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Policy brief for Sri Lanka

Evaluation of South Asia's Current Community Health Worker Policies and System Support and their Readiness for Community Health Workers' Expanding Roles and Responsibilities within Post-Astana National Health Care Strengthening Plans

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Address: UNICEF Regional Office for South Asia (ROSA)
P.O. Box 5815, Lekhnath Marg, Kathmandu, Nepal
Tel: +977-1-4417082
Email: rosa@unicef.org
Website: www.unicef.org/rosa/

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Authors
Subha Sri Balakrishnan and Margaret Caffrey

Principal Investigator/Team Lead - Margaret Caffrey
Study Advisor - Matthews Mathai
Gender Advisor - Subha Sri Balakrishnan

Data synthesis
Subha Sri Balakrishnan and Margaret Caffrey

LSTM Desk review contributors
Margaret Caffrey
Tara Tancred
Simone Filiaci

LSTM Research Support Team
Matthews Mathai, Study Advisor
Fiona Dickinson
Barbara Madaj
Somla Gopalakrishna
Tara Tancred
Simone Filiaci

LSTM Programme and logistics support team
Clare Littlewood
Keri Murray

UNICEF Team
Luula Mariano
Sam Bickel
Paul Rutter
Barsha Pradhan

Content

Acronyms

ANC	Antenatal Care
BCC	Behaviour Change Communication
BPHS	Basic Package of Health Services
CBHC	Community Based Health Care
CPD	Continuous Professional Development
FHB	Family Health Bureau
FP	Family Planning
GBV	Gender Based Violence
ICM	International Confederation of Midwives
IST	In-Service Training
MDG	Millennium Development Goals
MOH	Medical Officer of Health
MNH	Maternal and Newborn Health
NCDs	Non-Communicable Diseases
NIHS	National Institute of Health Sciences
NTS	Nurse Training Schools
OOP	Out-Of-Pocket
PHC	Primary Health Care
PHI	Public Health Inspector
PMCU	Primary Health Care Units
PHM	Public Health Midwife
PHNs	Public Health nurses
PHNO	Public Health Nursing Officer
PSC	Public Service Commission
PSE	Pre-Service Education
RMNCAH	Reproductive Maternal, Newborn, Child and Adolescent Health
SGBV	Sexual and Gender-based Violence
UHC	Universal Health Coverage
WHO	World Health Organisation
WWC	Well Woman Clinics

Introduction and background

The Astana Declaration of 2018 reaffirmed the importance of Primary Health Care (PHC) towards achieving Universal Health Coverage and the health-related SDGs. It reiterated the urgent need to build sustainable PHC systems that are people-centred, responsive to community needs, holistic in scope, and able to engender socio-cultural changes among communities and providers to promote and preserve good health and well-being.

> We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is acornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals.
>
> **Astana Declaration 2018**

Community Health Workers (CHWs) are the backbone of Primary Health Care systems. Evidence highlights the effectiveness of CHWs in delivering a range of preventive, promotive and curative services related to reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases, and neglected tropical diseases. However, CHW programmes often face several challenges including lack of clarity in roles, inadequate pre and in-service training, lack of clear career pathways, poor supervision mechanisms, and poor linkages with both the health system and communities.

South Asia has a rich history of vibrant CHW programmes and CHWs in the region continue to play a substantive role in Primary Health Care and act as bridges between the community and the health system. Simultaneously, countries in the region are witnessing demographic and epidemiologic transitions with increasingly ageing and urbanized populations and a rising burden of non-communicable diseases. In such a scenario, there is an urgent need to enhance the contribution of CHW programmes to PHC strengthening and achieving the post-Astana goals and commitments in the region.

> CHWs are health workers based in communities (i.e. conducting outreach beyond PHC facilities or based at peripheral health posts that are not staffed by doctors or nurses), who are either paid or volunteer, who are not professionals, and who have fewer than two years training but at least some training, if only for a few hours.
> **World Health Organization**

Evaluation of Community Health Worker programmes in the South Asia region

- Formative evaluation in seven countries – Afghanistan, Bangladesh, Bhutan, Maldives, Nepal, Pakistan and Sri Lanka
- Objectives
    - o To understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes
    - o To determine the key policy adjustments and interventions needed to address any gaps
    - o To assess the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans
- Desk review and key informant interviews at the national level in seven countries
- Analysis frameworks
    - o WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs, 2018
    - o WHO health systems building blocks
    - o Operational framework for Primary health Care by WHO and UNICEF
    - o WHO gender responsiveness assessment scale

In order to understand the CHW policies and system support that are currently in place to support the effective functioning of CHW programmes, and to determine the key policy adjustments and interventions needed to address any gaps, a formative evaluation was conducted of Community Health Worker (CHW) policies and systems support in South Asian countries. The evaluation also assessed the readiness of CHW programmes for their expanding or changing roles and responsibilities within the post-Astana national health care strengthening plans. The evaluation comprised a desk review and key informant interviews at the national level in seven countries with a wide range of stakeholders. The information was analyzed along the WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programs, 2018, the six health systems building blocks of WHO, and the operational framework for Primary health Care by WHO and UNICEF. A gender analysis of the CHW programmes was also done.

This policy brief (technical brief?) presents the key findings from a formative evaluation of CHW programmes in the South Asia region conducted by the Centre for Maternal and Newborn Health, Liverpool School of Tropical Medicine, with support from UNICEF Regional office for South Asia. It details the policy and system support available for diverse cadres of CHWs in the region and measures to optimize the contribution of CHWs to PHC. It also highlights the reforms needed in CHW programmes and will be useful to inform the design of a set of feasibility and prioritization criteria that will support countries to develop an action plan aimed at optimizing the contribution of CHWs to Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) and to the strengthening of PHC. This brief is intended for policy makers at national and sub-national level in the South Asian region.

Sri Lanka - Country Context

Since the late 1920s, the Sri Lankan health system has been based on an equitable and community-based approach to Primary Health Care (PHC), with equality of access to health and education at all levels for both men and women one of the core principles of national health priorities and development policies. The country achieved a comparatively high Human Development Index of 0.78 in 2019. Its health system has been recognized internationally as a highly successful low-cost model that has achieved positive national health outcomes and has contributed to Sri

Lanka's attainment of the health-related Millennium Development Goals (MDGs), and the 2015 targets set for child mortality, maternal mortality, reproductive health, and eradication of malaria were met.

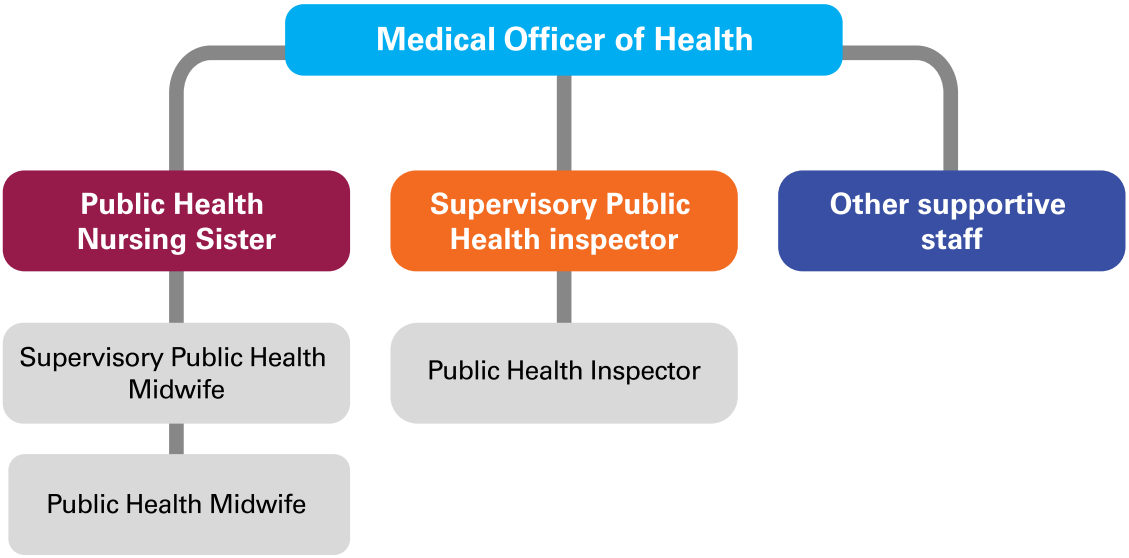
Indicator	Figure	Source
MMR	32 per 100,000 LB	WHO, 2019
IMR	8 per 1,000 LB	WHO, 2019
NMR	6 per 1,000 LB	WHO, 2019
U5MR	9 per 1,000 LB	UN Inter-agency Group for Child Mortality Estimation, 2018

However, health status improvements are not distributed equally across the population and some inequities still remain. Estate residents, households where the mother has no formal education and poor people show higher mortality rates and prevalence of malnutrition. With the control of communicable diseases, non-communicable diseases (NCDs) have become the leading causes of death and disability in the country, increasing from 48% prevalence in 1990 to 75% in 2015.

