A case series of country-level descriptions of existing public health nutrition workforce capacity

Lessons for future capacity building efforts

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A country-level case-series: PHN workforce capacity

- Descriptive case studies across 6 countries (north and south) using a pre-determined workforce capacity analytical framework
- Country-level sample included:
  - Australia
  - Canada
  - Brazil
  - Indonesia
  - Mozambique
  - Iran

Capacity analysis framework

- Based on previously identified determinants of workforce capacity
  - Existing public health nutrition priorities
  - Policy mandates for action
  - Structure and stability of the PHN workforce
  - Size of the PHN workforce
  - Workforce organisation
  - Leadership and professional supports
  - Workforce functions vs current practice
  - Workforce preparation system- adequacy & gaps
  - Workforce development needs
  - Expected outcomes from PHN workforce capacity building

Public health nutrition priorities

- Double burden of malnutrition
- Nutrition transition underway or well progressed
- Undernutrition still a common priority (Iran, Brazil, Indonesia, Mozambique- more isolated in Australia and Canada)
- Socio-economic differentials a consistent determinant for all-form malnutrition
- The complexity of issues that the workforce (within and across country) needs to address creates significant challenges for workforce development

Policy mandates

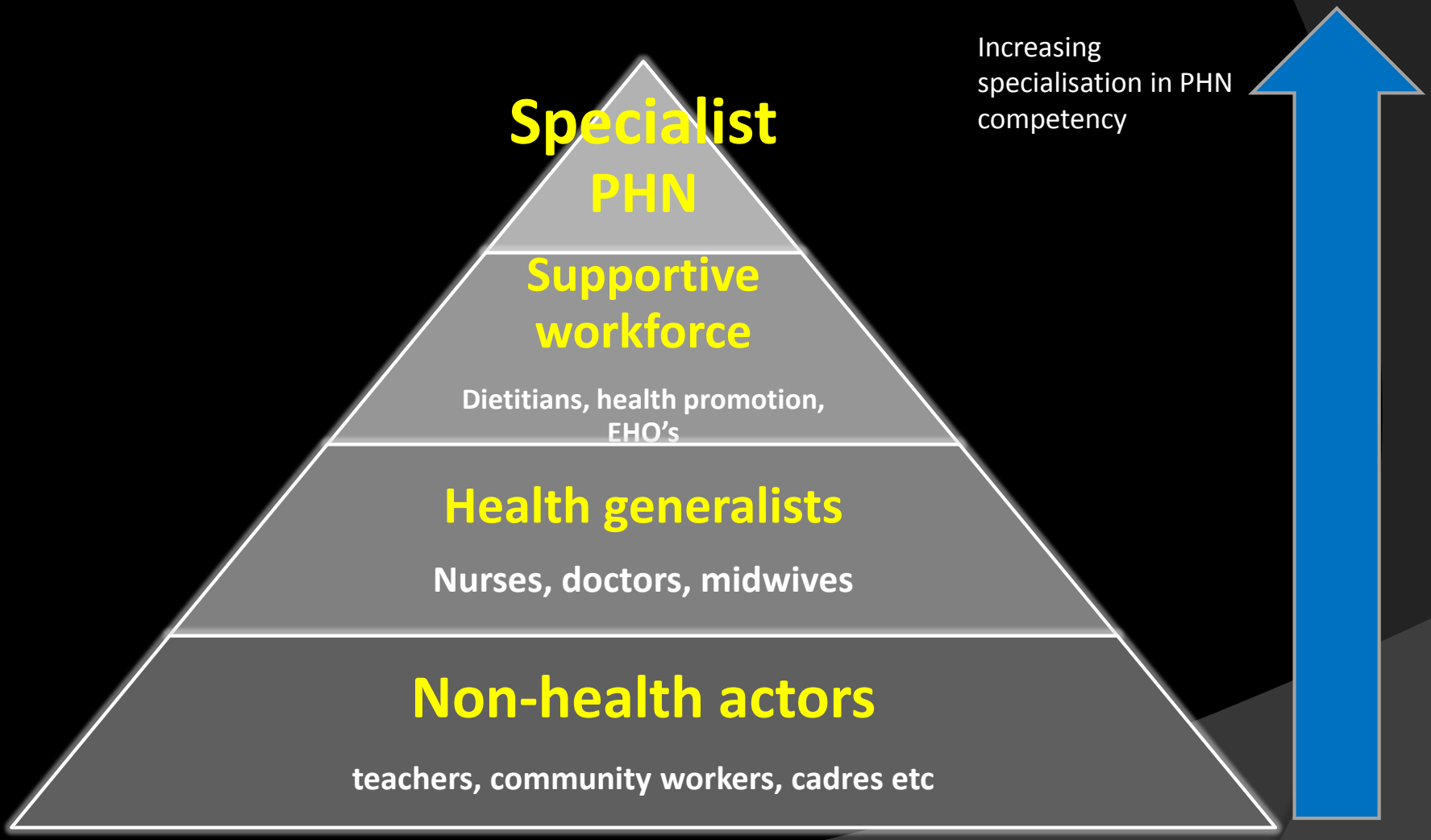
- Policy mandates and government plans exist specific to nutrition in most Countries
- Explicit identification of workforce development and capacity building are key platforms in some (Australia, Brazil, Mozambique), **but not all**, plans/mandates

