POLICY BRIEF

Strengthening human resources for adolescent health in Sri Lanka through health and education sector collaboration

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Current Problems and Issues

Sri Lanka has made considerable progress towards addressing the Millennium Development Goals, however, there are still gaps reflected in adolescent health and social indicators and in the delivery of services.

- Low adolescent sexual and reproductive health knowledge: Only 57% of adolescents knew that condoms can reduce the risk of transmission of sexually transmitted infections (STIs) while even less (18%) have this knowledge in the estate sector (plantation areas that are largely privatised) [DoCS 2008]. Three quarters of females and two thirds of males 10-14 yrs report low levels of sexual knowledge [De Silva, Karunathilake & Perera. 2009].

- Rising teen pregnancy: While there has been a decline in the adolescent fertility rate from 35 per 1000 live births among women aged 15-19 in 1993 to 27 in 2000, in 2006/07 it has again increased to 28. The adolescent fertility rate for the estate sector in 2006/07 was 37/1000 [Government of Sri Lanka Department of Census and Statistics 2009].

- High rates of sexual abuse: Nearly 10% of early adolescents and 14% of mid and late adolescents admitted to having been sexually abused [DoCS 2001],with youth in the Estate sector at greater risk [Dissanayake 2006]

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Midwife and teacher at Tea Estate in Matugama.
Photo by Angela Dawson.

Out-migration of mothers for employment overseas leaves adolescents particularly vulnerable: While improving the household income, mothers being absent from the family home can negatively affect the emotional and psychological well-being of children, affecting their relationships and exposing them to potential risks [Ukwatta 2010]. However, a recent study of a representative sample, shows that father and mother migration positively affects children's school enrolment [Sunethra & Jampaklay 2011].

- Increasing demand for adolescent sexual and reproductive health (ASRH) information: Enrolments in schools are increasing in Sri Lanka as participation in the labour force for 15-19 year olds is declining [PRB 2006]. This means that secondary teachers who have been identified as a key source of ASRH information [Yakandawala 2007] are facing an increasing demand for ASRH education.

- Failure of youth specific service centres trials such as the youth corner in hospitals: Adolescents in Sri Lanka have poor knowledge and utilisation of existing adolescent specific health services [Agampodi, S, Agampodi, T & Piyaseeli 2008].

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Inter-sectoral collaboration will ensure efficient use of current resources to improve the provision of health services and information to adolescents

- ASRH is inter-factorial and underpinned by biological as well as social determinants.
- The approach to ASRH service delivery needs to be comprehensive enough to address the range of factors affecting outcomes through policy and interventions beyond health.
- Integrated services, team approaches and the collaboration of human resources (HR) beyond health are responsible for large, sustained impacts on adolescent health [Hughes & McCauley 1998; Speizer, Magnani & Colvin 2003].

A key study [Dawson, Wijewardena & Black 2010] in the Kalutara District has found that collaboration between adolescent health services and education programs is limited. Services are ad hoc, not comprehensive and suffer from a lack of rigorous evaluation.

Recommendations

Key recommendations to address ASRH service and information delivery issues are:

1. Establish clear policy on adolescent sexual and reproductive health across the ministries of health, education and youth affairs.
2. Establish a responsible media policy in ASRH
3. Develop an inter-sectoral approach to delivery of services across the health and education sectors.
4. Develop guidelines, regular reporting mechanisms and indicators for continuous quality improvement across both the health and education sectors.

Key recommendations to address human resource policy and practice are:

- Ensure all provider job descriptions contain specific reference to their responsibilities to deliver ASRH care, services and information.
- Incorporate performance indicators for teachers and primary health care workers in ASRH.
- Ensure regular appraisal of ASRH key performance indicators by supervisors.
- Establish regular programs of pre and in-service education and training for teachers and primary health care workers in ASRH.