Currently, the Sri Lankan public health sector is organised into two parallel streams: one being the curative care services delivered through a variety of hospitals; and the other the preventive primary care stream offered through a decentralized approach. At the PHC level, curative care is centred around the Primary Health Care Units (PMCU), which deliver primary outpatient and maternity care, and Divisional Hospitals (DH) that offer outpatient and inpatient care.

PHC preventive services are provided across a network of 354 Medical Officer of Health (MOH) Units, each serving a population of approximately 60,000-100,000 people. To address the emerging disease burden, the government has been testing and evaluating various models of health service delivery over the years, and lessons learned have informed the PHC reforms that are now being implemented in a phased manner by the government of Sri Lanka.

Figure 1: Primary Health Care preventive services



The Sri Lankan economy is also transitioning from a rural-based economy towards a more urbanized economy oriented around manufacturing and service, and the service sector has overtaken agriculture as the largest employer (MoH/WHO, 2018). This has implications both for health care service delivery in urban areas and also in training and retention of the health care workforce.Sri Lanka has made significant progress towards achieving gender equity and equality. Equal educational opportunities for girls, the promotion of female literacy, and efforts to increase the age of marriage for girls have promoted greater gender equality in the country. However, female labour force participation Sri Lanka remains low, and has shown no increase over the past decade.

Community Health Worker programmes in Sri Lanka

There are two key cadres of Community Health Workers in Sri Lanka who are currently active – the Public Health Midwife (PHM) and the Public Health Inspector (PHI). A profile of these CHWs is presented below.

	PHM	PHI
Total number (2,017)	5,746	1,720
Rate per 100,000 population (2,017)	26.8	8.0
Gender	All women	Could be men or women, but almost all men
Sector located in	Completely in the public sector	Completely in the public sector
Place of location	Community	Community
Payment structure	Salaried staff paid by government	Salaried staff paid by government

A PHM is expected to cover a population of 3000. In recent years, there has been an overall decline in the availability of PHMs and only a small improvement in the availability of PHIs. The 2017 Human Resources data from the Regional Director of Health Service are not disaggregated by sex, age, ethnicity or other stratifiers for the CHWs' number or distribution.

The PHM and PHI have varied roles and responsibilities as depicted below.

	PHM	PHI
Type of services provided	Preventive, promotive, curative	Preventive, promotive
Areas of health covered	• Maternal health – Antenatal care, identification of high risk, counselling for institutional birth, assist home birth of required, postnatal care including promotion of breastfeeding • Reproductive health including family planning • Child health • Nutrition	• Immunization • Disease surveillance • School health • Environmental health – Water, sanitation • Occupational health

Health policy and system support for Community Health Worker programmes

The strong PHC foundation on which the Sri Lankan health system was built has contributed to the country's success in achieving positive health outcomes, particularly, maternal and child health targets. The 2005 policies on the re-categorization of health care institutions, along with financing policies and the decentralisation of healthcare, have contributed to expanded specialized curative services and infrastructure. However, they have also led to the underfunding and neglect of primary level facilities and other PHC sub-system component, such as service quality; availability of the health workforce; facilities and infrastructure; and supply chains.

The Ministry of Health has several relevant and comprehensive policy frameworks and operational guidelines in place for PHC, and for the governance and delivery of services, including RMNCAH services.

- The provision of Maternal and Newborn Health (MNH) services is guided by the **National Strategic Plan Maternal and Newborn Health (2017-2025)** whose goal is "a country in which there are no preventable deaths of mothers, foetuses and newborns, where every pregnancy is planned and wanted, every birth celebrated, and women, babies and children survive, thrive and reach their full potential". The MNH Strategic Plan also addresses the PHC health workforce and the need to ensure the availability of 'adequately staffed teams of competent health care workers' to provide quality MNH care for every mother and baby.
- The **Strategic Plan on Adolescent and Youth Health (2018-2025)** aims to provide guidance for the provision of adolescent and youth friendly health services in both the curative and preventive sectors, optimising accessibility, acceptability and coverage.
- The **2017 Report on Reorganising PHC in Sri Lanka, the 2018 Sri Lankan Essential Services Package (SLESP), and the 2018 Policy on Healthcare Delivery for Universal Health Coverage** provide the policy framework and strategic direction for the reorganisation of the Sri Lankan PHC system and for achieving integrated services. A key focus of the reforms and reorganisation will be on strengthening PHC curative facilities and staffing to address the emerging NCD burden.
- The **World Bank supported 'Primary Health Care System Strengthening Project'** aims at reorganizing PHC and provides for a public health nursing officer (PHNO) in the PMCU to support screening services and provide domiciliary care for high risk clients and the elderly.
- A **HRH Coordination Unit** has been operationalized to strengthen the planning, development and management of the health workforce.

Healthcare service delivery in Sri Lankan is managed by the central Ministry of Health (MoH) and the nine provincial ministries of health. Within the MoH, the development and regulation of activities related to PHC is the responsibility of the Directorate of Primary Health Care Services.

A national steering committee, chaired by the Secretary of the Ministry of Health, Secretary of the Provincial Council and Local Government Ministry has been established to provide oversight and guidance for the PHC reforms and reorganisation, while financial and technical support is provided by the Asian Development Bank, the World Bank and WHO. Within the MoH, the FHB is responsible for the planning, coordination, monitoring and evaluation of the National Family Health Program, including RMNCAH services. It is responsible for the policy direction, the strategic planning, capacity building, and monitoring and evaluation. The nine provincial directors of health services are responsible for the management of secondary and PHC institutions and have the authority and responsibility to develop PHC systems in their respective provinces.

HR management functions are divided between the central and provincial ministries. Provincial ministries are responsible for the employment of the PHM and PHI cadres, and pay their salaries, and provide transport, communication and other allowances from their budgets.

The MOH area or divisional health unit is responsible for the implementation of the Family Health Program. The MOH team provide the whole range of RMNCAH services through field clinics and at households. The secondary and tertiary hospitals in the area provide referral outpatient and inpatient services. In addition to RMNCAH services, the MOH team is also responsible for the prevention and control of communicable diseases, vector control initiatives, environmental health, food safety, and surveillance and reporting of notifiable diseases.

The health sector has more than 100 trade unions and professionals associations in total, two of which are for the PHM cadre and one for PHIs.

