

[Sri Lanka]

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

Indika KARUNATHILAKE,*¹ Pubudu De SILVA*²

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 programme 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 in 1935 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

*1 Secretary, Sri Lanka Medical Association, Colombo, Sri Lanka (slma@eureka.lk).

*2 Assistant Secretary, Sri Lanka Medical Association, Colombo, Sri Lanka.

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