KRISHNI RATNAM

Elective report

Subject- Community Medicine (Public Health and Primary Care)

Location- Sri Lanka

I did my elective with the University of Colombo's Community Medicine department. Community medicine in Sri Lanka covers both Public Health and certain aspects of Primary Care. I spent most of my time at various government public health departments and also the medical officer of health (MOH) office in Pitta-Kotte, which is essentially a community level health outpost, where I observed clinics and other multi disciplinary members which addressed certain social determinants of health. The purpose of this elective is to determine how community medicine actually works in Sri Lanka and the differences between Sri Lanka and the UK.

Background

Sri Lanka is a tropical lower middle income island situated roughly 30 km off the coast of India to the south. It has various landscapes ranging from the flatlands of the coast to the central highlands. It is governed by a democratic parliament, with 9 provincial councils with their own separate powers and each province is then further divided into smaller divisions beneath them. This can be seen reflected in how its health system is divided as each province itself has its own powers determine what their own region needs. The system itself is similar to the UK health system in allocating health resources according to geography, albeit this really only extends itself to preventative medicine as opposed to curative medicine facilities.

Sri Lanka's health system- preventative versus curative

Preventative medicine resource allocation, which is what community medicine concerns itself the most about, is geographically divided into provinces, then regions and then divisions. At the divisional level, these areas are lead by a physician known as the medical officer of health (MOH). As such these areas are also known as MOH areas. The MOH is then helped by other physicians (Additional MOHs). The MOH area I was in was also covered by the university's community medicine faculty and so provided their own physicians as well. The MOH area is then also serviced by public health inspectors (PHIs), public health nurses (PHNs) and public health midwives (PHMs), each with their own role to play. PHIs cover communicable disease surveillance (for example the MOH I was with was currently running a special campaign covering dengue fever), water/ food safety, sanitation, school health, occupational health and building safety. PHMs are the first point of call for women seeking antenatal/ postnatal care and also helps register women of a child bearing age for family planning (if they meet certain eligible criteria). PHNs help with running clinics and undertake certain tasks such as administering vaccinations.

The clinics provided at the MOH office (and also through other mobile clinics) are based on the idea of the life cycle. Starting from birth the "well baby clinic" covers infants up until they attend school, at which the school program takes over. The well baby clinic monitors the baby's growth and milestones, nutrition and supplement provision (e.g. vitamin A), mother's health, and also vaccinations. Assuming that the child is a female, usually once she is newly married she will be

registered and invited to attend family planning clinics. If she were to become pregnant she will then be registered to attend antenatal classes (and will also be referred on to the obstetrician). Once a woman reaches the age of 35 she is then further invited to attend the "well woman" clinic where screening for various non communicable diseases and cervical cancer takes place, along with health promotion. Health promotion occurs at both an individual level but also through various group sessions set on specific days covering different topics. The university has also piloted a new clinic which covers elderly care for both males and females, starting from the age of 40 (although mainly aimed at over 60s) but is hoped to be extended to cover those aged 35. In light of Sri Lanka being in the final phase of its demographic transition, this clinic will be implemented across the rest of the country and hopefully cover this group, especially men, which had been neglected in the past.

The geographical coverage of preventative medicine does not occur with curative medicine. Curative medicine aspect of the Sri Lankan health system allows anyone to access any hospital and any particular service in any place. In terms of primary care access for minor ailments these occur at separate institutions from the MOH; the central dispensaries and divisional hospitals (which have some inpatient facilities). Sometimes these central dispensaries carry out some of the clinics run by the MOH but don't necessarily have to. The staffing at these dispensaries are variable although there will always be a physician (who simply needs to hold an MBBS) or an assistant medical officer, similar to the "barefoot doctors" in Maoist China, in that they have received less training (although this type of staff has been slowly phased out as there are no new trainees). Whilst healthcare is provided free through the government there are also a number of private facilities as well, including private general practitioners.

Alongside the MOH system there are also special campaigns which target specific diseases as a vertical program. These diseases are typically communicable diseases and are set up at the regional level but can vary in how they are set up in terms of utilising the MOH staff across the regions. Regardless there are meetings with both the regional staff in these special programs and MOH staff and there is some flexibility in utilising resources from both teams in certain situations. An example of this is how the special program targeting rabies works with the MOH; the regional medical officer in charge of the program have their own PHIs but also use information gathered from the MOH's PHIs in order to evaluate the situation. Disaster relief is structured in a similar way.

The MOH, special programs and disaster relief receive advice from their respective line ministries (the central level), and feedback data to them. So whilst power over health resource allocation is largely decentralised to the smaller regions, there is still a central level presence in the form of providing advice and data collection, and for certain situations they take responsibility for implementing the program if there isn't a dedicated regional office.

Differences between the UK and Sri Lanka

The main difference between how the UK health system works in primary care is that mainly falls under the remit of the general practitioner and their MDT at the lowest level. In order to access non urgent secondary care, all patients in the UK must go through the GP, unless they go through private services. The GP undertakes both the responsibilities seen in central dispensaries and the medical clinics undertaken by the MOH. The GP also has more staff and facilities used to target the medical aspect of health, allowing them to also take responsibility over chronic disease management as opposed to leaving this to the hospital outpatient department. However primary care in the UK, in

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the GP setting does not cover the wider social determinants such as sanitation. This is left to a different authority and therefore primary care is far more distinguishable from the Public Health services. In the UK, Public Health is divided into geographical areas but cover much larger areas than a GP catchment area. In Sri Lanka, the MOH office serves as a base for which both public health services and preventative primary care services work together in order to evaluate what needs to be done in the same area at the same level. In the UK unless a health issue such as epidemic arises, these services are largely kept separate. This system arrangement is probably due to the UK having a different disease profile, greater resources and also a lack of hygiene/ sanitation issues, resulting in there being less of a need to work together on a more frequent basis. Nevertheless the system in Sri Lanka allows public health surveillance to be more specific and hold more autonomy over smaller areas, whilst still being able to escalate to higher levels if needed, which should ensure more efficiency and more targeted initiatives being used, which is something which the UK can learn from. Screening for non-communicable diseases (not just cancer) as a preventative measure is also something which the UK could consider given its prevalence and cost to manage.