
Tackling Rural and Remote Access Issues Through Competency Development for Community-Based Workers: A Yukon Child and Youth Mental Health Framework

Presenter: Gillian Mulvale, McMaster University
Co-Authors: Dr. Stanley Kutcher

Background:
Rural and Remote health care access is a common problem. Difficulties arise because of the small population base and geographic challenges that together affect funding, transportation, ability to attract and retain health care providers and access to specialized services. The case of child and youth mental health is particularly illustrative. Ontario estimates suggest 1 in 6 children and youth with a mental disorder receive services, and access is likely worse in rural and remote areas, despite potentially higher need especially in First Nations communities. In 2013, the Yukon Government partnered with McMaster and Dalhousie University researchers to develop a child and youth mental health and addictions framework for the territory. Strategic approaches such as health and human workforce competency development within communities and across the Territory and electronic infrastructure support offer important lessons for rural and remote access issues in other jurisdictions.

Objectives:
The purpose was to develop a Child and Youth Mental Health and Addictions Framework for Yukon that was tailored to its unique economic, geographic and population characteristics, such as a limited resource base, small geographically dispersed population, complex governance structures, population needs, social and cultural considerations.

Methods:
A community-based participatory policy case study was carried out in partnership with a Working Group from Yukon Health and Social Services and Education departments, Kwanlin Dun First Nation and the Yukon Council of First Nations. The first phase focused on understanding the Yukon context. Input was gathered from the Working Group, key informant and focus group interviews with almost 100 stakeholders (young people, families, service providers and policy advisors), and a workshop involving child and youth mental health clinicians. The second phase gathered experiences and lessons learned from document analysis and key informant interviews in jurisdictions with similar contexts to the Yukon.

Findings:
A cascading model of service delivery is proposed that brings mental health care, identification and referral into each Yukon community using existing health and human service workers with basic, advanced and enhanced mental health competency development depending on geographic location. Basic competency training would be provided to all health and human service workers in communities throughout Yukon.
Advanced competency training would be provided to primary care providers and health and human service workers in regional hubs and enhanced training would be provided to workers providing specialized services in Whitehorse. Workers in each community and regional hub would be supported to refer more serious and complex cases to the next level of care and would be linked and supported through telehealth capacity, an electronic data set and a website that offers mental health resources and rapid access to electronic specialty support.

**Conclusion:**
Enhancing mental health competencies of every health and human service worker can transform traditional siloed delivery. The framework allows children, youth and families to receive care in their home communities to the greatest extent possible, and establishes rational and efficient referral of complex needs to more specialized services and providers.

**Take Home Message:**

1) Addressing access issues in rural and remote health service delivery requires particular attention to local context including economic, geographic, population, social and cultural considerations.

2) A strategy of child and youth mental health and addictions competency development for health and human service workers can be a foundational element to transform traditional siloed service delivery approaches in the Yukon.

3) Competency development with combined with electronic support and referral may be considered a core strategy to improve service delivery in other areas of healthcare in rural remote regions.

**Building the Rural Dietetics Workforce: Examining the Impact of the Northern Ontario Dietetic Internship Program**

**Presenter:** Ms. Denise Raftis, Northern Ontario School of Medicine  
**Co-Authors:** Pan Wakewich, Mary Ellen Hill

**Background:**
The most common route to certification as a Registered Dietitian (RD) is the completion of a university undergraduate degree in food and nutrition followed by practicum training through a recognized accredited dietetic internship program. While many dietetic internship programs offer positions arranged and made available through training within academic teaching hospitals, the Northern Ontario Dietetic Internship Program (NODIP) is unique and fortunate in that the programming and accountability is integrated within the Northern Ontario School of Medicine (NOSM).
NOSM is the only medical school in Canada that holds this level of dietetic training integration and responsibility. And with its incorporation in 2002, NOSM also became the first medical school in Canada with a social accountability mandate through a model of distributed community engaged learning.

Community engagement is consistent with NOSM’s goal and includes a focus on Aboriginal and Francophone communities and organizations, rural and remote communities, as well as larger urban areas of Northern Ontario. There are over 90 communities in Northern Ontario that support health professional education. This enables learning to take place in a variety of health settings that expose, attract, and recruit learners to future potential working environments in areas of greatest need including rural practices.

As one of the 12 accredited dietetic internship programs in Ontario, NODIP is a 46-week program providing practice experiences in urban, rural, and under-serviced areas of Northern Ontario. Similar to NOSM, admission criteria to NODIP include an emphasis on candidates who have a desire to live, work and serve Northern and rural communities. NOSM graduated its first class of the NODIP in 2008. Yet there is little known about the effectiveness of dietetic practicum models designed to increase the number of RDs choosing to practice in rural and underserviced communities.

