[Sri Lanka]

Retention of Family Health Workers in Rural Communities as an Important Strategy in Task-shifting—The Sri Lankan experience

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Sri Lanka is an island located in the Indian Ocean south east to India with a population of approximately 20 million. Approximately 72% of the population is living in the rural community (Department of Census and Statistics, 2008). The primary health care system of Sri Lanka is a unique system with family health workers reaching out to these rural communities at grass root level. The Public Health Midwife (PHM) is the key family health worker at the grass root level. Today the services of PHM have evolved into a professional carrier taking a holistic approach in preventive health covering many aspects other than midwifery. Their services are immensely valued in rural setting where health resources are scarce. The success of PHM recruitment, training programe and employment in the rural sector can be seen by its ultimate impact in the health indices. Over the past years maternal mortality ratio (MMR) dropped from 265 in 1935 to 5.3 per 10,000 live births in 2003 and infant mortality rate (IMR) from 263 in1935 to 11.2 per 1,000 live births in 2003 (Ministry of Healthcare and Nutrition, 2003). These indices highlight the effectiveness of task shifting and delegating the responsibilities to the grass root level health workers. It is important to ensure that PHMs are retained in the most needed areas. The paper discusses the main strategies that have been followed by Sri Lanka to ensure the retention of PHMs in the rural areas of Sri Lanka; need-based recruitment, capacity development as "experts" at the grass root level, Continuous Professional Development (CPD) and providing financial incentives.

Need-based Recruitment

The recruitment criteria for PHM training are based on educational qualifications. The eligibility criterion for enrolment is a minimum of simple passes for all three subjects in the Advanced Level examination. However on several occasions (in 1996, 2000, 2002 and 2009) the educational qualifications for recruitment have been lowered to enable trainees from very rural settings to participate in PHM training course. This decision was taken considering the fact that very rural settings may not have applicants with required educational qualifications for the PHM training course. These recruitments were done mainly for plantation sector in the rural and underprivileged districts of Central, Sabaragamuwa and Uva Provinces and to war-torn areas of the Northern & Eastern Provinces.

The recruitment policy of the country favours recruiting PHM trainees from very rural settings. It is mandatory to recruit trainees from all Provinces proportionate to the population living in each Province. This provides opportunity for those in Provinces with more rural settings to get selected for training. Thus those who are living in the Province can be trained within the Province, resulting in fewer defaulters from the rural settings. Those who are selected from a particular Province will later be enrolled to serve within that Province.

A significant proportion of PHMs was provided for Provinces with poor health indicators. In 2004, more than 90% of the trainees attending the PHM training course were posted to rural

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settings after completion of the training course. It is worth to note that the highest proportion was sent to Northern & Eastern Provinces in 2006, 2007 and 2008 (De Silva, 2009).

Capacity Development as "Experts" at the Grass Root Level

The training courses for PHM consist of 1 year basic training and midwifery, in a Nurses' Training School and 6 months training in community health management in Regional Training Centers of the National Institute of Health Sciences (NIHS). NIHS is the premier training centre of the country for primary health care workers. The curriculum is designed to ensure that PHMs gain knowledge and competence that enables them to function at a higher capacity than a usual grass root level community health workers of other developing countries. A World Bank report on Sri Lankan PHMs has shown that this had enabled them to gain a high recognition among the rural communities, who identify them as experts in maternal and child health, thus helping to retain these "experts" in rural communities (Pathmanathan & Rajapaksha et al., 2003).

Continuous Professional Development (CPD)

The PHMs are kept updated through various local as well as regional and national programmes. At district level all most all districts in the county has conducted at least one training programme. Even the PHMs from the very rural settings have attended these training programmes. At national level the Family Health Bureau has conducted at least one training programme for the PHMs in each district. A World Health Organization report on the CPD for Sri Lankan PHM has shown high participation for continuous professional development by these PHMs in very rural settings and this was not due to economic gains and neither was it linked to promotions or re-registrations (WHO, 2004). The same report indicates that CPD is a requirement of majority of the health care workers and is one reason for internal migration of health professionals. Therefore it is mandatory to providing CPD facilities to those working in rural settings in order to retain then in the rural areas.

