WEEKLY EPIDEMIOLOGICAL REPORT

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WEER SRI LANKA - 2010

Good care is about people (Part1)

"On 03rd September 2010 many distinguished medical and non medical professionals met in a national scientific and policy forum on 'Strengthening Healthcare at the Primary Level' organized by the Planning Unit of the Ministry of Health, Sri Lanka to discuss how Sri Lanka should adopt the Primary Healthcare model suggested by the World Health Organization."

Biomedical science is, and should be, at the heart of modern medicine. Yet, as William Osler, one of its founders, pointed out, "it is much more important to know what sort of patient has a disease than what sort of disease a patient has". Insufficient recognition of the human dimension in health and of the need to tailor the health service's response to the specificity of each community and individual situation represent major shortcomings in contemporary health care, resulting not only in inequity and poor social outcomes, but also diminishing the health outcome returns on the investment in health services.

Putting people first, the focus of service delivery reforms is not a trivial principle. It can require significant even if often simple departures from business as usual. The reorganization of a medical centre in Alaska in the United States, accommodating 45 000 patient contacts per year, illustrates how far-reaching the effects can be. The centre functioned to no great satisfaction of either staff or clients until it decided to establish a direct relationship between each individual and family in the community and a specific staff member. The staff were then in a position to know "their" patients' medical history and understand their personal and family situation. People were in a position to get to know and trust their healthcare provider, they no longer had to deal with an institution but with their personal caregiver.

Complaints about compartmentalized and fragmented services abated. Emergency room visits were reduced by approximately 50% and referrals to specialty care by 30%; waiting times shortened significantly.

With fewer "rebound" visits for unresolved health problems, the workload actually decreased and staff job satisfaction improved. Most importantly, people felt that they were being listened to and respected, a key aspect of what people value about health care. A slow bureaucratic system was thus transformed into one that is customer responsive, customer owned and customer-driven.

In a very different setting, the health centres of Ouallam, a rural district in Niger, implemented an equally straightforward reorganization of their way of working in order to put people first. Rather than the traditional morning curative care consultation and specialized afternoon clinics, the full range of services was offered at all times, while the nurses were instructed to engage in an active dialogue with their patients. For example, they no longer waited for women to ask for contraceptives, but informed them, at every contact, about the range of services available. Within a few months, the very low uptake of family planning, previously attributed to cultural constraints, was a thing of the past.

People's experiences of care provided by the health system are determined first and foremost by the way they are treated when they experience a problem and look for help: by the responsiveness of the health-worker interface between population and health services. People value some freedom in choosing a health provider because they

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want one they can trust and who will attend to them promptly and in an adequate environment, with respect and confidentiality. Healthcare delivery can be made more effective by making it more considerate and convenient, as in Ouallam district. However, primary care is about more than shortening waiting times, adapting opening hours or getting staff to be more polite. Health workers have to care for people throughout the course of their lives, as individuals and as members of a family and a community whose health must be protected and enhanced, and not merely as body parts with symptoms or disorders that require treating.

The service delivery reforms advocated by the PHC movement aim to put people at the centre of health care, so as to make services more effective, efficient and equitable. Health services that do this start from a close and direct relationship between individuals and communities and their caregivers. This, then, provides the basis for person- centredness, continuity, comprehensiveness and integration, which constitute the distinctive features of primary care.

The distinctive features of primary care

Effectiveness and safety are not just technical matters

Healthcare should be effective and safe. Professionals as well as the general public often over-rate the performance of their health services. The emergence of evidence based medicine in the 1980s has helped to bring the power and discipline of scientific evidence to healthcare decision making, while still taking into consideration patient values and preferences.

Over the last decade, several hundred reviews of effectiveness have been conducted, which have led to better information on the choices available to health practitioners when caring for their patients. Evidence-based medicine, however, cannot in itself ensure that health care is effective and safe. Growing awareness of the multiple ways in which care may be compromised is contributing to a gradual rise in standards of quality and safety. Thus far, however, such efforts have concentrated disproportionately on hospital and specialist care, mainly in high and middle income countries. The effectiveness and safety of generalist ambulatory care, where most interactions between people and health services take place, has been given much less attention. This is a particularly important issue in the unregulated commercial settings of many developing countries where people often get poor value for money.

