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Caribbean Centre for Health Systems Research and Development
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Stakeholder Dialogue Summary

Strengthening the primary health care system in Trinidad and Tobago to achieve universal health coverage, with emphasis on human resources for health

JULY 2021

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REPORT
STAKEHOLDER DIALOGUE SUMMARY

Strengthening the primary health care system in Trinidad and Tobago to achieve universal health coverage, with emphasis on human resources for health

Draft

July 2021

Caribbean Centre for Health Systems Research and Development

The University of the West Indies, Caribbean Centre for Health Systems Research and Development (CCHSRD) is a research centre at The University of the West Indies (The UWI), St. Augustine. The Centre was established to pursue a program of work in Health Policy and Systems Research (HPSR) to address pressing policy and system issues faced by decision-makers in the Caribbean region.

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Acknowledgements

The Stakeholder Dialogue Summary was developed as part of the Knowledge to Policy (K2P) Center Mentorship Program for Building Institutional Capacity for HPSR and Delivery Science [BIRD Project]. We would like to acknowledge the team at K2P Center, American University of Beirut for their technical support and guidance during the planning and facilitation of the Stakeholder Dialogue. The template for the Dialogue Summary was adapted from K2P Center's Dialogue Summary.

This work was supported by the Alliance for Health Policy and Systems Research [BIRD Project]. The Alliance can conduct its work thanks to the commitment and support from a variety of funders including long-term core contributors from national governments and international institutions, as well as designated funding for specific projects within their current priorities. For the full list of Alliance donors, please visit: https://www.who.int/alliance-hpsr/partners/en/.

The authors also wish to thank the members of the EBP Working Group, Ms Jennifer Andall, Dr Oscar Ocho and Dr Karen Pierre, for their support throughout the process.

Dialogue

The Stakeholder Dialogue on *Strengthening the primary health care system in Trinidad and Tobago to achieve universal health coverage, with emphasis on human resources for health* was held virtually on June 17, 2021. The Stakeholder Dialogue was co-facilitated by Professor Donald Simeon, Director (CCHSRD), Ms Shelly-Ann Hunte, Research Fellow (CCHSRD), Ms Kershelle Barker, Junior Fellow, Evidence Synthesis (CCHSRD), Ms Racha Fadlallah, Evidence Lead Specialist (K2P Center), and Dr Oscar Ocho, Working Group Member (The UWI).

The views expressed in the Dialogue Summary are the views of the Dialogue participants and should not be taken to represent the Evidence Brief for Policy (EBP) Team, Working Group or CCHSRD.

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Preamble

PREAMBLE

The CCHSRD's Stakeholder Dialogue was convened virtually (via the *Zoom* platform) on June 17, 2021, to discuss the strengthening of the primary health care system in Trinidad and Tobago to achieve universal health coverage, with emphasis on human resources for health. The dialogue hosted 21 diverse stakeholders from different sectors and multi-disciplinary backgrounds to ensure richness of discussions. These included representatives from:

- Ministry of Health
- Ministry of Labour and Small Enterprise Development
- Regional Health Authorities (Eastern, North Central, North-West, South-West)
- Academic Institutions (The University of the West Indies, Faculty of Medical Sciences (The UWI), University of Trinidad and Tobago (UTT), University of the Southern Caribbean (USC)
- Professional Associations of Trinidad and Tobago (Medical Board, Medical Association, Nursing Council, Registered Nurses Association, Dental Council, Council of Professions Related to Medicine)
- Private Sector and Non-Governmental Organisations (NGOs) such as PAHO/WHO T&T (& Netherland Antilles); Women Working for Social Progress Trinidad and Tobago; and Trinidad and Tobago NCD Alliance.

The Stakeholder Dialogue was facilitated by Professor Donald Simeon, Director, (CCHSRD), Ms Shelly-Ann Hunte, Research Fellow (CCHSRD), Ms Kershelle Barker, Junior Fellow, Evidence Synthesis (CCHSRD), Ms Racha Fadlallah, Evidence Lead Specialist (K2P Center), and Dr Oscar Ocho, Working Group Member (UWI)

Prior to the deliberations, an animated video was presented, summarising the findings of the pre-circulated Evidence Brief for Policy (EBP), i.e., the problem, policy elements to address the problem, and implementation considerations.

