A model Family Health Center for rural settings in Sri Lanka – a case study

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Introduction

The "Community Oriented Primary Care" framework was developed in 2011 by the Department of Community and Family Medicine, Jaffna. With support from the Ministry of Health, World Bank, University and other donors, the Family Health Center (FHC) was launched in 2012. It was conceived as an innovative model for a community-based intersectoral approach to health care. The FHC was also envisioned as a practical training ground for medical students in primary care and family medicine. Working within the jurisdiction of the Nallur MOH Area – also the University Field Project Area – the FHC began operations in a building adjacent to the Divisional Hospital Kondavil.

In its first phase of operation spanning six years, the FHC has served patients through over 5,000 in-clinic and home visits as well as community screening, health educational events and yoga classes. Interviews with various stakeholders indicate that the activities of the FHC are effective and highly valued. However, several challenges confront the FHC and must be addressed so that it can optimize operations and serve as a model that can be replicated across the country.

Case presentation

The FHC collaborates with the Divisional Hospital for clinical and administrative services. When needed, patients are referred to the professorial units at the Teaching Hospital Jaffna for specialist care. The current operational team includes a family physician, a public health nursing sister, nursing officer, community health assistant, public health inspector, part-time technical officer with medical laboratory technician training and lab assistant. Interviews were conducted with the FHC supervisory and operational teams, patients and their family members, community representatives and medical students. Their qualitative responses about the FHC were recorded and analyzed. The challenges that were identified are summarized below:

A: Challenges from perspective of **clinical staff:**

1. Community and patient responsibility – Given the history of health services in Sri Lanka, patients tend to view their health management as the responsibility of physicians and the health system.
2. Patient education, monitoring and compliance – The wide range of educational levels and individual knowledge of healthcare and medical terms among patients requires different approaches in doctor-patient interactions while ensuring compliance with medical instructions.
3. Patient records – With the current system, patients are given a number and retain their clinical book. Their corresponding drug book is kept at the clinic. Both books are taken by the patient to the pharmacy for dispensation of prescriptions. If the patient loses the books, their entire record is lost. Paper slips stapled to the books have been accidentally dislodged resulting in dispensation errors. Errors also occur when healthcare providers are busy and fail to cross-check and verify the patient's history and previous prescription.
4. Referral and follow up back-referrals – There are no systematic procedures for referrals. Patients may be placed on a waiting list and not receive a timely appointment. In other cases, they may be seen by the specialist but there is no mechanism for back-referral to the FHC, resulting in loss of continuity of care.
5. Staffing – The high work load and increasing patient numbers highlight problems arising from personnel shortage at each level of clinical service.
6. Training – Staff indicated the lack of time and opportunity for continuing education and professional development.
7. Teamwork – Staff tended to focus on their own specific areas of expertise and responsibility which was often times detrimental to the smooth flow of service. There is a need for sustainable mechanisms of engaging other stakeholders and services.
8. Equipment – The FHC currently has about 80% of the equipment needed for primary care delivery. Deficiencies have been identified due to resource constraints.

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B: From perspective of **patients and other stakeholders**

Challenges identified by this group that are already indicated in section A are not included below.

1. Access to and frequency of care – Patients cited a range of reasons including distance, over-crowding, long waits without appointment times and possible infection through exposure to other sick people as reasons for not accessing a FHC or other public health service.

2. Perception of quality and seniority – Although citing the cost factor, patients viewed private doctors and consultants as being more trained and experienced compared to public sector physicians.

Conclusion

In its first six years of operation, the FHC is widely recognized as providing a critical service in community-oriented healthcare. While the model is meeting expectations, several challenges were identified through a qualitative interview process of stakeholders. Optimization of the FHC model and its utility in being implemented across Sri Lanka for a comprehensive approach to primary healthcare delivery will benefit from further investigation of constraints and developing solutions to these challenges.

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