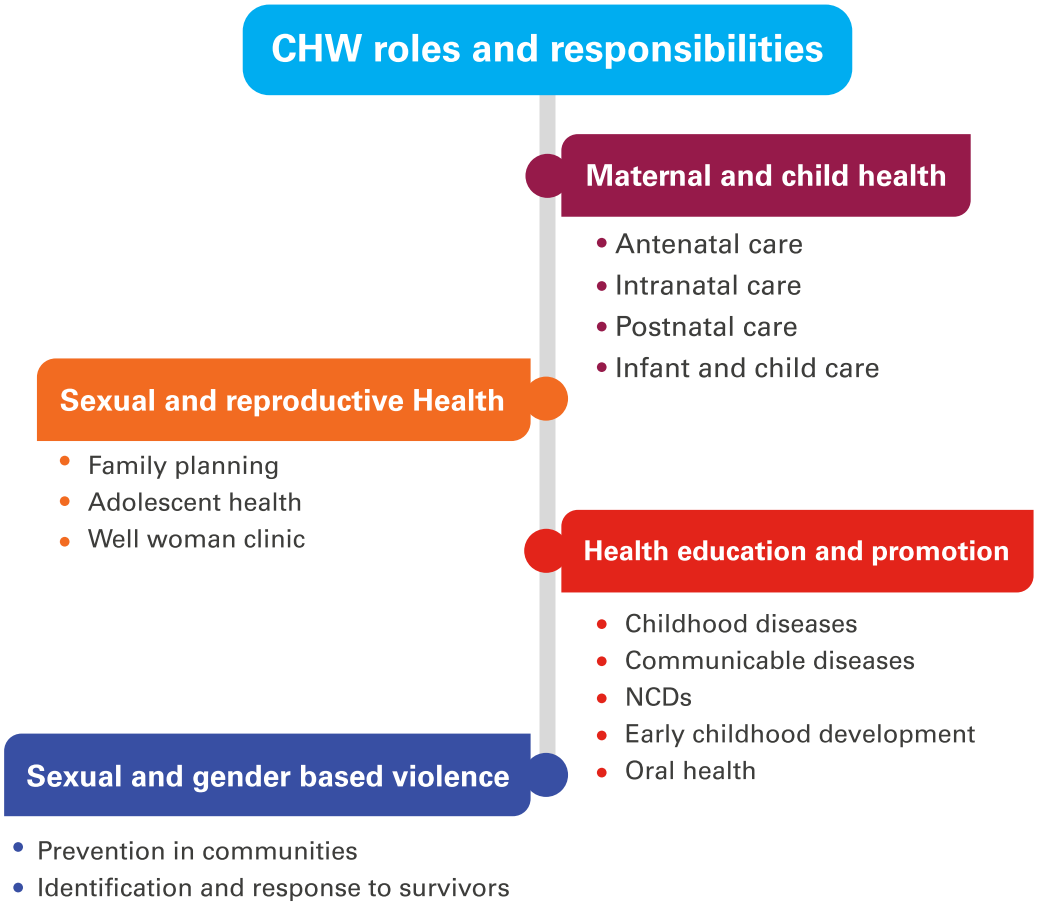
The policy response from the heath sector towards considering and addressing gender based issues has been strong with gender equity and equality considered in many health policies. The 2016 Policy Framework and National Plan of Action to address Sexual and Gender-based Violence (SGBV) in Sri Lanka is a multisectoral initiative across 9 different sectors. The aim of the health sector SGBV response is to provide SGBV care in a patient-centred, responsive, effective and timely manner, free of charge, as a part of routine care.

Roles and responsibilities of Community Health Workers

Each PHM is responsible for providing a wide range of services, across the continuum of maternal, newborn and child health care to a population of three to five thousand. The PHM's roles and responsibilities are clearly defined and documented in a 'Duty List' or job description, last revised in 2006.

> "...Counter domestic violence, reject disrespect and abuse towards women/girls, by ensuring equal access to resources, education, including sexual education and information".
>
> **2017-2025 MNH strategy**

Figure 2: Roles and responsibilities of Public Health Midwifes



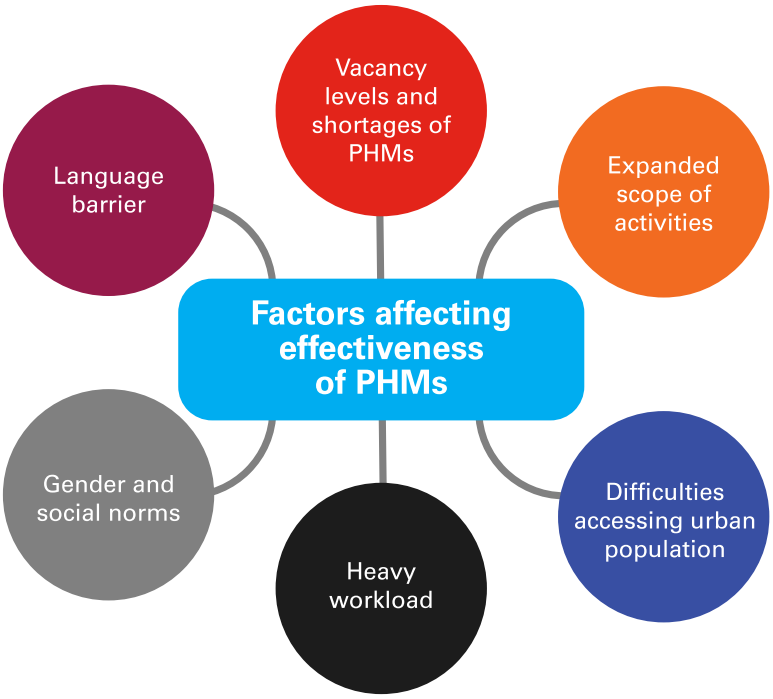
- The PHM, residing in the community, is expected to identify and register all eligible families within her duty area. She provides antenatal care (ANC), intra natal care, post-natal care (PNC), infant and childcare, school and adolescent health, and family planning (FP) services to these eligible families, through a dedicated office, MCH and FP health clinics within the community, and through door-to-door household visits. PHMs are rarely responsible for labour and birth assistance, as 99.5% of all deliveries are institutional.
- The PHM is expected to participate and assist with the clinics provided by the local health facilities, to conduct field clinics in her area, and to assist with and refer women to the Well Woman Clinics (WWC).
- Other activities include health education and promotion for all family members on the prevention and control of childhood diseases, communicable and NCDs, early childhood development, and oral health, as well as reporting and assisting in the investigation of maternal deaths. The PHM is also expected to cater for the needs of working women and those 'not in frequent contact'.
- PHMs, along with other health care providers at the PHC level, play a role in the preventive side of the health sector's response to SGBV. The PHMs' dual role, as set out in the MoH GBV SOP, is firstly in the prevention of SGBV in the communities in which she works, and secondly, to identify and respond to survivors.
- The PHM is expected to participate, together with other public health staff, in the adolescent and youth friendly health clinics. PHMs are also expected to raise awareness of these clinic through their household visits and PHIs through their work in schools and workplaces.

PHMs are recognized to have made a significant contribution to the high coverage for maternal health and breastfeeding in Sri Lanka. The PHM was perceived to be providing "a very important service in the country" and was described as a 'unique' cadre because she can work in both institutional and community settings.

Several factors were identified as impeding the effectiveness of the PHMs.

PHMs often have to perform multiple roles, including, 'doctor', 'nurse', 'health educator', 'occupational therapist' and 'physiotherapist'.

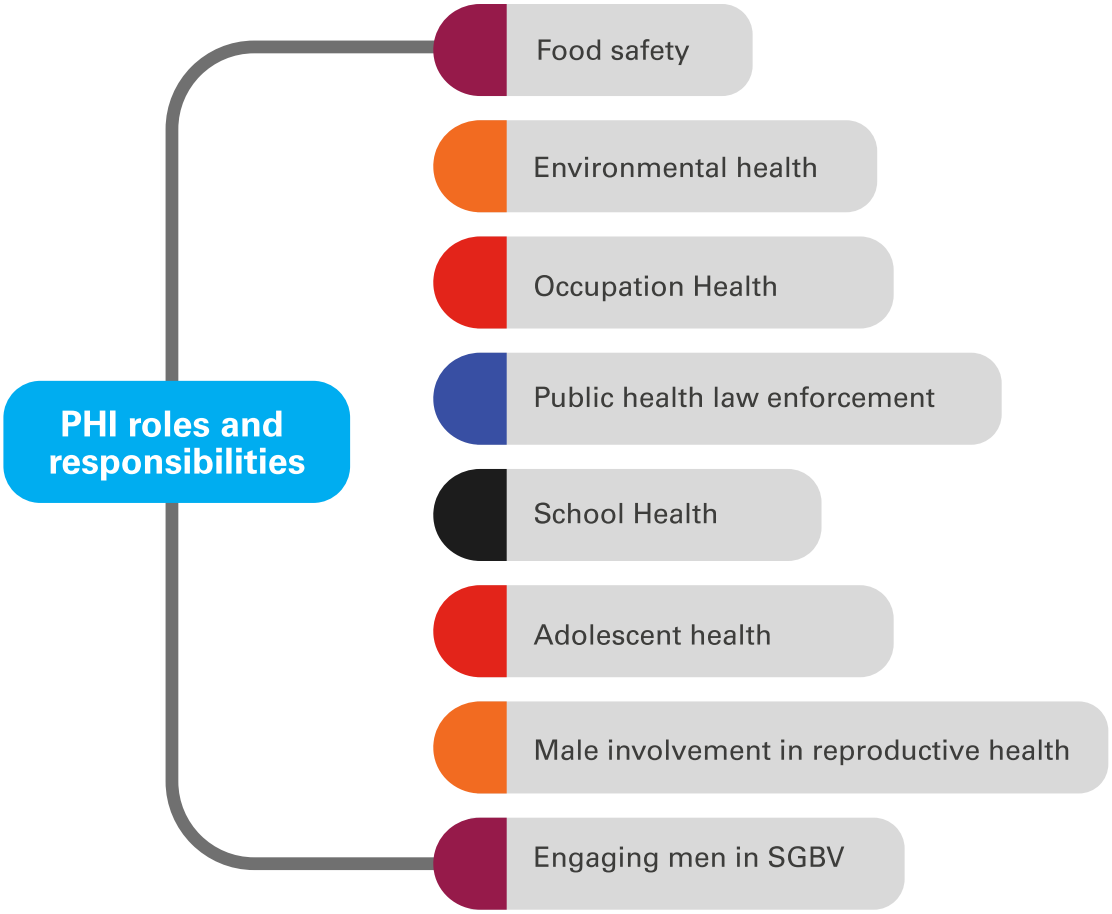
Figure 3: Factors affecting effectiveness of Public Health Midwifes