**Objectives:**
This study represents an evaluation of the early practice experiences of the first five cohorts (2008-12) of NODIP graduates. The primary goal was to understand how NODIP contributes to recruitment and retention of the dietetics workforce particularly in rural, northern and remote communities. Objectives were to track their employment experiences, employment decisions, preparation for practice, and future career plans.

**Methods:**
Graduates (n = 62) were invited to complete a 27-item questionnaire that included Likert-type items and open-ended items which answered five research questions: (i) What are the graduates’ employment experiences in the first two years immediately following their completion of the program? (ii) In what types of health care settings are they practising and what positions do they hold? (iii) How have their employment decisions been impacted by practice factors, as well as community and family considerations? (iv) How well has the NODIP program prepared them for practice? (v) What are their career plans over the next five years? With approval from the Lakehead University Research Ethics Board, survey packages were mailed approximately 22 months after graduation, with a follow-up three weeks later. Results were analysed descriptively using SPSSx frequency and multiple response procedures. Responses to Likert-format items on graduates’ perceptions of the program and their practice location decisions were analysed categorically. Modal categories (to indicate the most common responses) and ranges (to demonstrate the convergence or divergence of opinions) were highlighted. Likert-type items also were summed as an overall indicator of how frequently particular categories were selected.
Findings:
This presentation reports an analysis of data from the first five NODIP cohorts, to be completed in September 2014. Preliminary results from the four-cohort database reveals two-thirds of graduates were practising in rural and underserviced areas. Confirming factors identified in the rural allied health literature: prior awareness of employers, prospects for full-time employment, flexible working conditions, interprofessional practice and continuing education, along with personal and community factors, influenced practice decisions.

Conclusion:
A key measure of long term success of the NODIP is the ability to attract and retain dietitians in Northern Ontario. This study provides early evidence about the effectiveness of the NODIP distributed community-engaged learning model on recruitment and retention of dietitians including those working in rural practices. Results are being used to inform curriculum design, practicum experience planning, and strategies to recruit and retain dietitians to underserviced areas of Ontario.

Take Home Messages:

1) Many dietetic graduates who complete an internship in a rural, or northern location choose such locations as the settings for their first years of employment.

2) Graduates see themselves as very well prepared for entry level dietetics practice and are confident that they can function well in the interprofessional environments found in rural and underserved communities.

3) Intentions to remain in current dietetic practice settings were shaped by working conditions, including workloads, salary and benefits, opportunities for professional development and specialization, as well as ongoing personal commitments.

Practice Ontario: Helping to Connect Medical Residents to High-Need Communities

Presenter: Mr. James Draper, HealthForceOntario on behalf of Mr. Jay Orchard
HealthForceOntario

Background:
HealthForceOntario Marketing and Recruitment Agency (HFO MRA) is an operational service agency funded by the Ontario Ministry of Health and Long-Term Care. The Agency is focused on building and maintaining the province’s health human resources capacity, leading to two categories of activity: retention and distribution of Ontario’s health professionals; and recruitment and outreach to internationally educated health
professionals living in Ontario, Ontario’s recruitment community and practice-ready physicians living outside of the province who are practising in high-need specialties.

Launched in 2010, Practice Ontario is a joint initiative between HFO MRA and Ontario’s six medical schools offering free career-planning services for medical residents.

Objectives:
One of the key challenges rural communities face with physician recruitment is limited exposure to medical residents. Practice Ontario supports physician recruitment to rural communities by making residents aware of job opportunities throughout the province and the benefits of rural practice.

Methods:
Practice Ontario supports connecting medical residents to rural and remote opportunities through:

- Presentations outlining transition-to-practice information, including rural incentives;
- Personal job search support, exposing residents to permanent and locum opportunities in rural Ontario;
- Assistance with résumé preparation;
- Support arranging site visits to communities of interest;
- Assistance with partner/spousal employment;
- Integration/retention support of physicians in their new communities;
- Guidance for international medical graduates with return of service commitments.

Findings:
Since the inception of Practice Ontario in 2010, there has been an increasing number of Practice Ontario clients placed in rural Ontario communities (defined as a Rurality Index of Ontario [RIO] score of 40 or greater). In addition, surveys and testimonials show a high satisfaction rating from residents who receive Practice Ontario career support services. The high satisfaction is supported by increased uptake, with the number of active Practice Ontario clients growing year over year since inception. Practice Ontario has also experienced increased medical school support and is now well established in all six of Ontario’s medical schools.