Box 1: BACKGROUND TO THE STAKEHOLDER DIALOGUE

The Stakeholder Dialogue was convened to facilitate a full discussion of relevant considerations (including research evidence) about a high-priority issue to inform action.

Key features of the dialogue were:

1) Addressing a priority health issue being faced in Trinidad and Tobago;
2) Informed by a pre-circulated Evidence Brief for Policy that synthesised both global and local research evidence about the problem, underlying factors, policy elements and key implementation considerations;
3) Informed by a discussion about the full range of factors that can inform how to approach the problem and ways to address it;
4) Brought together parties who would be involved in or affected by future decisions related to the issue;
5) Ensured fair representation among policymakers, researchers and stakeholders;
6) Engaged facilitators to assist with the deliberations;
7) Allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed"; and
8) Did not aim for consensus.

Participants' views and experiences and the tacit knowledge they brought to the issues at hand formed key input to the Dialogue. The Dialogue was designed to spark insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The Dialogue was also designed to generate action by those who participated in the Dialogue and by those who review the Dialogue Summary.

Deliberations about the Problem

Framing the Problem

Dialogue participants discussed the overall framing of the problem of deficits in the planning and development of human resources for health (HRH) in primary health care (PHC) in Trinidad and Tobago (T&T). All participants acknowledged the existence of the problem in T&T and agreed on the need to address it. Stakeholders concurred that the absence of a national HRH policy is at the core of the problem, and emphasised the need to ensure that when developed, such a policy is in fact aligned to the current national needs. An assessment or evaluation of the status quo, specifically at the Regional Health Authorities (RHAs) was deemed necessary to ensure HRH policies and plans are aligned to current needs.

Stakeholders highlighted the need for greater investment in HRH to create more opportunities for hire, as well as the importance of continuing education for health professionals. One stakeholder indicated that the T&T Government has committed funding for additional PHC workers and new facilities.

Other issues were discussed, such as the importance of advocacy, sustainability, and the need for standardisation of PHC teams in the RHAs. Stakeholders also highlighted the need for collaboration beyond the health sector, i.e., with critical input from the Ministry of Labour and Small Enterprise Development (MOLSED) and the Ministry of Finance, as it relates to HRH planning and development. It was also noted that addressing deficits in skills and competencies is hindered by the fact that the contractual arrangements of hiring fall within the remit of MOLSED or the Public Service Commission and not the Ministry of Health (MOH).

There was also mention of gaps in monitoring and evaluation, as there was no framework to measure the efficiency and effectiveness of interventions in relation to HRH, and a lack of readily available HRH data.

One stakeholder highlighted the need to include allied health professionals when referencing PHC teams, as they may appear to be excluded in the multi-disciplinary approach. There are also limited opportunities for allied health professionals to complete mandatory fieldwork in PHC settings, thus pushing them into the private sector.

Underlying Factors

Participants then proceeded to discuss the factors underlying the problem, at the governance, financial, and delivery arrangements levels. Stakeholders agreed on the multi-level underlying factors:

- There is no national HRH policy or long-term strategy to identify and respond to the population's health care needs. Stakeholders reiterated the need for an HRH policy, with clear national priorities.

- There are inadequate policies or regulations to attract and retain professionals in rural or underserved areas. Stakeholders agreed on the need for such policies and added that this challenge is related to job satisfaction and the lack of adequate facilities in these areas.

- PHC training is not sufficiently included in the medical and nursing schools' curricula. Stakeholders discussed that this factor could be addressed in the long term. Also, similar consideration should be given for other categories of health professionals.

- Inter-cultural competencies are not part of job descriptions or performance assessments. There was agreement on the importance of cultural competencies and skills, especially in health professionals working in rural areas and other underserved groups.

- There is a lack of collaboration in systematic planning between the private and public health sectors, educational institutions, and regulatory agencies. One stakeholder suggested the explicit inclusion of the Regional Health Authorities in this collaboration.

- There are also capacity challenges in the areas of workforce strategic planning, management and monitoring and evaluation, which were confirmed by stakeholders, echoing the need for relevant and up-to-date national HRH data.