- **Vacancy levels and shortages of PHMs:** These were perceived to be affecting the range, depth and quality of the services provide.
- **Expanded scope of activities and heavy workloads:** They were overloaded with numerous vertical programs, including "nutrition programs, work on gender-based violence, nutrition, reproductive health, counselling. With lighter workloads and behaviour change communication (BCC) skills PHMs could be more effective in influencing and changing behaviour, especially in the areas of nutrition and breastfeeding and adolescent health.
- **Language barriers:** Because of PHMs shortages, 'most of the nurses and the midwives and the paramedics for the northern province and the estate sector come from other districts" and they do not speak the local language, which affects their integration into the community and acceptability of their services.
- **Difficulties accessing urban populations:** PHMs are not as effective in urban areas. This was attributed to urban populations improved access to doctors and facility based care.
- **Gender and social norms:** PHMs' work, behaviour and attitudes may also be affected by the prevailing gender and social norms in the community. Thus, they may provide stereotypical responses to survivors of violence or have difficulties interacting with men in the community.

PHIs are fewer in number than the PHMs, and cover a larger target population, sometimes over 10,000. PHIs have a large array of responsibilities as shown in Figure 4.

Figure 4: Roles and responsibilities of Public Health Inspectors



Selection, education and certification

Selection

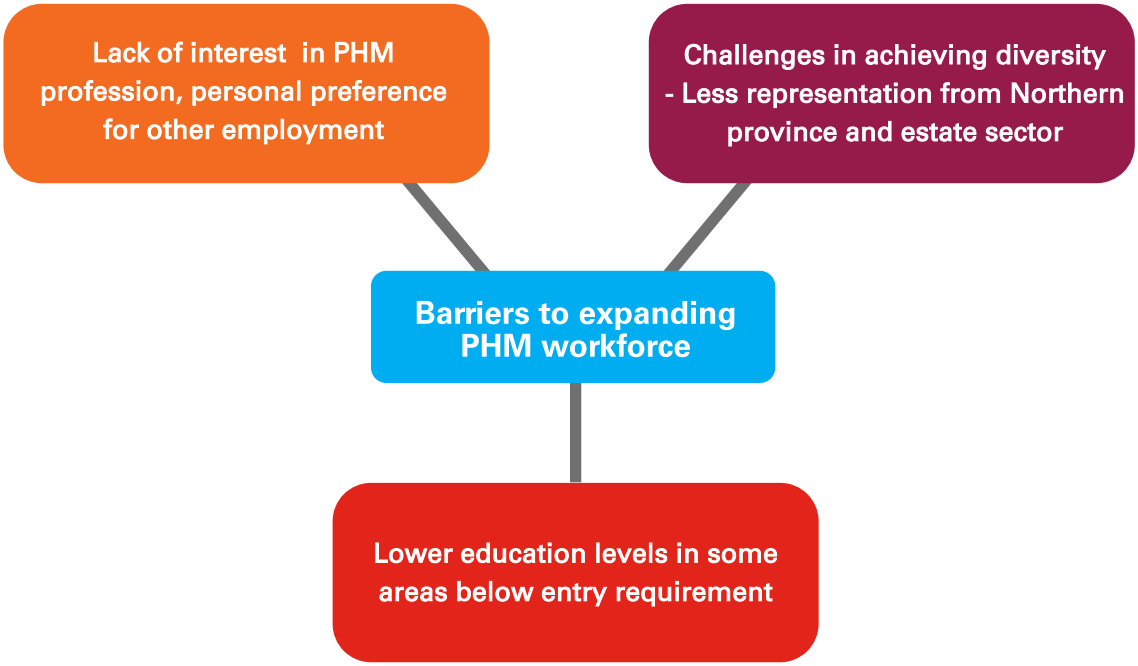
Sri Lanka has a policy of recruiting and then training its health cadres based on the number of vacancies identified across the sector. As both the PHM and PHI are approved government posts, they are selected according to Public Service Commission (PSC) criteria for their respective training programs.

Concerningly, the numbers of students applying and recruited from the Tamil-populated Northern provinces and the 'estate sector' remains low. While lower education levels in these areas was identified as one of the reasons for low applicant numbers, another factor was the personal preferences of those who had required qualifications for other training or employment options. Another challenge is that even when applicants are allocated a PHM midwifery training place, some may still opt for nurse training, partly due to the perception/misconception that nursing is a superior profession. This overall lack of interest in the PHM/midwifery profession and the challenges around attracting sufficient numbers and achieving greater diversity are barriers to expanding the PHM workforce and meeting the projected requirement.

Criteria for selection of CHWs

- Sex specific criteria
  - o PHM – Women only
  - o PHI – Can be men or women
- Advanced level qualifications in science

Selection, education and certification



Education and training of Community Health Workers

Public Health Midwife Pre-Service Education

PHMs undertake an 18-month PHM/midwifery training program, common to both the PHM and the hospital midwife who is facility-based. The program consists of 12 months of theoretical training in one of the 18 Nurse Training Schools (NTS), followed by six months of practical fieldwork attached to one of the National Institute of Health Sciences (NIHS) Regional Training Centres across the country. For the field work component of the training, students are assigned to a certified PHM in the community. Courses are provided in Sinhala or Tamil. Training is publicly funded, and students receive a monthly allowance for the duration of the training. Those who satisfactorily complete the Midwifery Training Program receive a diploma and are certified and accredited when they register with the Sri Lanka Medical Council.
The development of the midwife curriculum has been informed by the WHO and International Confederation of Midwives (ICM) competency frameworks, adapted for the Sri Lanka context, with the participation of a range of stakeholders. The specific content of training covers family planning (methods and counselling), nutrition education (identifying nutritional needs in children and providing counselling to parents), antenatal care, care of children with special needs (recently added content), and the psychosocial and reproductive needs of young widows. Gender and SGBV specific modules have been incorporated to build the knowledge and skills of this cadre on preventing and addressing SGBV in the community.

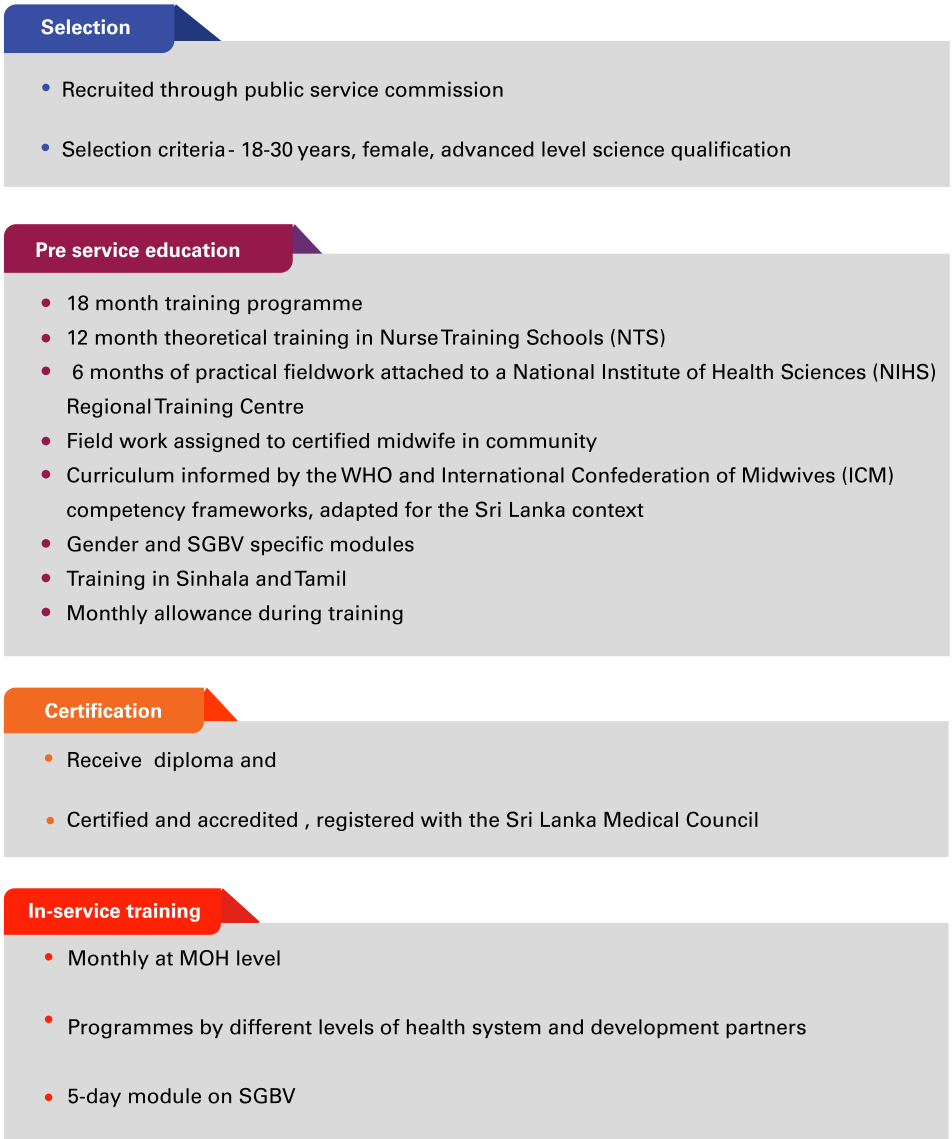
There are challenges however with the system's capacity for managing the required training loads and providing the training.