- Policy mandates that strategically identify and focus resource allocation for capacity building are critical for effective policy implementation

Structure of the workforce

- Multi-level and inter-disciplinary workforce structures a consistent feature across countries (mostly within health sector)
  - Nutritionists, nurses, Doctors, community workers, teachers etc
- Designated public health nutrition positions well established in some countries (A, C), emerging in others (B, I).
- Degree of specialisation varies- some reliance on generalists with limited capacity to address complexities of nutrition

Workforce structure



Workforce size

- Limited workforce enumeration data available
- Range
  - Nutritionists :
    - <0.5 per 10^5 population (Iran)
    - ~ 20 per 10^5 (Australia)
- Much smaller workforce: population ratios for specialist PHNs (eg. Australia & Canada: ~400 nationally)

- The size and structure of the public health nutrition workforce is a major determinant of capacity for action. In most (if not all) countries, the limited PHN workforce constrains scaling up nutrition action

Workforce organisation

- A disorganised workforce is an inefficient workforce
- In most cases, workforce distributed across:
  - Jurisdictions (local, provincial, state/national)
  - Functions (curative, primary care, prevention)
  - Sectors (health, agriculture, education, social security)
- Variable roles/functions/competency mix
- Ensuring coordination, career pathways and collaboration across systems is a major challenge.

- "It is not just size that counts, but how you use your workforce!"

Leadership

- Leadership for nutrition primarily from health sector, although stretching across other sectors (Agriculture, Trade, education) in some cases (e.g. Indonesia, Brazil)
- Identified as a key contribution needed from a designated PHN workforce (technical, professional leadership)
- A target of PHN advocacy (political leadership)

- Leadership required across multiple levels to ensure capacity for action .....**a need for leadership development strategies within the PHN workforce**

Professional organisation supports

- Variable and numerous country-level professional support organisations
- Collaboration and articulation across professional organisations variable, and in some cases competitive
- Functions of professional organisations vary in terms of workforce support

Core workforce functions

- Workforce functions are well defined in some countries (+), ambiguous in others (-).
- Variable functions by country, level, jurisdiction.
- Consistent functions include:
  - Assessment, monitoring and surveillance
  - Capacity building- community, organisation, workforce
  - Intervention management- design, planning, implementation, evaluation
  - Nutrition guidance and advocacy

Current practice

- Often do not align with required functions (e.g. Australia, Indonesia- low population reach, low impact and under-evaluated)
- Evidence that current practices are a reflection of inadequate workforce preparation
- An under-utilised workforce in most countries

- Practice improvement and reorientation is needed to enhance workforce impacts- this needs to be a priority for workforce development effort

Adequacy of workforce preparation

- All country-cases identified the need for continual improvement in workforce preparation
- Existing workforce preparation geared to clinical nutrition/dietetics and only starting to emphasise public health and public administration.
- Key deficits in community practice based capacity building, intervention design and management and broader engagement with social, economic and environmental policy
- Public health nutrition by definition involves social, political, economic, environmental as well as biological aspects of nutrition and health. Workforce preparation in the social, political, economic and environmental domains needs enhancing

Workforce preparation systems

- Variable university/academic infrastructure between cases (ranging from very low- very high)
- Often a large number of providers (universities, colleges).....under-developed quality assurance in some countries
- Numerous levels and types of qualification/ graduate competency .....variability
- Limited specialist training options for PHN
- Lack of evidence that curriculum is informed by competency standards??
- The adequacy of, and quality of, workforce preparation has a major role in determining workforce capacity. Establishing standards and curriculum guidance is an important potential role of professional associations.

Workforce development needs

- Workforce development needs vary and can be very specific to practice context....workforce development systems and strategies therefore need to be flexible and responsive
- Workforce development infrastructure limited in some cases (eg. Mozambique)- workforce capacity building will continue to be constrained if academic capacity and investment in education is not increased
- Workforce preparation in the social, political, economic and environmental competency domains needs enhancing. High level expertise in food and nutrition remains the core.

Workforce development is more than just training

- A failure to ensure a workforce system that integrates workforce preparation with paid employment/ career pathways, will continue to stifle workforce capacity and stability (e.g. Australia, Indonesia: producing many more graduates than jobs : Supply > demand)
- Note: Demand does not equate with need

  In most countries, investment in the PHN workforce is significantly less than need

Expected outcomes of WFD

- The downstream outcome of public health nutrition workforce development is more effective, targeted and “adequate dose” interventions and services that improve dietary quality and adequacy amongst populations

Competence>>>Employability>>> Health Impact

A role for the WPHNA

- Professional/technical guidance to support country-level workforce development
  - Competency standards
  - Curriculum guides
  - Program accreditation system
  - International certification system
  - Job description templates
  - Continuing professional development (workshops, conferences etc)
- International community- exchange, support, strengthening>>>>building capacity

Acknowledgements

- Case study authors:

  - Indonesia: Sonia Blaney, Prof Hamam, Pak Minarto, Puti Marzoeki
  - Mozambique: Edna Possolo, Sonia Khan
  - Brazil: Betta Recine
  - Canada: Ann Fox
  - Iran: Nasrin Omidvar, Zalra Abdollah, Abolgahassem Djazeri
  - Australia: Roger Hughes