Deliberations

Deliberations about the Policy Elements to Address the Problem

Dialogue participants discussed the four elements that were examined in the Evidence Brief for Policy (EBP).

Element 1: Strengthen education and training to improve the number, skill-mix, and competencies of the PHC workforce.

Stakeholders deliberated on the importance of strengthening the PHC workforce through education and training and agreed that the sub-elements are relevant to do so.

> ***Element 1a)*** *– Improve policies and programs at health training institutions to achieve greater diversity of students, who are better suited to careers in rural and other underserved communities.*

One stakeholder noted that Element 1a can prompt discourse at the highest levels to ensure that policies and programs at academic institutions are aligned to a broader national HRH policy. Stakeholders agreed that more attention should be placed on *how* to increase the number of PHC physicians. Participants suggested regulations which would require graduates to work in rural areas during their internship to stimulate interest, rather than mainly hospital-based settings, as is the current practice.

Furthermore, one stakeholder posed the question of whether institutions should set up policies or incentives to specifically recruit students from rural communities into medical and allied health programmes. The importance of cultural competence was also discussed, considering the differences in experiences and behaviours between patients from rural and urban areas, and because there are health professionals from different cultures working in our health care system.

> ***Element 1b)*** *– Revise the curriculum of health training institutions to align with current and emerging population health needs.*

Stakeholders suggested that bolstering the PHC workforce should incorporate advanced practice training for medical and other health graduates within three to five years of graduation as well as setting skillset benchmarks to ensure continued professional development. These mechanisms must also be sensitive to the need to serve rural communities and the skillset required to communicate with and address problems facing the rural population. Additionally, stakeholders suggested amending the curriculum to increase opportunities for those who would like to return to and operate within their rural communities.

> ***Element 1c)*** *– Develop the competency of medical sciences faculty to develop and deliver inter-professional education (Interprofessional Faculty Development)*

Stakeholders suggested rephrasing Element 1c to clarify whether this sub-element is restricted to the Faculty of Medical Sciences or applies across the wider grouping of health professionals,

including social sciences. One stakeholder suggested including “allied health professionals”, as the exclusion of this category leads to limited field experience and narrowed job perspectives within the public sector and thereby drives the public-private imbalance and/or emigration of professionals. In implementing this element, stakeholders recommended specifically addressing the acute shortage of District Health Visitors, as well as focusing on the relevance and number of psychologists, in light of the high prevalence of mental health problems.

Element 2: Introduce appropriate mechanisms to attract and retain health professionals in rural and other underserved areas.

Dialogue participants deliberated on the second element on attraction and retention of PHC workers and agreed on its importance and relevance. Four key strategies were highlighted in the EBP, i.e., education, regulation, financial incentives, and personal and professional support. Stakeholders emphasised that the main aim should be to increase job satisfaction, as financial remuneration was not enough to secure commitment to rural work. Stakeholders discussed the need for professional interactions, not only within the community, but with secondary and tertiary health institutions as this can improve job satisfaction and prevent rural workers from feeling isolated, abandoned, or ill-prepared. Focus should also be placed on ensuring adequate facilities, equipment, and conditions for PHC workers to effectively function in rural areas, and consideration should be given to allow qualified health care workers to move through the system, i.e., from one health field/discipline to another.

Professional growth was also recognised as an important factor of job satisfaction. There is a need for opportunities for PHC workers to continue training and development before, during and after placements in rural areas. Additionally, stakeholders raised the concern that sometimes, senior professionals hinder juniors from accessing such opportunities, and within RHAs, contract or temporary employees do not always have the privilege of continuing their education as permanent employees do. There is therefore a need for change, to allow professionals at all levels to equitably receive opportunities to advance in their careers. Participants were informed that the RHAs are reviewing their human resource policies, and that information shared in forums such as this Dialogue may influence the adoption of new policies. Health workers should also be encouraged to join professional associations, not only in T&T, but globally, so they can continue to grow professionally and enhance their skillsets.