- **Inadequate training capacity:** There are no dedicated PHM/midwifery training institutions, PHM/midwifery student are trained in the NTS facilities, who also have large numbers of nursing students to accommodate. This lack of training capacity constrains the numbers of PHMs that can be produced on an annual basis.

The uniqueness of the PHM/midwifery training program is that it "trains for the institutional competencies expected, as well as the community requirements" producing a versatile cadre that can provide RMNCAH services in both hospital and community settings.

- **Duration of training:** The 18 month training period has remained unchanged since the PHM cadre had been established 93 years ago. A longer timeframe, of up to 3 years or a degree level program were suggested by some key informants to enable PHMs to provide 'better quality care'.
- **Gaps in curriculum:** Gaps in the PHM curriculum were identified in the areas of health promotion, counselling, infection control and mental health, and in IT skills.
- **Lack of dedicated teaching faculty:** The lack of dedicated faculty for the PHM/midwifery training affects the quality of the training. The absence of obstetricians and doctors and midwifery faculty as trainers was seen to affect quality of training.

Figure 5: Selection and training of Public Health Midwifes



In-service training for Public Health Midwifes and hospital midwives

In-service training programs for PHC preventive staff are conducted by a range of programs and providers from different levels of the health system. A number of development partners also support in-service training for the PHM cadres. The PHMs also receive SGBV training using a pre-designed 5 day interactive training module.

Several challenges in in-service training were identified. These include lack of proper training needs assessments, lack of training evaluation systems, and poor quality of training conducted at MoH level. There are more opportunities of training for PHMs in the field sector than in the hospital sector.

Public Health Inspector pre-service education and in-service training

PHIs also undergo an 18-months training program. However, the training content was perceived to be not fit for purpose given their changing roles and responsibilities. Establishing a 3-year BSc in Public Health was suggested towards addressing this. PHIs also face challenges accessing in-service training.

Management and supervision

Deployment

Once the PHM has successfully completed their training, vacancies and posts are advertised and candidates are selected based on 'their merit score and national ranking'. As there is no explicit policy for deployment, deployment decisions are made on an individual basis, within the province or between the province and line ministry.

However, several gaps and challenges in deployment exist.

- **Staff shortages and maldistribution:** These are seen particularly in rural and more remote areas. Distributional imbalances also occur between rural and urban areas within some districts, and between different institutions.
- **Preference for deployment in facilities:** Increasingly, midwives prefer to be based in a health facility with PHM numbers declining, while the supply of hospital midwives is more stable.
- **Role of hospital midwives should be better defined:** With a majority of women now seeking MNH care and services at higher level facilities, the role and relevance of the hospital midwives is questionable.
- **External influences:** Deployment was perceived to be susceptible to influences and pressures from a number of factors including unions, politicians and the personal interests and preferences of the individual.
- **Language barriers:** Efforts to equitably distribute qualified PHMs is also constrained by language barriers and personal financial considerations of the PHMs.
- **Changes in transfer policies:** Recent changes in transfer policies affect the distribution of PHMs, with some being moved from the area where they have been serving for years to a new area.

The deployment and distribution of PHIs also face similar challenges.

Supportive supervision

The preventive sector has a well-established and structured system of supervision.

- The Monitoring and Evaluation Unit of the MoH FHB monitors the implementation of the RMNCH program, including the activities of the PHM.
- At the MOH level, the supervision of the PHM is shared between the MO in charge of the MOH Unit, the PHNS, and the SPHM, who work according to a common supervising roster.
- The SPHM, who directly supervises the PHM, undergoes a 3-months residential training program in NIHS, to equip her with the supervisory and information management skills to undertake her supervisory role. Standardised supervision and performance evaluation guidelines and tools are available for the SPHM to monitor and support the PHM's activities. The SPHM is expected to provide supportive supervision for approximately 10 PHMs per month.
- The PHNS, based at the MOH facility, supervises both the SPHM and the PHM.
- Typically one SPHI is responsible for the supervision of around 10 to 15 PHIs. In recent years, provincial level PHI posts have been abolished and PHI supervisors are now mostly located at regional and MOH levels.
- The MOH, as well as the provincial and national levels, can access through the information system a range of dashboards to monitor the PHM's progress and RMNCAH related activities. The FHB uses information generated through the supervisory processes and performance data collected through the information system to evaluate the PHM's performance.

While the strengths and effectiveness of the supportive supervision system were highlighted by respondents and in the literature, the need to strengthen these processes and procedures at all levels was also noted.

- **Staff shortage:** The scarcity of supervisory PHMs and midwives in both the field and hospital settings was a concern, with "no supervisors in many places".
- **Inadequate training for supervisors:** It was suggested that the supervisory training for SPHMs is too short and not sufficiently comprehensive.
- **No pay incentive:** Promotion as SPHMs does not attract any increase in pay or allowances.
- **Supervision not supportive:** Monthly MOH conferences are reported to be not always supportive or empowering, and supervisees are often not treated with respect.
- **Opposition to nurses as supervisors:** There were strong feelings about PHMs and hospital midwives being managed and supervised by PHNS and nurses who were perceived to have limited midwifery training or knowledge.

Remuneration

The remuneration of PHMs and PHIs is aligned with government pay structures and usually their salaries are paid on time. They also receive a range of allowances for housing and maintaining and office in the community in which they are based, as well as transport and communication allowances. The type of allowances provided, their predictability and timeliness depends on the resources allocated to and available at the provincial level.

The level of pay for these cadres was perceived by many to be too low. Reportedly there is no pay difference between males and females. However, there were suggestions for pay parity between public health workers and those in the curative sector. The allowances for public health staff were also perceived to be inadequate and there were suggestions to revises them to meet market rates, especially in Municipal Council areas.

Administratively, these cadres fall under the provincial government and the limited budgetary allocation at this level constrains the ability to improve remuneration and allowances for them.

Career progression

Both PHM and PHI can progress only one step to a supervisory PHM or supervisory PHI and there are limited positions at these levels. The lack of career advancement was perceived as a barrier to attracting these cadres

Integration into and support by health systems and communities

The PHM and the PHI cadres are generally well integrated into the formal government health system and civil service structures. However, there was a perception that PHMs were not so well integrated at the MOH level, with PHMs playing a mainly supportive role to the facility based staff. PHMs are not always given respect or recognition by other health care providers, contributing to attrition among this cadre.

At the MOH, RMNCAH is given priority, while curative services are prioritised by politicians and policy makers at the national level. There is not enough support for the PHI's work. It was suggested that a Public Health Department should be established, which would ensure PHIs and PHMs had proper representation at the national level and that preventive and public health services were prioritised.