Conclusion:
Practice Ontario has a direct impact on supporting the placement of physicians in rural and remote communities, fostering an overall positive effect on the distribution of physicians in the province.
Take Home Messages
Career services through Practice Ontario lead to:

• Successful connecting of physicians to job opportunities in rural Ontario;
• Longer-term retention of Ontario's physicians through well-matched physicians and communities;
• High resident satisfaction rates for one-on-one personal career assistance.

The Rise and Fall of Dental Therapy in Canada: An Examination of the Recent History of Oral Health Services for Inuit and First Nations Communities

Presenter: Mrs. Victoria Leck, McMaster University
Co-Authors: Dr. Glen Randall

Background:
Oral health contributes to overall health and has been linked to quality of life as well as specific conditions such as diabetes and heart disease. The limited availability of oral health professionals in rural and remote areas has made accessing oral health care especially difficult for individuals in many Inuit and First Nations communities. In order to address the issue of equity of access to oral care, a school for training dental therapists was opened in 1972 with the support of the federal government. Students were recruited primarily from northern communities in the hope that they would return home on graduation to provide services. In November of 2011, the only remaining dental therapy program was closed when the federal government discontinued funding of the program.

Objectives:
This study explores the federal government's adoption and ultimate rejection of the training and use of dental therapists as a means to enhance equity of access to oral health care for Inuit and First Nations communities.

Methods:
An analysis of a variety of documents from governments, professional associations and academic journals is conducted within a policy framework that identifies the role of ideas, interests and institutions in policy development. Documents were identified through a literature search using PubMed, Web of Science and Google to identify initial sources. Additional documents were identified through a review of the reference list of each of the originally identified documents.

Findings:
Dental therapists are a recognized occupation in more than 50 countries around the world. The vast majority of studies report that dental therapists provide care within their scope of practice at the same level as that of dentists. Some research argues that dental therapists
are a more cost effective approach to delivering some oral health care services. There are provincial/territorial variations in if and how dental therapists are allowed to practice in specific jurisdictions and restrictions on practice appears to be, at least in part, related to lobbying efforts of other oral health professions. One possible approach to improving access to oral care may be expanding the scope of practice for dental hygienists.

**Conclusion:**
The elimination of Canada's only dental therapist program will further exacerbate the current inequitable access to oral care within Inuit and First Nations communities. It appears that social, cultural and political complexities will make the implementation of a single national solution unlikely.

**Take Home Messages:**

1) Dramatic disparities in oral health between Inuit and First Nations populations and the rest of Canada persist due, in part, to the lack of access to oral health care professionals.

2) The absence of coherence policy action to ensure equity of access to quality oral health care for Inuit and First Nations communities can be expected to contribute to growing health inequalities and have long-term social and financial impacts.

3) In the absence of adequate funding for a dental therapy program, expanding the scope of practice for dental hygienists should be considered as an approach to ensuring access to care.

**Lifting the “Cloak of Invisibility” on Health Canada’s Evacuation Policy**

**Presenter:** Ms. Karen Lawford, University of Ottawa

**Background:**
Human health resources administrators are bombarded by a variety of policies that guide, direct, and even limit their work. In some cases, policies that affect their work are shrouded by a ‘cloak of invisibility,’ preventing them from fully understanding the extent to which these policy affect decisions about the allocation of resources.

**Objectives:**
The purposes of this presentation are to lift this cloak of invisibility and highlight the concepts of invisible policy from a variety of literature sources.

**Methods:**
Review of literature to develop a tool to identify an invisible policy.
Findings:
In a manner consistent with well-established approaches to policy analysis, the identification and analysis of “invisible” policies relies on three components: allocation of resources, material impacts, and reactions. Allocation of resources can be economic, human, or otherwise. Material impacts of a policy are those that are tangible and can be described as physically impacting in some manner. Finally, the reactions of those impacted by the policy, like agencies and scholars, provide a third lens through which these policies can be understood and identified. To make this analysis concrete, I will apply this analytical tool to Health Canada’s evacuation policy, which is responsible for the evacuation of pre-term Aboriginal women from rural and remote reserves in Canada to southern cities for birth.

Conclusion:
The unveiling of invisible policies is an important process as these policies may reveal a multitude of previously unaccounted gaps and enable systematic approaches so that Aboriginal Health Workforce issues can be addressed in a comprehensive manner.

Take Home Messages:
1) Some health policies are invisible.
2) Invisible health policies do affect human health resource allocations.
3) A tool to identify invisible policy does exist.