PRIMARY HEALTH CARE IN SRI LANKA

Dr. Marcus Fernando

In 1977 the Thirtieth World Health Assembly decided that the main social target of governments and the WHO in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life".

In 1977 the government pledged itself to "restore the high standard of health care and disease prevention that existed earlier, and make further improvements in our health services, particularly in the rural areas through both Ayurvedic and Western systems". This commitment was further strengthened when in 1980 the government signed the Charter for Health Development with the World Health Organisation, thereby formally endorsing the concept of "Health for all by the year 2000" with Primary Health Care as the key approach.

Primary Health Care is essential health care based on practical, scientifcally sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community, through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an intergral part of both the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

The government provides health care free of charge to the entire population of Sri Lanka through a network of over 900 institutions scattered throughout the country and a cadre of about 40,000 health personnel. The services provided are curative and preventive. Preventive services are provided by the Medical Officers of Health through their field staff by home visits and through ante-natal, well-baby and Family Planning Clinics. Curative services are provided through a variety of institutions ranging from visiting stations to base and provincial hospitals. Prevention and control measures in relation to malaria, filaria, leprosy, sexually transmitted diseases and respiratory diseases (T. B.) are carried by vertically organised special campaigns.

Significant progress has been made in improving the health status of the people in Sri Lanka during the last four decades as indicated by the indices for infant mortality, maternal mortality and crude birth and death rates.

Infant Mortality 19/1000 live births
Maternal Mortality 0.6/1000 live births
Crude Birth Rate 21/1000 population
Crude Birth Rate 6/1000 population

While these indices are encouraging, these national averages tend to mask the numerous deficiencies that exist in the present health system. Some of these deficiencies are:-

* Lack of pure water for drinking, to a majority of the people.
* Lack of proper sanitation.
* Prevalence of malnutrition, both chronic and acute.
* Inadequate attention to risk groups.
* A weak referral system.
* A wide gap between service providers and the people.
* Prevalence of communicable diseases such as malaria, dengue, diarrhoea, infective hepatitis, dysentry etc.
* Increase in non communicable diseases.
* Rapid increase in population.
* Absence of coordination between preventive and curative services.
* Underutilization of services and institutions.
* Lack of manpower.
* Uneven distribution of health resources.
* Overemphasis on curative services.
* Lack of community participation.
* Increasingly complex nature and cost of health care.

Inability of the health care delivery system to provide the basic health care needed by the individual or family warranted a radical change in the existing health system and a draft proposal for PHC emphasized a change in strategies.

The corner stones of these strategies were as follows:-

(a) The establishment of a National Health Development Network to ensure intra-sectoral and inter-sectoral coordination for health development activities.

(b) Decentralization of health administration.

(c) Identification and prioritization of PHC components for implementation.

(d) The development of an implementation model for subsequent application on a national scale.

The main objectives of thes strategies are:-

(a) To strengthen peripheral health services with increased reliance on community participation and promotion of self reliance.

(b) Guarantee a basic package of health care to all people which consist of 17 areas of activeity:-

1. Proper and adequate nutrition.
2. Safe water.
3. Basic sanitation and hygiene.
4. Maternal care.
5. Child care with emphasis on the infant and pre-school child.
6. Family Planning.
7. Immunization.
8. Prevention and control of common communicable diseases.
9. Prevention and control of common non communicable diseases.
10. Appropriate and early management of common minor ailments and injuries.
11. Simple rehabilitation.
12. Mental Health.
13. School Health.
14. Oral Health.
15. Occupational Health.
16. Prevention of Blindness and Visual Impairment.
17. Health Education and community organisation for PHC.

(c) Promote integrating preventive and curative services.

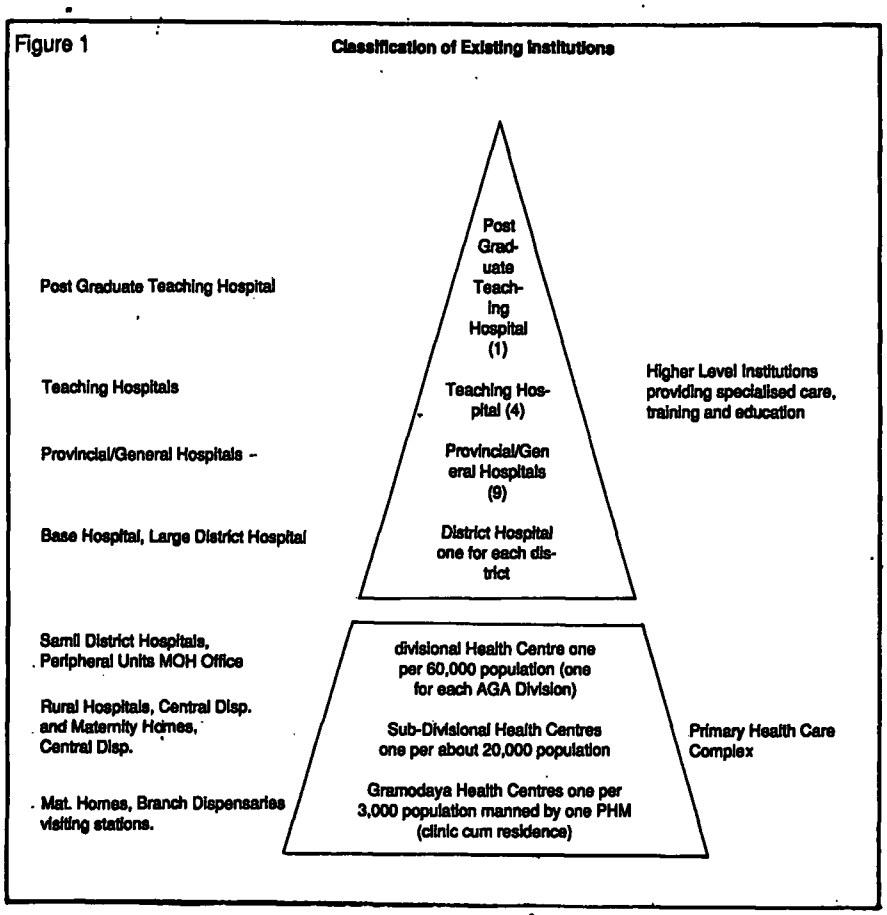
(d) Promote better utilization of peripheral institutions.