Financial Incentives

Various types of allowances are presently provided for the PHMs to retain in the rural communities. These are:

1. Office allowance — Approximately 1.5 US$ are given monthly to maintain a office in the respective PHM area (However the present cost for renting an office is approximately ten times the allowance).
2. Field (Transport) allowance — A payment of 1.25 US cents per kilometer is paid with a maximum limit of 10 US$ (However when considering the present fuel and transport prices this is not adequate).
3. Clinic allowance — An allowance of 1.75 US$ per clinic sessions (for maximum of 8 clinics per month) is given for conducting community clinics.

Apart from these the availability of good quality schools, transport facilities and good road networks are other non health amenities required by PHMs when retained in the rural communities to provide primary health care. Providing other benefits available for government servants such as the availability of pension schemes, cost of living allowance and subsidized mobile communication facilities will attract more PHMs to work in rural areas (De Silva, 2007).

The Lessons Learnt

The success of the Sri Lankan primary health care system lies on its ability to retain grass root level primary health workers in remote/rural areas. The contributions from the PHM training programmes are immense. However the flexibility of the educational standards has helped to retain PHMs in very rural settings. The PHM training curriculum has given them the confidence to work in rural setting and it has obtained the recognition of the rural communities as well. Conducting ongoing CPD progrmmes and conducting out reach educational programmes for the most rural primary health care workers helps to keep the staff in rural settings since the opportunity to update the knowledge is given. There is high participation for CPD programmes by rural communities.

The favorable government policies which had been continuously present since the inception of primary health care system in Sri Lanka is one of

the main reasons for its ability to retain PHMs in remote/rural settings. The contribution from the non health factors had been another crucial aspect for the provision of PHM services to rural settings. These include providing equal educational opportunities for girls, high female literacy (87.9%), increasing age at marriage of girls (25.5 years 1994), high health literacy level, and minimal gender discrimination (Department of Census and Statistics, 2008). This provides the opportunities for the females to achieve the required educational qualifications to apply for the PHM training course.

Conclusion

Strategies to retain grass root level health workers are essential in successful implementation of task-shifting.

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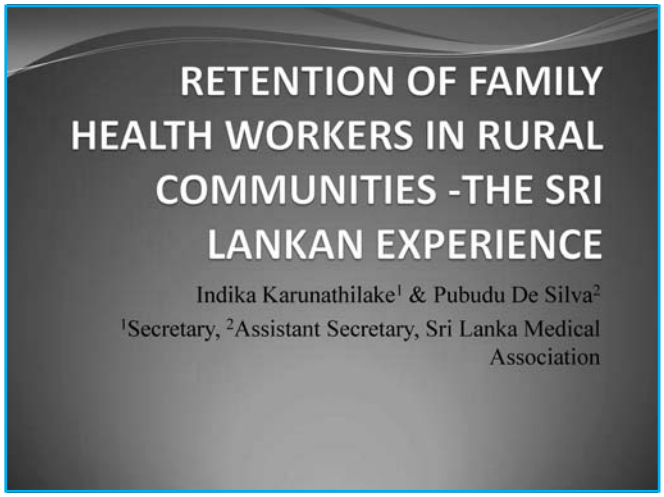
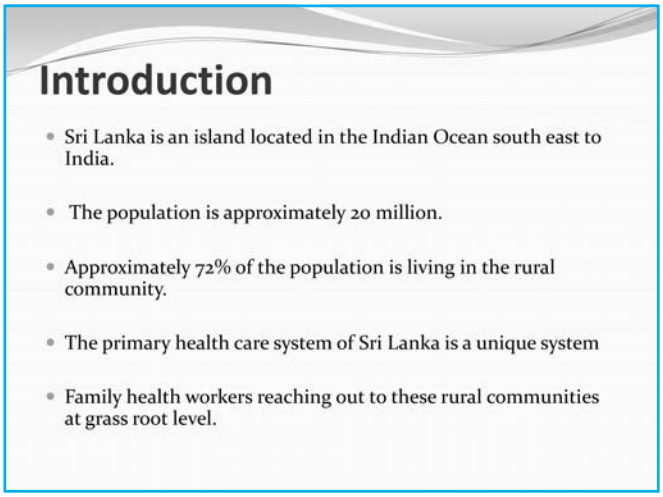