Technical and safety parameters are not the only determinants of the outcomes of health care. How services deal with people is also vitally important. Surveys in Australia, Canada, Germany, New Zealand, the United Kingdom and the United States show that a high number of patients report safety risks, poor care coordination and deficiencies in care for chronic conditions. Communication is often inadequate and lacking in information on treatment schedules.

Nearly one in every two patients feels that doctors only rarely or never asked their opinion about treatment. Patients may consult different providers for related or even for the same conditions which, given the lack of coordination among these providers, results in duplication and contradictions.

There has, however, been progress in recent years. In high-income countries, confrontation with chronic disease, mental health problems, multi-morbidity and the social dimension of disease has focused attention on the need for more comprehensive and person centered approaches and continuity of care. This resulted not only from client pressure, but also from professionals who realized the critical importance of such not enough. How services deal with people is also vitally important. Surveys in Australia, Canada, Germany, New Zealand, the United Kingdom and the United States show that a high number of patients report safety risks, poor care coordination and deficiencies in care for chronic conditions. Communication is often inadequate and lacking in information on treatment schedules.

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In low-income countries, this evolution is also visible. In recent years, many of the programmes targeting infectious disease priorities have given careful consideration to comprehensiveness, continuity and patient-centredness. Maternal and child health services have often been at the forefront of these attempts, organizing a continuum of care and a comprehensive approach. This process has been consolidated through the joint UNICEF/WHO Integrated Management of Childhood Illness initiatives. Their experience with programmes such as the WHO's Extended Programme for Immunization has put health professionals in many developing countries a step ahead compared to their high income country colleagues, as they more readily see themselves responsible not just for patients, but also for population coverage. More recently, HIV/AIDS programmes have drawn the attention of providers and policy makers to the importance of counselling, continuity of care, the complementarity of prevention, treatment and palliation and critically, to the value of empathy and listening to patients.

Source: World Health Organization

to be continued

Table 1: Vaccine-preventable Diseases & AFP

21st - 27th August 2010(34th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2010	Number of cases during same week in 2009	Total number of cases to date in 2010	Total number of cases to date in 2009	Difference between the number of cases to date in 2010 & 2009
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	01	01	00	00	00	00	00	00	00	02	01	60	50	+ 20.0 %
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	-
Measles	00	00	00	00	00	00	00	00	00	00	04	67	109	- 38.5%
Tetanus	00	00	00	00	00	00	00	00	00	00	00	16	18	- 11.1 %
Whooping Cough	00	00	00	00	00	00	00	00	00	00	03	20	40	- 50.0 %
Tuberculosis	02	08	01	08	17	00	20	06	00	62	248	5942	6674	- 11.0 %

Table 2: Newly Introduced Notifiable Disease

21st - 27th August 2010(34th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2010	Number of cases during same week in 2009	Total number of cases to date in 2010	Total number of cases to date in 2009	Difference between the number of cases to date in 2010 & 2009
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	12	03	06	00	06	14	07	02	01	51	144	2281	11800	- 80.7 %
Meningitis	02 CB=1 GM=1	02 ML=2	02 GL=2	00	07 KM=4 TR=3	02 KN=2	03 AP=3	00	01 KG=1	19	49	1187	739	+ 60.6 %
Mumps	06	05	05	01	06	06	01	03	06	39	48	764	1282	- 40.4 %
Leishmaniasis	00	00	01 HB=1	00	00	00	02 PO=2	00	00	03	08	223	505	- 55.8 %

Key to Table 1 & 2

Provinces: W: Western, C: Central, S: Southern, N: North, E: East, NC: North Central, NW: North Western, U: Uva, Sab: Sabaragamuwa.

DPDHS Divisions: CB: Colombo, GM: Gampaha, KL: Kalutara, KD: Kandy, ML: Matale, NE: Nuwara Eliya, GL: Galle, HB: Hambantota, MT: Matara, JF: Jaffna, KN: Killinochchi, MN: Mannar, VA: Vavuniya, MU: Mullaitivu, BT: Batticaloa, AM: Ampara, TR: Trincomalee, KM: Kalmunai, KR: Kurunegala, PU: Puttalam, AP: Anuradhapura, PO: Polonnaruwa, BD: Badulla, MO: Moneragala, RP: Ratnapura, KG: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008.

