A mental health human resources strategy for Sri Lanka

H Minas

Sri Lanka is justly famed for, and proud of, the remarkable progress made in population health, well beyond what might be expected based on national income. These gains have no doubt been correctly attributed (1) to government leadership in matters such as public universal education and health services, the creation of community-level public health infrastructure, immunisation coverage, maternal and child nutrition, and training of and support for health workers. Despite the 2004 tsunami and the long-running armed conflict there has been a substantial improvement in the Human Development Index (HDI) since 1990 (2). Sri Lanka has the highest HDI in South Asia. Although disparities between regions and social groups continue to exist the poorest regions of the country are receiving increased attention, in line with the commitment to equity of the National Development Programme.

The national development programme (3) identified “absence of a realistic approved cadre, imbalance in the recruitment and production of different categories of staff, geographic inequity, imbalances in deployment and a disparity between expected job performance and training, including quality of training” as key problems for human resource development. The human resources for health situation analysis commissioned by the Ministry of Health and published in 2009 (4) noted that the issues identified in national development programme “have persisted over several decades [and] have been documented in various policy documents though no concrete action has followed”. Based on the situation analysis (4) the Human Resources for Health Strategic Plan (2009-2018) (5) highlighted a wide range of problems, which are summarised in the Table 1.

The HRH strategic plan was adopted in 2009 and it may be that many of the problems identified in the strategic plan have been resolved. However, many of the identified problems persist in the mental health system. In relation to mental health the HRH situation analysis noted that “Development of the country and the pressure and demand it exerts on the younger population may lead to increase of NCDs and mental health conditions in the future… The recently concluded conflict in the North and East has led to the need of rehabilitation of many young victims of war both mentally and physically in the future and the health sector has an important role to play in that scenario… There is an imperative need to look at the community level mental healthcare services in future reforms in HRH in Sri Lanka” (4). It was further suggested that “policy changes may be required in integrating public health and curative services at Primary Health Care level to include care of the elderly, Chronic NCD care and Mental Health services and in stren-...
1. HRH Policy Development and Planning

2. HRH Training and Production
   2.1. Recruitment. Recruitment of trainees ineffectively aligned with staffing requirements.
   2.3. Degree programs. Production of health professionals is not based on service needs. Inadequate planning for absorbing allied health graduates into services.
   2.4. In-service programs and continuous professional development (CPD). Absence of regular in-service programs for most categories of staff to update their competencies. CPD programs not well established.
   2.6. Private sector. Numbers of trained nurses and other allied healthcare categories are below requirements of the private sector. Public sector health professionals working part-time in the private sector.

3. HRH Management
   3.1. Weak human resources management capacity. No single unit or person responsible for human resources across the sector. Timely information on HRH not available to decision makers.
   3.2. Inadequate human resource management (HRM) staff development. Low productivity of HRM staff.
   3.3. Lack of coordination of HRM functions. Delays in personnel management (appointments, promotions, payments, etc.). Inadequate coordination between supply side and demand side units.
   3.4. Unsatisfactory working conditions. Work environment for some is not conducive to productive work.
   3.5. Workforce distribution, processes and procedures are not conducive to productive work. Inequities in workforce distribution.
   3.7. Decentralisation. Decentralised system has led to difficulties in transferring staff in and out of provinces.
   3.8. Trade union influence. Trade union actions.
   3.9. Productivity and quality improvement and performance appraisal. Human resources not optimized to enhance health sector performance. Low workforce productivity.
   3.10. Attitudes: Symptomatic responses to problems, mainly through political decision makers.

Table 1. HRH problems identified in the Human Resources for Health Strategic Plan

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Officer of Mental Health (MoMH)</td>
<td>1</td>
</tr>
<tr>
<td>Community Psychiatric Nurses (CPN)</td>
<td>2</td>
</tr>
<tr>
<td>Public Health Inspector (PHI)</td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation workers</td>
<td>2</td>
</tr>
<tr>
<td>Psychosocial workers</td>
<td>at least 3</td>
</tr>
</tbody>
</table>

The Action Plan specified additional mental health staff for each district, and minimum staff for each acute psychiatric unit and for intermediate care units that included trained nurses, psychologists, social workers and occupational therapists. The plan envisaged a comprehensive training plan and identified the categories of mental health workers who would require training, and suggested the minimum duration of training, who would do the training and a very brief indication of the content of training.

Although progress has been made in a number of areas, many of the targets are far from being achieved, due primarily to the absence of a strategic plan for achieving the identified objectives. There is an urgent need to develop a comprehensive mental health human resources strategy (13). The strategy would need to be fully aligned with the Human Resources for Health Strategic Plan (2009-2018) (5), and should be guided by the WHO HRH Action Framework (14).

The current process of revision of the national mental health policy represents an opportunity to ensure that the effort to continually improve the mental health system does not neglect the most vital component of the mental health system, the mental health workforce. Without adequate numbers of skilled health workers, who are equitably distributed, adequately remunerated and encouraged and supported to continuously improve performance, other important elements of the national
mental health policy cannot be effectively implemented and population mental health cannot be improved. Implementing and continuously monitoring and evaluating a comprehensive human resources for mental health strategy will require creative and sustained leadership at all levels and among all stakeholder groups, investment in education and training capacity and in the mental health service system, and strengthening of health management information systems.

Although all stakeholders must be engaged, psychiatrists should be particularly active in the creation and implementation of an HRMH strategy since, in addition to direct clinical work, they will be increasingly responsible for: a) leading multi-disciplinary mental health teams; b) training, supervising and mentoring other mental health workers; and c) ensuring the highest possible mental health system performance for the population they serve.

H Minas, Head, Global and Cultural Mental Health Unit, Centre for Mental Health, School of Population and Global Health, The University of Melbourne
E-mail: h.minas@unimelb.edu.au

References