Point of View

COLLABORATION BETWEEN PREVENTIVE AND CURATIVE HEALTH SECTORS FOR MATERNAL AND CHILD CARE

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Introduction

Collaboration is the process whereby health care professionals jointly manage care. The goal of collaboration is to share authority while providing quality care within each individual's professional scope of practice[1]. In discussing collaboration of maternal and child care, there are several general considerations, which should be mentioned briefly before turning to any of the details. The first general consideration is the value of establishing personal contact between individuals concerned in attaining 'collaboration'. Taking the time and trouble to sit down and hear the other person's problems and point of view is important in providing quality maternal and child care to the same community.

Vertical integration of services for mothers and newborns is the rational linking together of services at community level, health centre level and at the first referral hospital. Effective prenatal care and safe normal deliveries cannot be achieved without the development of services in the community and health centre. If mothers and newborns are going to benefit from both, there needs to be a referral system linking the two levels, good communication between them and clearly understood protocols indicating when the services of one or the other is required [2].

It has become clear that teamwork among midwives, obstetricians, and paediatricians can improve the well being of mother and their newborns. When the pregnant woman and her husband appreciate and understand that collective care is available, they can face the months of pregnancy and the outcome of labour with confidence and without fear. The midwife needs to cooperate completely in antenatal care and can assist in allaying the expressed and unexpressed fears of the woman, her husband, and the rest of the family. The midwife, in cooperation with an obstetrician, is the ideal person to prepare the woman intellectually and emotionally for childbirth[2]. Teamwork is productive and saves both time and money. Midwives and doctors need to cooperate in educating the public that better care in pregnancy, delivery and puerperium diminishes the death rate of mothers and infants [1].

In Sri Lanka, public health midwives, who are the backbone of the national health care delivery system, have contributed to the reduction of the maternal mortality rate to one of the lowest in all of the developing countries[3]. In addition, there is a standard system for referral and back referral of pregnant mother during antenatal, natal and postnatal care from community health care to hospitals. However, there is no formal method for Public Health Midwives (PHMM) to discuss the matters arising during antenatal and postnatal care with obstetricians and paediatricians and give feedback. In my opinion it is very important to have regular and formal method to share the antenatal, natal and postnatal experience for further improvement of quality of maternal health care.

A study conducted in Nigeria on causes of maternal mortality in a semi-urban Nigerian setting by using focus group discussions with pregnant mothers, community leaders and health care workers identified that a lack of coordination between different levels of care as one of the factors for delaying or preventing effective care and treatment for women with pregnancy-related complications [4].

A significant proportion of the perinatal mortality in developing countries may be associated with basic errors or omission in health service delivery. These deaths become readily apparent when perinatal mortality is audited and deaths are classified according to avoidability [3,5].

Policy implementation in any health care system relies upon provider commitment. Policies that do not address the organizational, professional and social contexts are unlikely to achieve successful implementation. When barriers to policy implementation exist in any of these contexts, the policy may fail to meet its objectives. Policy makers need to carefully consider not only the intent and objectives of a policy, and the evidence for and against alternative approaches, but also the contextual barriers faced by policy implementers[6].

Overview of the Family Health programme in Sri Lanka

Presently, in Sri Lanka Family Health services are delivered to the whole population through the well planned system integrating every aspects of both curative and preventive health services (see figure 01).

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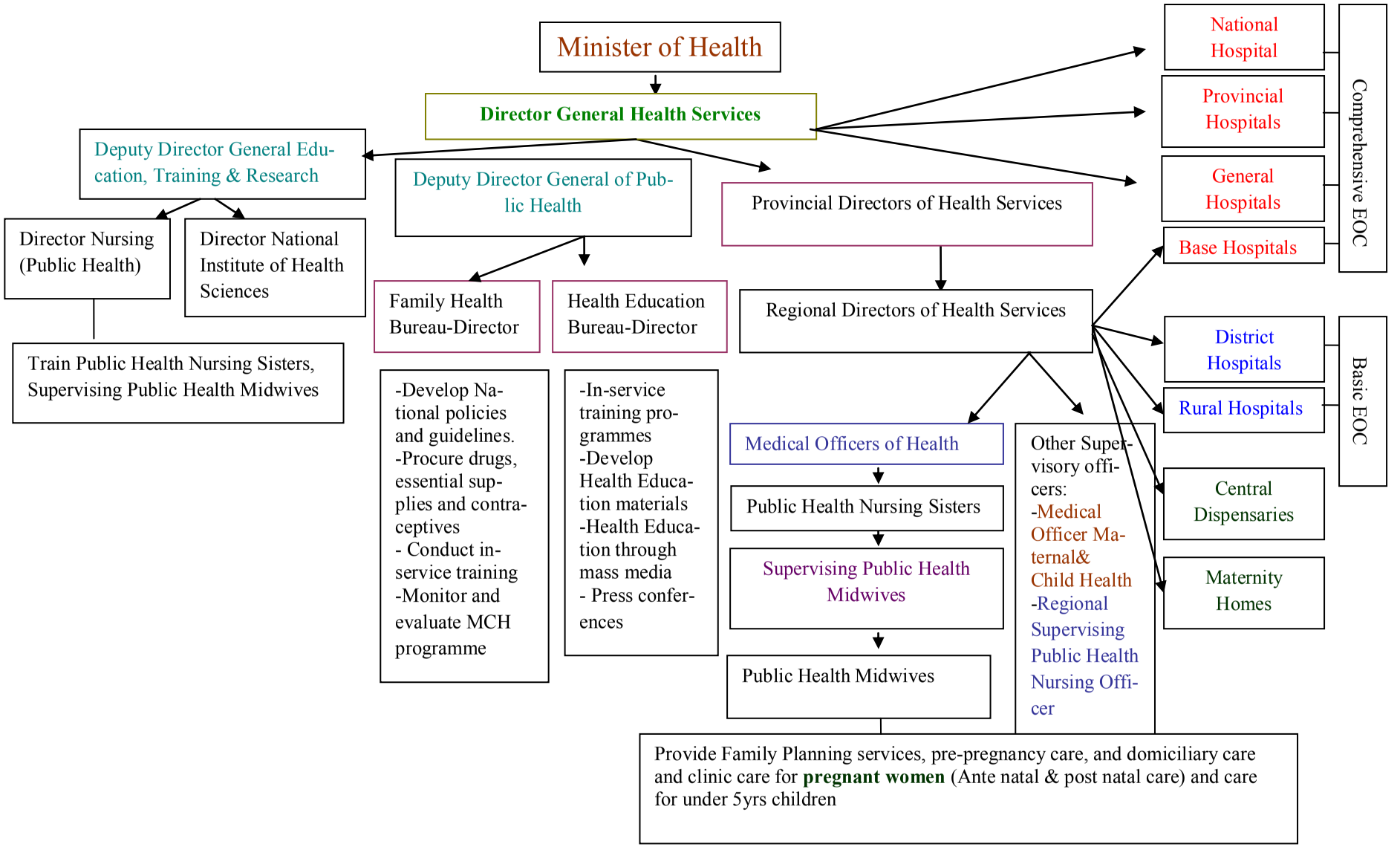
Figure 01-Organizational Structure of the Ministry of Health Sri Lanka to Provide Maternal and Child Care Services