Target population

Each PHM is officially required to cover a population of 3000 people. This requirement is fulfilled in many locations; however in understaffed areas, the PHM could serve a population anywhere from 5000 to 8,000. PHIs have a variable target population, from 10,000 to 40,000, as well as schools.
The larger catchment population and geographical spread the PHMs have to cover has increased the PHM's workload.

Reducing the PHM's target population would enable them to deliver more family centred care. However, such a reduction would entail increasing the production and supply of PHMs, which would be challenging as discussed earlier given limited training capacity.

Availability of medicines and supplies

The stock and availability of the supplies PHMs require, including family planning commodities, provided by the FHB, are generally good. For PHI, the lack of sampling instruments and "food quality checking instruments" was reported to be affecting the quality of the PHIs work in communicable diseases and, food safety work.

Collection and use of data

The PHM plays a significant role in the collection of RMNCAH and other public health data through their household visits and field clinics. The PHM maintains a daily diary to record her activities and has a number of paper-based registers. Using this information and data, she compiles a paper based comprehensive monthly report, which she submits to the MOH office. At this point, the information is entered into the electronic information system, which creates a range of dashboards that can be accessed at all levels, including by the MoH FHB M&E Unit.

However, data collection requirements for both the PHM and PHIs were considered unduly burdensome. The system is still manual, precluding the use of real time, granular data at the national level.

Community integration and engagement

Historically, the PHM has "a good reputation in the community, and is well respected", especially in rural areas. Communities also take responsibility for the PHM's safety and security.
The PHI is also generally well accepted in the community and can call on a network of community groups to support them carry out their immunization and environmental health activities.

Some PHMs find it challenging to engage with male family and community members. More PHMs are getting involved in addressing SGBV in their community; however, they may have internalized prevalent societal gender norms that justify harmful behaviours. More recently, PHIs are being used to address men's health issues in the community, and promote male involvement in reproductive health.

The acceptance of the PHM in urban areas and her ability to access and provide services to women in urban communities was perceived to be more of a challenge. Further, language barriers, age and other cultural constraints may also affect the integration and acceptability of the PHM and PHI cadres, especially those deployed from outside the area to areas where the availability of local PHMs is constrained.

Fulfilment of World Health Organisation recommendations by the Community Health Worker programmes

The following table lists the recommendations by WHO on the policy areas around CHW programmes and depicts the fulfillements of these recommendations by the CHW programme in Sri Lanka using a colour code. (Green – complete fulfilment of all dimensions of the recommendation, Yellow – Partial fulfilment of some dimensions, but not others, Red – All or almost all dimensions of the recommendation not fulfilled)

Policy area	WHO recommendation	Fulfilment	Remarks
Selection	Specify minimum educational levels		
	Require community membership and acceptance		No community involvement in selection
	Consider personal capacities and skills		Not considered
	Apply appropriate gender equity to context		Not considered for PHIs, but considered for PHMs.
Pre-service training duration	Based on scope of work, roles and responsibilities		
	Consider competencies required		
	Consider pre-existing knowledge and skills		
	Social economic and geographic circumstances of trainees		Not considered
	Institutional capacity to provide training		Inadequate institutional capacity
	Expected conditions of practice		

Competencies in pre-service training curriculum	Include core competencies domains-preventive & promotive, diagnostic, integration with wider health system, interpersonal skills, social determinants of health, personal safety		
	Include additional competency domains- treatment and care services- if required		
Training Modalities	Balance theory and practice		
	Use face-to-face and e-learning		
	Conduct training in or near the community		
	Consider interprofessional training approaches where relevant		Midwifery faculty not available
Competency based certification	Use competency based formal certification for CHWs who have successfully completed pre-service training		
Supportive supervision	Establish appropriate supervisor – CHW ratios		Shortage of supervisory cadres
	Train supervisors		
	Coach and mentor CHWs		Supervision not always supportive
	Use of observation of service delivery, performance data and community feedback		Community feedback not included
	Prioritise improving quality of supervision		PHC system strengthening project includes this
Remuneration	Remunerate practising CHW with a financial package commensurate with job demands, complexity, number of hours, training and roles		CHWs remunerated, but package considered low
Contracting Agreements	For paid CHWs provide written agreements specifying roles, responsibilities, working conditions, remuneration and workers' rights.		Duty list provided, but needs updating
Career Ladder	Offer career ladder to practising CHWs		Very few supervisory positions, no payment increase
	Further education and career development linked to selection criteria, duration and contents of pre-service education, duration of service and performance review		No career pathway
Target population size	Expected workload		Defined target population, but high workload
	Frequency of contacts		
	Local geography		Not considered
	Nature and time requirements of the services provided		
Collection and use of data	CHWs document the services they provide		
	CHWs collect, collate and use health data on routine activities		
	Train CHWs and provide feedback on performance based on data		
	Minimize reporting burden, harmonize requirements		High burden, digitalization required

Type of CHWs	Adopt service delivery models comprising CHWs with general tasks as part of integrated primary health care teams		
	CHWs with more selective/specific tasks to play a complementary role based on population health needs, cultural context and workforce configuration		
Community Engagement	Involve communities in selecting & monitoring CHWs & in priority setting of CHW activities		No community involvement
	Support to community-based structures		
	Engage relevant community representatives in decision making, planning, budgeting & problem-solving		
Mobilization of Community Resources	**CHWs to identify priority health and social problems and action plans**		
	Community needs and develop required responses		
	CHWs mobilise and coordinate local resources		
	CHWs to facilitate community participation and links to health facilities.		
Availability of supplies	Ensure CHWs have adequate and quality-assured commodities and consumables through the integration in overall health supply chain;		
	Adequate reporting, supervision, management, training, and mHealth to support supply chain functions		

Financing for Community Health Worker programs

The government is the main funder of health services in the country. While public health services are provided free of charge at the point of delivery, out-of-pocket (OOP) expenditure on health has been rising over the years, mostly as a result of a growing NCD burden, increasing income levels, and demand for better care.

The levels of domestic financing for health generally are declining, but more especially for public health and preventive services. Currently, most investments are focused on curative services, especially at the tertiary level, with PHC preventive services representing only 7% of health expenditure.

The government plans to finance PHC reform and reorganisation through domestic resources and to achieve efficiencies in supply chain management, administration, and other key health system components. Other strategies are proposed to improve the alignment of health financing systems with health system policy, such as expanding the allocation of public financing for PHC services, rather than shifting funds from within health services; increasing disbursements to provinces to enable allocations that respond to local priorities and needs; and increasing financial incentives for performance.

Private sector involvement in Community Health Worker programs

There is limited involvement of the private for profit sector in PHC preventive services in Sri Lanka, or the community based programs delivered by the PHM and PHI.

Prioritized measures to optimize the contribution of Community Health Workers to respond to post-Astana requirements and Primary Health Care strengthening

This section identifies measures that could be prioritized to optimize the contribution of CHWs to Primary Health Care and help the country meet Post Astana requirements. The section is organised into two sub-sections – policy support measures and system support measures.

Policy support measures

Primary Health Care policies and reforms

While Sri Lanka has not articulated any specific post Astana commitments, its leadership, supportive policy environment and strategic frameworks have demonstrated a strong focus on PHC and on achieving UHC. The reform and reorganisation of the PHC system is now underway in Sri Lanka, guided by the 2018 Policy

on Healthcare Delivery for Universal Health Coverage and implemented through the Primary Health System Strengthening Project. These reforms are expected to achieve a more effective and integrated PHC system and equitable and efficient 'family and people-centred primary health care'.

Involving and building capacities of all stakeholders

- The involvement of health sector stakeholders at all levels, including policy makers, managers, facility and community based healthcare providers, as well as professional associations will enhance stakeholder ownership and buy-in, and reduce resistance to the reform agenda, and its objectives and results, enabling the government to realise its ambition of an integrated PHC system.
- Community engagement, education and empowerment are necessary conditions for the effective use of PHC services and for achieving the government's community engagement and social accountability ambitions, set out in its 2018 Policy. The involvement and participation of individuals, families, formal and informal community leaders, as well as under-represented or marginalized groups would be critical towards this.
- Leadership and management capacity of sub-national leaders, managers and supervisors at provincial, regional and district/MOH levels will need to be strengthened to achieve the agenda of PHC reforms.