Background and Rationale

Government commitment but no clear policy

This is an opportune time to address workforce issues relating to adolescent health in Sri Lanka. The Sri Lankan Government identifies the provision of reproductive health information and services to adolescents and youth as a key priority [UNDP/NCED/Government of Sri Lanka 2005]. The Ministry of HealthCare and Nutrition's (MoHCN) Health Master Plan will be implementing initiatives that specifically target adolescent girls [MoHNW/JICA 2003a] as well as healthy life programs. The Sri Lankan Family Health Bureau within the MoHCN has begun to establish a network of stakeholders at different levels to coordinate adolescent health programs [UNFPA/DSW 2003, p. 80]. Despite this, and an initial commitment to and continuing interest in inter-sectoral action, there is a lack of leadership. The Population and Reproductive Health Policy (1998) is out of date and the National Youth Policy remains in draft form.

Need to maximise current workforce and manage providers more effectively

Separate services for adolescents are expensive and difficult to sustain. The youth friendly services established at base and general hospitals in the country have lost momentum and are no longer operating. In addition, many of the counselling service points established through the Sexual and Reproductive Health Information, Education, Counselling and Services to Adolescents and Youths program, co-ordinated by the United Nations Population Fund (UNFPA) and non-government organisations under European Commission (EU) funding, are no longer functioning [Dawson, Wijewardena & Black 2010]. Maximising the efforts of the current workforce to deliver ASRH care, services and information makes economic sense. However, these short-lived ASRH projects have demonstrated that improving the management of staff can improve provider motivation [Lokubalasooriya 2010] and bring education and health providers together [EU/UNFPA 2003].

Adequate inter-sectoral workforce planning and performance management is required

Government efforts recognise the important role that health, media, education and youth workers play in making large, sustained impacts on adolescent health [Hughes & McCauley 1998; Speizer, Magnani & Colvin 2003]. However, there are no clear guidelines from a human resource perspective concerning cross-sector collaboration, nor have HR elements of these initiatives been evaluated. This is exacerbated by a lack of a human resources policy and development plan [MoHNW/JICA 2003b]. A recent study has outlined the lack of health workers with necessary skills and experience in ASRH [Shankar 2008] and another study recommends more research and a inter-sectoral approach that is supported by public health policy and legislation [De Silva, Somanathan & Eriyagama 2003, p.

18]. Other studies have also called for collaboration between the health, education, social, cultural and legal sectors to better address ASRH problems [[Agampodi, S, Agampodi, T & Piyaseeli 2008; Mirkuzie & Olsson 2008; Ratnayake 2002]. A meeting of the National Adolescent Health Programme Managers in the South-East Asia Region, which included Sri Lanka, called upon the health sector to contribute to the strengthening of other sectors to enhance adolescent health outcomes [WHO 2008].

Evaluation and continuous quality improvement of ASRH services and provider performance is also weak. A monitoring and evaluation system is built into the Maternal and Child Health/Family Planning program information system, which links service providers and program planners at all levels. But this information system needs to be further strengthened and should be altered to cater for the changing needs of the system [WHO/SEARO 2005]. For example, daily returns for midwives do not include ASRH indicators. In addition, job descriptions of primary health workers and teachers do not specifically mention ASRH responsibilities and there are no key performance indicators to assess provider performance in this area [Dawson, Wijewardena & Black 2010].

Recommendation: An inter-sectoral approach to ASRH is needed that is guided by policy and effective human resource management across the health and education sectors. The diagram below outlines the components required to effectively deliver ASRH across the health and education sectors in the Sri Lankan context.