The success story of the Sri Lankan Health system

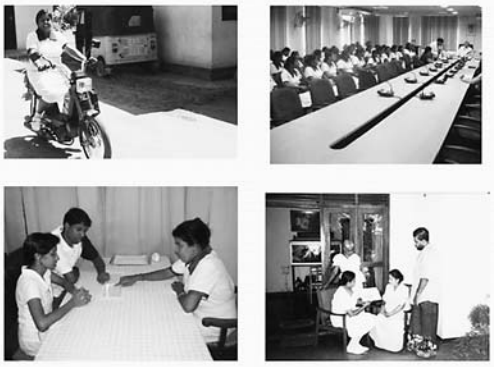
- Over the past years maternal mortality ratio (MMR) dropped from 265 in 1935 to 5.3 per 10000 live births in 2003
- Infant mortality rate (IMR) from 263 in 1935 to 11.2 per 1000 live births in 2003
- These indices highlight the effectiveness of selective task shifting and delegating the responsibilities to the grass root level health workers.

Role of the Public Health Midwife

- The Public Health Midwife (PHM) is the key family health worker at the grass root level.
- Today the services of PHM have evolved into a professional carrier taking a holistic approach in preventive health
- Their services are immensely valued in rural setting where health resources are scarce.

Strategies to ensure the retention of PHMs

- Need-based recruitment
- Capacity development as "experts" at the grass root level
- Continuous Professional Development (CPD)
- Providing financial incentives.



Need-based recruitment

- The recruitment criteria for PHM training are based on educational qualifications.
- The eligibility criterion for enrolment is a minimum of simple passes for all three subjects in the Advanced Level examination.
- However on several occasions (in 1996, 2000 2002 and 2009) the educational qualifications for recruitment have been lowered to enable trainees from very rural settings to participate in PHM training course.

Need-based recruitment – Contd...

- This decision was taken considering the fact that very rural settings may not have applicants with required educational qualifications
- These recruitments were done mainly for plantation sector in the rural and underprivileged districts

Capacity development

- The training courses for PHM consist of 1 year basic training and midwifery, in a Nurses' Training School.
- And 6 months training in community health management at the National Institute of Health Sciences (NIHS).
- NIHS is the premier training centre of the country for primary health care workers.

Capacity development – Contd...

- The curriculum is designed to ensure that PHMs gain knowledge and competence.
- That enables them to function at a higher capacity than a usual grass root level community health workers of other developing countries.
- This had enabled them to gain a high recognition among the rural communities.
- They identify them as experts in maternal and child health, thus helping to retain these "experts" in rural communities.

Continuous Professional Development (CPD)

- The PHMs are kept updated through various local as well as regional and national programmes.
- At district level all most all districts in the county has conducted at least one training programme.
- At national level the Family Health Bureau has conducted at least one training programme for the PHMs in each district.

Continuous Professional Development (CPD) – Contd...

- There is a high participation for CPD by the PHMs in very rural settings.
- This was not due to economic gains and neither was it linked to promotions nor re-registrations.

Financial incentives

- Office allowance – Approximately 1.5 US$ are given monthly to maintain a office in the respective PHM area
- Field (Transport) allowance – A payment of 1.25 US cents per kilometer is paid.
- Clinic allowance – An allowance of 1.75 US$ per clinic sessions

Lessons learnt

- The success of the Sri Lankan primary health care system lies on its ability to retain grass root level primary health workers in remote/rural areas.
- The flexibility of the educational standards has helped to retain PHMs in very rural settings.

Lessons learnt – Contd...

- The PHM training curriculum has given them the confidence to work in rural setting.
- It has obtained the recognition of the rural communities as well.
- Conducting ongoing CPD progrmmes and Out reach educational programmes for the most rural PHCWs helps to keep them in rural settings

Conclusion

- Strategies to retain grass root level health workers are essential in successful implementation of selective task-shifting