Strengthening community health care systems and leveraging Community Health Workers skills

- PHMs and PHIs are the link between families and health services and key change agents at the community level. Leveraging their unique experiences, knowledge of the language, culture, and socioeconomic realities and the social determinants of health of these communities will support the achievement of these goals.
- Strengthening community health care systems and investing in the development and management of CHW cadres, strong linkages between the primary level and the secondary and tertiary level facilities will ensure a continuum of quality care for all.
- Robust governance and administrative systems at all levels will be critical for the implementation of training, recruitment, deployment and incentive policies to redress the availability, distribution and retention of these CHW cadres and the provision of RMNCAH services.
- Greater integration of curative and preventive services at PHC will create opportunities to build a more integrated and multidisciplinary PHC workforce and promote a culture of inter-professional collaboration.

Health workforce policies

Despite the recommendations of the Human Resource Strategic Plan 2009-2018, no training or recruitment plans have yet been developed to address the identified workforce challenges. Further interventions and changes are proposed such as the rationalisation of PHM workloads and streamlining the deployment of other preventive primary health cadres.

The implementation of these proposed interventions will have implication for the make-up, roles and responsibilities and skills mix of the current and future PHC workforce, including the PHM, PHI and other community based cadres.

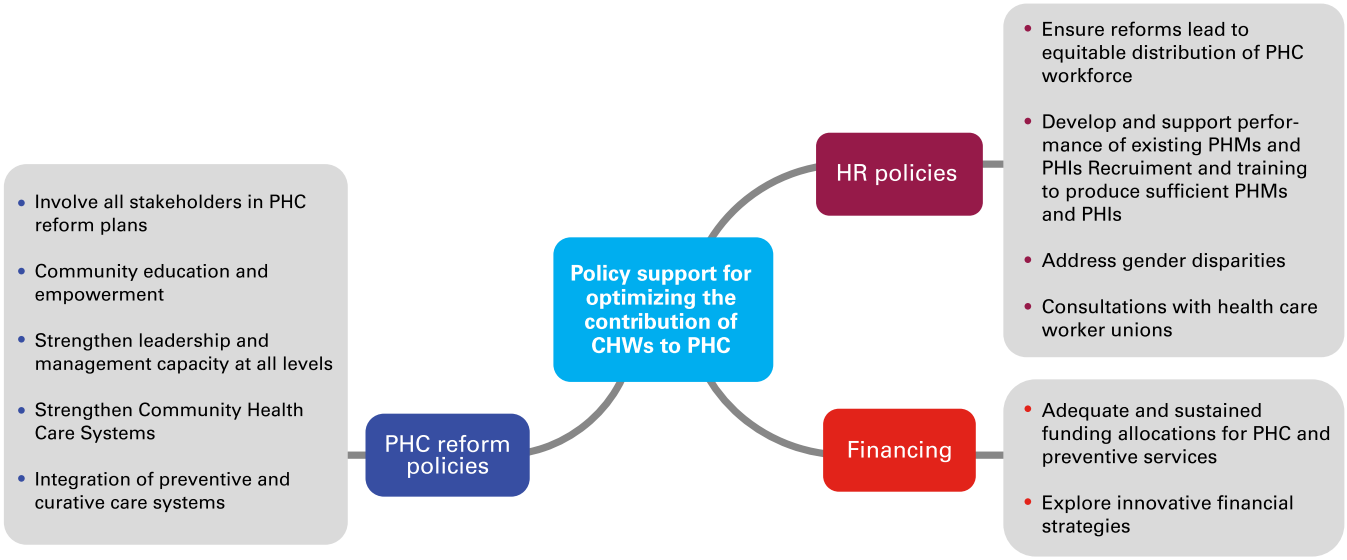
- The proposed PHC workforce interventions should be well managed at central and sub-national levels and any effects and impact on the PHC workforce monitored leading to the equitable distribution of an appropriate mix of health care providers at all service delivery points, including the community.
- HR policies should focus not only on improving the training and production of additional PHC cades, but also on developing and supporting the productivity and performance of existing PHMs, PHIs and other CHW cadres.
- The current CHW-population ratio is affecting the PHM's performance and their workload needs to be reduced. More robust recruitment, education and training policies and systems should focus on producing sufficient numbers.
- Gender disparities in the remuneration, planning, recruitment, deployment, retention and motivation of these cadres and the overall PHC workforce need to be addressed.
- Strengthening bipartite social dialogue mechanisms and processes with health worker unions could help to enhance consultations and negotiations, as well as joint action to protect and promote the interests of these providers.

Financing

There is a need for increased financing for health overall, but particularly, adequate funding allocations for public health and preventive services, including CHW programs. Mobilising resources for strengthening the existing preventive care workforce and improving performance and quality should be given equal attention.

Stakeholder collaboration and innovative financing strategies are needed to mobilise multiple sources of funding and resources, including community resources, along with efficiency gains to improve maternal and newborn health outcomes.

Figure 6: Policy support measures to optimize Community Health Worker programmes



System support improvements to optimise Community Health Worker cadres

Optimising Community Health Worker roles and responsibilities

Safeguarding the role of the Public Health Midwife in the provision of RMNCAH services

It is paramount that the well-established PHC preventive sub-system, for which the PHM is vital, continues to be safeguarded in order to sustain and build on its achievements, especially in the area of RMNCAH. Ongoing reforms on the strengthening of the PHC workforce such as the introduction of several new cadres and improving competencies and skills mix may provide opportunities to enable these CHW cadres maintain their focus on their core functions of addressing RMNCAH needs of women and children. Maintaining a focus on improving the quality of RMNCAH services should be a key consideration for future PHC planning, budgeting and programming.

Expanding the scope of work of Public Health Midwifes and Public Health Inspectors

There were conflicting views amongst key informants on whether the current roles of PHMs should be expanded. Despite other emerging health challenges such as NCDs, one view is that PHMs should continue to focus primarily on RMNCAH, otherwise the gains made in that area could be lost. However, a contrasting view is that the PHM's role should be expanded to provide total care for the family, including addressing the needs of the other family member and playing a more supportive role in NCDs.

If PHMs and PHIs are to play a role in NCD prevention and control efforts, within the scope of their current roles and responsibilities, appropriate system support, including training and supervision, compensation, and an enabling environment (transport, communications) will be required.

However, many PHMs already have multiple tasks and responsibilities, and any additional tasks and expectation related to NCD health promotion and education or other services should be clearly defined, documented in a revised Duty List or job description and communicated to all, and should not interfere with or undermine their ability to undertake their core RMNCAH and other functions.

Addressing differential needs and challenges

Different needs and challenges were identified in the provision of, demand for, and utilisation of community based health care and PHM and PHI services, across geographical areas – remote, rural and urban, as well across gender, ethnic and cultural dimensions.

Context specific approaches and appropriate CHW programming will be needed to respond to the particular needs of urban populations. Urban based CHW programs and cadres could be better oriented to reach working women, men, and adolescents. Urban-specific adaptations to CHW roles, and other innovations needed for strengthening CHW programs in urban settings need to be made.

Addressing Sexual and Gender-based Violence and harmful gender norms

The role of the PHM and other community health workers in the prevention of SGBV and the support of survivors could also be enhanced with further training and support. Through their work and community networks, PHIs are well positioned to ensure men and boys have access to the health and social services they need and to work with communities to challenge and change harmful gender and social norms.

Selection criteria and availability and distribution of Community Health Workers

Community involvement in selection

In Sri Lanka, the community does not participate in the recruitment process and is not consulted on the final selection. This needs to be addressed to ensure community involvement in Primary Health Care.

Addressing challenges in selection and availability

Adjusting the entry requirements to allow the selection of applicants without science subjects, and lowering requirements for underserved and remote areas where there are insufficient numbers with the prior education requirement will help address inequitable distribution of CHWs. Providing bridging or foundation courses to enable those without the required science subjects to gain the qualifications to meet the selection criteria would be a useful intervention. Reportedly, PHM professional associations and unions are opposed to such adjustments to the entry requirements, and this issue will need further discussion and consultations at this level.

Pre-service education (PSE), in-service training (IST) and Continuous Professional Development (CPD)

Improve training capacity

Improved training capacity in NTS and regional training institutes – including faculty, teaching methodology and instructional design, and infrastructure – is needed to enrol and train the required numbers. Establishment of dedicated midwifery training schools, and the recruitment of faculty, including midwifery tutors and preceptors, would help address gaps in training capacity.

Strengthening training system

The overall training system, including the quality, relevance and consistency of PSE, IST and CPD for these cadres needs strengthening. Review and revision of the PSE curricula to include and expand on components such as NCDs, BCC and SGBV is needed. The ratio of theoretical (12 months) to practical training (6 months) for PHMs could be revisited to ensure they have the skills, competencies, confidence and resilience for working alone in the community.

