HEALTH AND EDUCATION SECTOR COLLABORATION IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN SRI LANKA

A situational analysis and case study of the Kalutara District

Technical summary

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Key Messages

- Adolescent sexual and reproductive health (ASRH) issues are multi-factorial and are underpinned by biological as well as social determinants. These issues include sexual abuse, family dysfunction, poor parenting, poverty, low education and socio-cultural issues. In addition, service delivery gaps affect adolescent use of facilities and access to information. This complex environment demands inter-sectoral interventions and the collaboration of human resources (HR) beyond health.
- A minimum package of adolescent sexual and reproductive health services and a service delivery model should be developed between health and education sectors. This can address provider, knowledge and skills gaps, attitudinal issues, provide support and encourage team work thereby enhancing health outcomes for adolescents.
- Such a package requires workforce collaboration between primary health care workers, teachers and counsellors which should be fostered through cross cadre team-based approaches to education and training, clear referral pathways between sectors and performance management.
- This collaboration must be supported by appropriate ASRH policy, adequate funding, planning and legislation across both the health and education sectors.
- Adequate monitoring and evaluation of ASRH programs in the health and education sectors is needed and must take into consideration HR issues and broader contextual factors in order to contribute to on-going quality improvement of ASRH programs.

Overview

The World Health Organization (WHO) acknowledges the complex nature of adolescent health determinants and recommends that an inter-sectoral approach is required beyond the health sector. Cross cadre collaboration is therefore necessary across health, education, media and social services to realise large, sustained impacts on ASRH outcomes.

Providers note that **adolescents have little knowledge of contraception** which is not taught in the school curriculum.

This report outlines the results of a case study to identify factors that contribute to improving the ability of health and education providers to collaborate and develop ways forward for human resources policy and practice.

The Kalutara district in Sri Lanka was selected to explore cross cadre collaboration across the health and education sectors in ASRH, as the country has made considerable progress towards reducing maternal mortality and providing access to reproductive health and primary education (MDGs 5 and 2).

This Technical Summary paper provides a brief insight (2 pages only) into the longer full-text report which is available at www.hrhhub.unsw.edu.au

ASRH services and programs: issues and challenges

In focus group discussions and key informant interviews, health and education providers identified a number of adolescent needs for sexual and reproductive health knowledge, access to commodities and counselling.

There is a reported lack of school counsellors and comprehensive focus across the life skills curriculum. There is also a disconnection between information and contraceptive availability. Providers note that adolescents have little knowledge of contraception which is not taught in the school curriculum, however, condoms and emergency contraceptives are available for them to purchase in pharmacies.

Participants noted that low adolescent use of health and counselling services was linked to perceived lack of confidentiality, as well as the low confidence and motivation of providers. ASRH services were seen as a low priority and, despite several programmatic efforts, these were usually short term, poorly supported and sector specific. This resulted in poor adolescent awareness, as well as low demand and participation.

Providers reported that parental support for providing knowledge and access to ASRH information is often absent

and, coupled with an unstable home environment, can contribute to the lack of openness about such matters. Some providers felt that this needed to be changed through greater parental involvement, as well as a focus on broader health programs developed within schools.

These efforts could be strengthened through the involvement of other sectors, such as the garment factory industry, in health promotion programs. This would serve to capture not only teenagers who have left school, but also those working in jobs after school.

The research provides a number of examples of ASRH education, counselling and clinical services that are provided by MoH and MoE. They do not, however, appear to be in regular communication and there is a lack of a coordinated approach to the provision of services. Similarly, programs involving schools are not always aligned with the curriculum.

Policy was regarded by the participants as a critical component in enhancing their ability to deliver quality service and information, as well as supporting and guiding a multi-professional approach across the sectors. They referred to policy not only at national level, but also at the facility level, to guide practice. It is therefore important to involve health and education providers in the development of policy in ASRH.

Providers need to be consulted at key stages to ensure policy is not only appropriate and relevant but well supported to facilitate effective implementation.

Recommendations

Recommendations are made in four key areas as outlined below:

Pre-service inter-professional education and training

- Development of an in-service joint education and health provider training program with focus on ASRH knowledge acquisition, skills building and attitude evaluation
- Specialised training for teacher counsellors
- Cultural competency training for non-government organisations (NGOs)
- Program planning and evaluation training should be incorporated into the pre and in-service training of health and education workers with ASRH included as a context example
- Media and social marketing training for health and education providers

Team performance management system

- Development of comprehensive job descriptions verified in writing and acknowledged by management
- Formalised recruitment policy for dedicated teacher counsellor roles
- Development of performance assessment indicators which reflect ASRH health targets

Monitoring and evaluation

- Quality improvement processes to ensure ASRH programs are accessible, appropriate and acceptable – informing workforce roles and management
- Involvement of other sectors in this process including parents, NGOs and community organisations which will feed into planning programs and services

Inter-sectoral policy, planning and financing

Joint Health and Education ministries policy to:

- Clarify roles and responsibilities of health workers, teachers and teacher counsellors
- Facilitate better linkage between services, information provided through the school curriculum and commodity availability
- Ensure appropriate resourcing and long term vision
- Gain buy-in from multiple stakeholders
- Partner with the media and the Ministry of Communication to develop guidelines for responsible reporting and media coverage of ASRH including editorial and programming policy within media agencies, training journalists and resources to assist script writers to insert ASRH issues into story lines

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