The topic of District Health Visitors (DHVs) was discussed again, in relation to rural work, and stakeholders reiterated that a concerted effort should be made to increase the number of DHVs by reintroducing or scaling up this service, as they have been instrumental in improving population health in T&T. It was especially important to ensure that jobs were in fact available for those trained as DHVs and nurse practitioners. One stakeholder informed participant that The UWI School of Nursing was collaborating with the MoH to address this. The MoH had sponsored 100 scholars, and training for one group had been completed. The curriculum had also been revised to move the programme from a Diploma to a Master’s Degree offering. Additionally, a Master’s in Advanced Practice Nursing was being considered.

Stakeholders also discussed regulation and the use of task-shifting in rural areas, which had been documented in research literature as an appropriate intervention in some contexts. There was uncertainty about task-shifting as a strategy in the local context, given physicians' general opposition to it.

Stakeholders noted that financial incentives were unsustainable and questioned the use of "superior housing" as one such incentive in the EBP, as this strategy might not be applicable to the local context. A similar approach was previously used and subsequently discontinued, though housing allowances may be an option. Stakeholders asked that instead of financial perks, the PHC worker's family/work life balance be considered, with benefits for other family members (such as lifestyle and children's education) to incentivise rural work placements.

Element 3: Strengthen primary healthcare management systems to enhance quality and responsiveness of care to population needs

The Stakeholders deliberated on the evidence for strengthening PHC management systems, which comprised two sub-elements.

> ***Element 3a)*** *– Promote interprofessional practice in PHC.*

Participants proposed that promotion of interprofessional practice should begin within training. They suggested using collaborative training modules during education, so that students in different fields get into the practice of working together, which could build better working relationships and encourage collaboration after graduation. Stakeholders highlighted the link between this sub-element and Element 1c.

> ***Element 3b)*** *– Utilise in-service training and quality improvement mechanisms to enhance skills and competencies of PHC teams*

In deliberating on Element 3b, one stakeholder questioned whether the use of technology was considered when reviewing the evidence for in-service training and quality improvement mechanisms. Especially in light of the current COVID-19 pandemic, stakeholders suggested including evidence on telehealth services. In response, participants were informed that the systematic reviews used in the EBP did not include this, but evidence would be revisited.

Additionally, participants highlighted contracts that prevent employees from pursuing education while practising, as a barrier to this policy element. One stakeholder referenced module-based training (as practised in the U.S.) where, before being hired into the medical system, health care workers are required to complete 90 days of module-based training, following which they are assessed. They are also required to upkeep their training. Participants were uncertain whether T&T would want to adopt such an approach but noted that it could be considered with access to technology and human resource managers tasked with ensuring that workers complete their modules. Stakeholders also highlighted the need for specialist training in areas such as rural health and nutrition education (especially for diabetes, renal care, and critical care patients).

Element 4: Strengthen human resource information systems to support HRH planning

Stakeholders agreed with the fourth element and stressed that a lack of timely access to data, and unstandardised data collection tools among agencies and academic institutions further exacerbate the deficiencies of HRH in PHC. There was agreement on the need for a robust Human Resource Information System (HRIS) that can be accessed at all levels, including by the MoH, RHAs, academic institutions and regulatory bodies. Stakeholders voiced that a lack of communication among the various bodies, coupled with poor feedback mechanisms, hinder the improvement of PHC.

Recognising the need for cohesion among the various bodies, one stakeholder shared that the MoH tendered for a national HRIS which would bridge gaps in data and communication. The MoH would house and implement the system, and all other regulatory bodies would contribute to it. For example, there would be several databases (including medicine, nursing, and other professions related to health) to solve the issue of disaggregation of HRH data. The MoH must, however factor the costs and technical capacity required to maintain the system. In this regard, Element 1 can be linked to Element 4, as education and training in HRIS would be a crucial skillset to develop. Additionally, the HRIS should have project management capabilities for proper planning and maintenance of the system. Existing policies may have to be altered to ensure that antagonistic relationships between new and established policies do not develop. One stakeholder asked that consideration be given to the fact that there is limited autonomy within the RHAs, as the authority to make final decisions rests with the MoH and can be a lengthy process.