Further information

For more information please download the full report: Health and education sector collaboration in adolescent sexual and reproductive health in Sri Lanka. A situational analysis and case study of the Kalutara District, visit www.hrhub.unsw.edu.au or email hrhhub@unsw.edu.au

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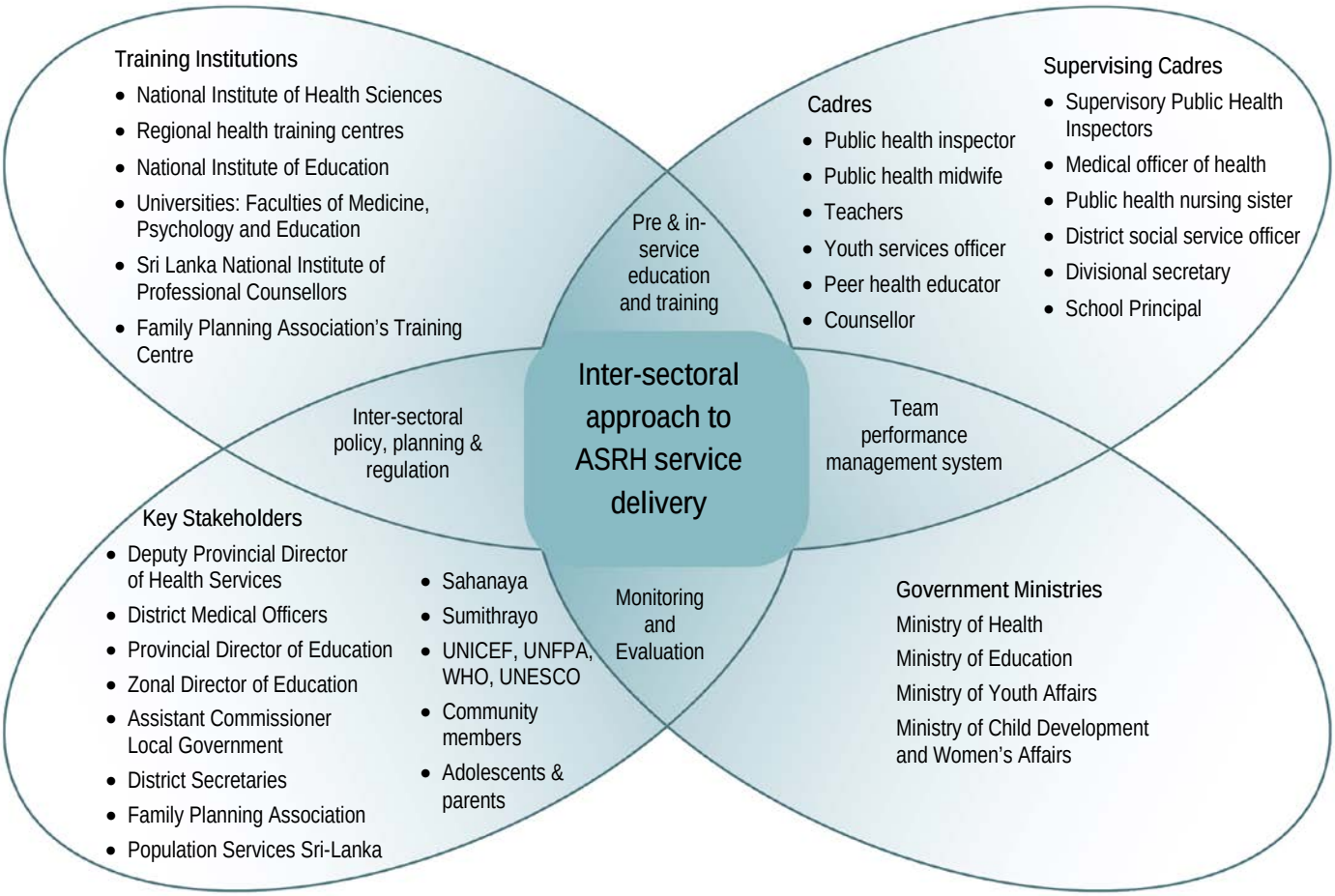
Framework for Inter-Sectoral Approach to Adolescent Sexual and Reproductive Health Service Delivery in Sri Lanka



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