Dengue Prevention and Control Health Messages

Look for plants such as bamboo, bohemia, rampe and banana in your surroundings and maintain them free of water collection.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

21st - 27th August 2010(34th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Re-
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	134	4965	4	223	0	14	4	100	0	32	6	409	0	7	0	48	0	1	**77**
Gampaha	67	3447	4	116	0	19	0	36	0	18	7	279	0	11	1	73	0	4	**80**
Kalutara	33	1553	4	182	0	13	0	17	0	74	2	243	0	2	0	27	0	1	**67**
Kandy	38	1396	3	242	0	4	0	22	0	4	5	77	0	111	10	88	0	1	**78**
Matale	9	531	3	252	0	5	1	30	0	70	1	72	0	4	2	40	0	0	**75**
Nuwara	7	176	4	290	0	0	1	101	0	84	0	21	0	50	1	32	0	0	**100**
Galle	30	929	2	203	0	5	0	5	0	12	1	65	0	18	0	10	0	3	**89**
Hambanto	23	686	1	61	0	5	0	1	0	10	1	76	1	70	2	9	0	0	**82**
Matara	14	491	5	143	2	8	4	9	0	49	20	224	4	104	1	17	0	0	**88**
Jaffna	26	2645	9	206	0	3	8	169	0	8	0	1	0	110	1	52	0	2	**83**
Kilinochc	2	26	0	11	0	0	1	9	0	1	0	1	0	0	0	0	0	0	**100**
Mannar	21	456	0	35	0	1	0	37	0	10	0	0	0	1	0	16	0	0	**60**
Vavuniya	2	556	0	34	0	3	0	40	0	8	0	2	0	1	0	10	0	1	**100**
Mullaitivu	0	5	0	2		0	0	1	0	0	0	0	0	0	0	0	0	0	**0**
Batticaloa	2	1158	1	136	0	3	6	24	0	30	0	10	0	3	0	4	0	2	**86**
Ampara	4	131	0	65	0	1	0	6	0	6	1	30	0	0	0	10	0	0	**86**
Trincomal	7	914	2	123	0	13	0	4	0	11	0	20	0	17	0	13	0	1	**90**
Kurunegal	33	1240	5	233	1	17	0	28	0	9	1	238	3	48	6	97	0	3	**95**
Puttalam	9	882	3	103	0	6	1	46	0	124	0	63	0	0	0	20	0	1	**89**
Anuradha	10	932	2	60	0	6	0	10	0	37	1	67	0	22	1	38	0	3	**95**
Polonnaru	3	357	8	72	0	1	0	6	0	8	0	52	0	1	0	36	0	0	**86**
Badulla	42	1065	8	154	0	1	0	69	0	16	3	59	4	73	0	79	0	0	**73**
Monaragal	34	877	8	138	0	1	2	33	0	4	0	30	5	64	1	66	0	2	**82**
Ratnapura	32	2267	5	376	0	4	0	11	0	26	4	292	0	47	1	75	0	2	**61**
Kegalle	14	770	2	113	0	12	0	47	0	19	3	187	2	17	0	73	0	0	**64**
Kalmunai	1	500	7	218	0	3	0	6	0	5	1	2	0	0	0	11	0	1	**77**
SRI LANKA	**597**	**28955**	**90**	**3791**	**03**	**148**	**28**	**1167**	**00**	**675**	**57**	**2520**	**19**	**781**	**27**	**944**	**00**	**28**	**81**

Source: Weekly Returns of Communicable Diseases WRCD).
*Dengue Fever / DHF refers to Dengue Fever / Dengue Haemorrhagic Fever.
**Timely refers to returns received on or before 27th August , 2010 Total number of reporting units =311. Number of reporting units data provided for the current week: 259
A = Cases reported during the current week. B = Cumulative cases for the year.

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to chepid@sltnet.lk.

ON STATE SERVICE

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