Stakeholders also shared that regarding HRH data collection, regulatory boards had been collecting specific information from health care workers and that a database of registrants was submitted to the MoH annually. However, other stakeholders questioned how this information was being used and how changes were being monitored, highlighting the need for mechanisms to keep relevant bodies informed. In response, a participant shared that the information was used to develop policies and reports, as for example, Manpower Plan for T&T, Cabinet Notes, etc. It was noted that a new project was on the way to better capture and standardise data moving forward.

Additionally, one of the mechanisms that could be leveraged to address HRH data challenges was the Cabinet-appointed Senior Joint Planning Committee (SJPC) which was chaired by the Principal of The UWI and the Permanent Secretary of the MoH and comprised other organisations. One relevant sub-committee of the SJPC is the Human Resource sub-committee, chaired by a representative of the MoH.

The challenge in establishing new initiatives such as the HRIS, was a drawn-out strategy/process. This process was critical however and must be considered in the implementation of this element.

Next Steps

Recommendations

The deliberations around the four policy elements were successful in obtaining agreement among the different stakeholders for the need for action. When asked to set priorities on which elements to focus on, some stakeholders suggested implementing Element 1 and 4 in the short term and Elements 2 and 3 in the medium to long term, while others suggested Elements 1 and 3, followed by Elements 4 and 2, respectively. However, there was no consensus among participants as to which elements to prioritise.

The recommendations and next steps covered a few actions that can be implemented immediately and others that could be considered for implementation at a later stage. These included:

Recommended Action	Stakeholders Involved
System (Regulatory and Policy) Level	
Develop and implement a national HRH policy in alignment with country priorities and PHC objectives	→ Ministry of Health (MoH) → Regional Health Authorities (RHAs) → Regulatory Bodies → Academic Institutions → NGOs → Community Group
Develop and implement a monitoring and evaluation (M&E) framework to measure the effectiveness and efficiency of interventions in relation to HRH objectives	→ MoH → RHAs → Regulatory Bodies
Increase investment in PHC workers and facilities	→ MoH → Ministry of Labour and Small Enterprise Development → Ministry of Finance
Define and standardise PHC teams in Regional Health Authorities	→ MoH → RHAs
Ensure adequate facilities, equipment, and conditions for PHC workers to effectively function in rural areas	→ MoH → RHAs
Advance the development of a national Human Resource Information System, and standardise the collection and use of HRH data across the MoH, RHAs and regulatory bodies	→ MoH → Regional Health Authorities (RHAs) → Regulatory Bodies → Academic Institutions

Recommended Action	Stakeholders Involved
Organisational / Institutional Level	
Revise the entry process for medical and other health programmes, especially for PHC physicians	→ Academic Institutions
Include PHC training in the medical and nursing school curricula	→ Academic Institutions
Develop and implement regulations to include internship placements in rural areas	→ MoH → RHAs
Scale up the training and production of District Health Visitors	→ Academic Institutions → MoH
Consider the use of module-based training for health care workers before being hired into the medical system, and the upkeep of training during practice	→ Academic Institutions → MoH → RHAs
Align education and training to HRH needs within RHAs	→ Academic Institutions → RHAs
Increase specialist training in nutrition education, especially for diabetes, renal care, and critical care patients	→ Academic Institutions
Professional Level	
Incorporate advanced practice training for medical and health graduates within three to five years of graduation	→ Academic Institutions → Regulatory Bodies → Professional Associations
Develop cultural competencies, especially for interacting with patients from rural areas	→ Academic Institutions
Ensure equity in access to continuing education and professional development opportunities	→ Professional associations → Regulatory Bodies
Promote interprofessional practice and collaborative training modules	→ Academic Institutions → Professional associations
Conduct further research to determine the best use of technology (e.g., telehealth services) in in-service training and quality improvement mechanisms	→ Academic Institutions

Next Steps

The CCHSRD Dialogue Summary along with the revised Evidence Brief for Policy will be shared with stakeholders, to be used by each stakeholder organisation as a road map for action to strengthen the planning and development of HRH in primary health care system toward the achievement of Universal Health Coverage. Stakeholders will communicate internally and externally with relevant bodies, agencies, and departments, to advocate for improvements to the planning and development of HRH. Relevant stakeholders and experts shall be engaged in the process.

An implementation plan must be developed to operationalise the recommendations that are agreed upon and accepted by the key stakeholders.

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