(e) Promote cooperation between health and other services.

The Model for Delivery of Health Services by the Ministry of Health. See Figure 1

(a) At the base of the pyramid will be the Gramodaya Health Centre, headed by a midwife, one for each Grama Sevaka area. The Public Health midwife (Family Health Worker) will be one of the first points of contact for the people with the health care delivery system and will provide a comprehensive package of primary health care services as described above and determined by her level of training and competance. The gramodaya Health Centre will receive adequate referral, managerial and logistic support from the higher levels.

Figure 1



This basic functional unit of the Gramodaya is responsible for delivery of health services to an average population of 3000. The Public Health Midwife will reside in her area. It is planned to provide all public health midwives with residential quarters and a clinic room.

(b) Above the Gramodaya Health Centre, will be the Sub-Divisional Health Centre. This institution will be under a Reg. Medical Practioner/Asst Medical Practioner and have only out-patient facilities. Two PHII, a Supervising Public Health Midwife and a Public Health Midwife will be attached to this place. They will work both in the institution and in the field and provide comprehensive services, up to their capability and the facilities available. Patients will be referred to the Divisional Health Centre or the District Hospital, depending on their condition. As no downgrading of existing institution is envisaged, all Rural Hospitals, Central Dispensaries and Maternity Homes, numbering about 538 will be classified as Sub-Divisional Health centres. Eventually each AGA Division will have about 2-3 Sub-Divisional Health Centres, each serving a population of 20,000 population.

(c) At the next level will be the Divisional Health Centre, one for each Divisional Asst. Govt. Agent area. These institutions will provide all health care services including in-patient care and will be headed by a Medical Officer. The majority of the District Hospitals and all Peripheral Units will be converted into this category in the first instance. The service function of the (MOH) Health Units will be incorporated into these Divisional Health Centres. All the present staff will be absorbed into these Health Centres. Divisional Health Centre will be a 60 bed hospital. The Medical Officer in charge known as the District Health Officer will be responsible for the health of the 60,000 population of his area. This institution will provide essential health care to a population of 3000 around the centre and also function as a referral centre (to examine and treat patients that are referred from sub-divisional and gramodaya health centres) for its population of 60,000.

(d) The proposed structure will have at its apex the higher level health institu-

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tions such as Teaching Hospitals, Specialised Hospitals and Provincial Hospitals as at present. The present Base Hospitals will remain as they are with the number increased to have one such hospital for each Administrative District. To be in line with this geographical basis, these hospitals will be redesignated as District Hospitals. However, in districts that have an existing Provincial Hospital (General Hospital) it would serve the function of the district referral centre. It is possible due to local variations and the policy of not downgrading any existing institutions certain districts would have more than one such institution.

They will at least provide general medical care as well as medical care in the main four specialities and will be the basic referral units.

The model worked out is being implemented in 33 AGA divisions with the assistance of the Asian Development Bank at a cost of US 9 million. The whole programme is estimated to cost US $ 170 million. It is to be implemented over a period of 10 years.

Progress in Implementation

One of the most significant and practical steps taken towards the achievement of the HFA goal is the successful establishment of the National Health Development Network (NHDN). The National Health Council and the National Health Development Committee are two important constituents of the NHDN.

The National Health Council was established in March 1980 under the chairmanship of the Hon.Prime Minister and Hon. Ministers from Health related Ministries. This council provides political leadership necessary for implementation of HFA activities.

The National Health Development Committee is chaired by the Secretary, Ministry of Health and has as its members the secretaries of all the ministries represented in the National Health Council and a few senior officials from related departments.

The 3 tier model that was developed for the delivery of PHC was expected to assure comprehensive coverage, logistics, referral and supervising support.

The proposed structure can be looked at as a pyramid. See Figure 1.

The model worked out has been implemented on a pilot basis in certain AGA divisions.

To further strengthen the preventive health services, it is proposed to appoint one medical officer of health per AGA division, and it is hoped that by 1992 one such officer would function in each AGA division, with a total of over 280 Medical Officers of Health in the island.

The PHC proposals calls for community participation and involvement as a key strategy. Active involvement of people individually as well as collectively for solution of health problems is considered indispensable, and more and more emphasis is being placed on community participation through involvement of volunteers and community leaders at grass roots level in the implementation of health programmes.

It is anticipated that by these measures deficiencies stated would be overcome to a considerable extent by the year 2000 or before and that essential health care would be provided to the entire population on a continuing basis.