Remuneration and allowances

PHM's low remuneration is a factor in attracting sufficient numbers and their equitable distribution across the country. Greater efforts should be made to make PHM or PHI careers more attractive to young people. The allowances for housing and office maintenance particularly should be better aligned with market rates, in both rural and urban areas. Vehicles for transport and/or improved transport and communication allowances should be provided.

Career progression

The PHM career structure, which is unchanged since the start of this program, should be revised. The establishment of a midwifery degree program would help to attract and retain these cadres, and to enhance the midwifery profession. A pathway to midwifery tutor could be created. PHMs and PHIs with appropriate training and supervision could be considered for specialist NCD prevention and promotion roles. PHMs and hospital midwives could also be allowed lateral entry to become a nurse.

Supportive Supervision

A strength of the current system is the supervision that is provided by multiple levels of the health system; however, the process needs to be more coherent and coordinated, so that outcomes and recommendations are acted upon effectively and efficiently.

The supervision of these cadres could take a more supportive and participatory form and should be combined with more individual supervision. Increasing the availability and distribution of SPHMs and SPHIs, as well as strengthening their skills, competencies and attitudes is urgently needed. The duration of the current supervisory training program for SPHMs and SPHIs needs to be extended beyond the current three months. Supervision competencies could also be integrated into the pre-service education curriculum for these CHW cadres so that supervisees too get the most out of the supervisory process and effectively utilise constructive feedback to improve their practice.

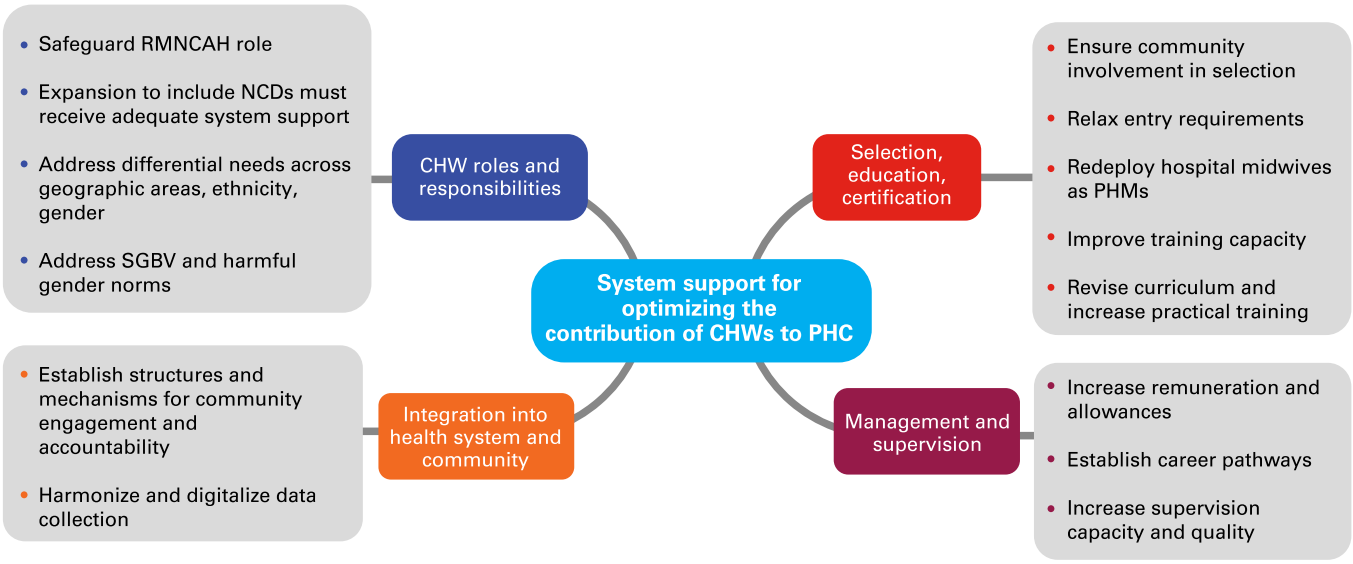
Community Health Worker integration into the health system and community

Accountability to the community rather than to health staff must be integrated into the programme through establishment of appropriate structures and mechanism for ensuring such accountability.

Data collection

Multiple stand-alone information systems that currently exist across the different programs should be harmonised and linked to with one information system which can be accessed by all units and programs. A move from the current paper-based system to an electronic one is necessary and urgent.

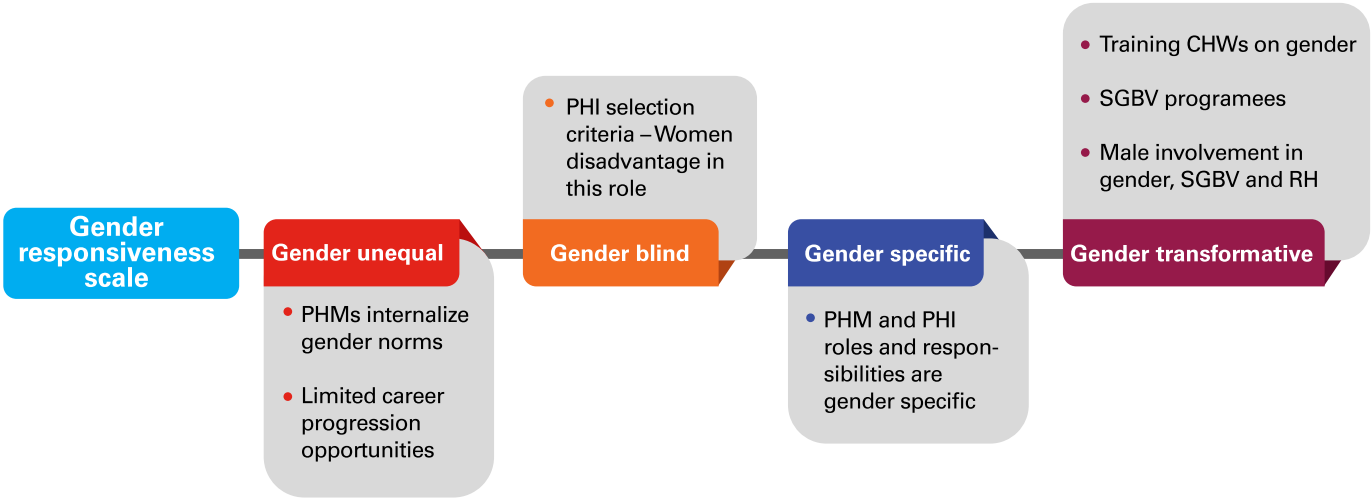
Figure 7: System support for Community Health Worker programmes



Making the Community Health Worker programmes gender transformative

More needs to be done to ensure policies and strategies are gender transformative. The figure below depicts some aspects of the CHW programme in Sri Lanka along the WHO gender responsiveness scale.

Figure 8: Gender responsiveness of the Community Health Worker programme



Key priorities for policymakers to promote gender equity in the PHM and PHI cadre include: recruitment and selection, safety and well-being, remuneration, and career progression opportunities. Women in CHW roles have increased agency and status in the community, which can be empowering for them and a force for change in the community. Continuous and ongoing sensitisation and training should be provided for PHMs to ensure that they themselves do not reinforce gender norms and perpetuate gender inequalities in their work because of their own gender norms.
Policymakers and implementers should consider gender dynamics during both the design and implementation of CHW programs to strengthen the equity and efficiency of such programs. It is imperative that health managers and health care providers are equipped with the knowledge and skills to address gender-based health inequities in their work.

Conclusions

It is recognised that policy and system support to realize the full potential of CHW programs and their contribution to PHC strengthening and UHC in Sri Lanka will require an all-of-government approach, sustained political commitment, predictable financing, robust leadership and governance, strong partnerships and multisectoral stakeholder collaboration, across health and other sectors, by levels of care and across professional boundaries.

The ongoing PHC reforms provide opportunities to create the enabling institutional, policy and operational environment to address the identified system support gaps and build stronger and sustainable PHC systems and workforces.

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Policy brief for Sri Lanka

Evaluation of South Asia's Current Community Health Worker Policies and System Support and their Readiness for Community Health Workers' Expanding Roles and Responsibilities within Post-Astana National Health Care Strengthening Plans

For Further Information:
UNICEF Regional Office for South Asia (ROSA)
P.O. Box 5815, Lekhnath Marg, Kathmandu, Nepal
Tel: +977-1-4417082 Email: rosa@unicef.org
Website: www.unicef.org/rosa/