The National Family Health Programme is aimed at improving the health and wellbeing of mothers and children and thereby improves the quality of life of the family.
Family Health covers a wide spectrum of services comprising:
1. Maternal care – pre-pregnancy, antenatal, natal and post-natal care
2. Family Planning services
3. Infant and child care
4. Special services to improve nutritional status of pregnant mothers and children
5. Care of the school children and the adolescents
6. Women's reproductive health care

The Department of health services provide Preventive Health Services (Public Health) and Curative Care Services through an island wide network of health institutions. There are teaching Hospitals (TH), General Hospitals (GH), Provincial Hospitals (PH), Special Hospitals, Base Hospitals (BH), District Hospitals (DH), Peripheral Units (PU), Rural Hospitals (RU), Maternity Homes (MH) to provide obstetric care for pregnant mothers and paediatric services for children. The state health services provide free medicine and care to all the patients who are attending the different facilities to obtain services.

The preventive health services provide comprehensive preventive care through well-developed infrastructure of Community Health Centres, Medical Officer of Health (MOH) Offices, and regional officers of seven control programmes of seven selected communicable diseases. Maternal and Child Health Services provide through domiciliary care and clinic care by PHMM under the guidance and support of Medical Officers of Health (MOH) and other field staff.

Administrative Structure in delivering health care
The present administrative structure can be classified into four levels namely, the national, provincial, district and divisional levels. Director General of Health Services (DGHS) is the chief administrator of health services at national level and there are eight Provincial Directors of Health Services (PDHS) to administer provinces. Districts and Divisions are under the purview of Regional Directors of Health Services (RDHS) and Medical Officers of Health (MOH) respectively.

All the Teaching and General Hospitals are directly under the purview of Director General of Health Services and Provincial Hospitals are under the Provincial Directors. Base Hospitals, District hospitals and other small hospitals are under the Regional Directors of Health Services. The provincial councils are responsible for providing preventive and curative health care services to the population in the respective provinces through PDHS, RDHS and MOH.

The RDHSS and MOOH are responsible for the provision of comprehensive health care including maternal and child care services to the community at the district and divisional levels. While RSHSS have administrative power over the preventive and curative services, MOOH have administrative power only over the preventive services.

An integrated approach to health care
As a medical doctor I have worked in both curative and preventive health sectors in Sri Lanka. I observed that when providing maternal and child health care, the coordination between health care providers in the preventive sector and hospitals is unsatisfactory. Furthermore, there is poor collaboration between the administrators of hospitals and administrators of public health care units.

Public Health Midwives are the grass root care providers who deliver maternal and child health service to the community. They work under the administration of Medical Officers of Health who are responsible for preventive health care at divisional levels. Hospital doctors, nurses and midwives work under the administration of the head of a hospital. As a rule heads of institutions of both preventive and curative sectors are invited for the review meetings in their respective institutions. However, participation at these meetings depends on the personal interest of the administrators since their attendance is not mandatory, thus affecting the quality of maternal and childcare. Therefore, I would like to investigate this problem with scientific evidence to in order to make suggestions to improve the quality of maternal and childcare.

Too often, public health staff and hospitals work in the same community are almost unknown to one another. Often, hospital staff has little knowledge about the community health problems, which the public health institution is struggling. In turn, the public health institution is equally unaware of the problems facing the hospitals. The first step in reducing this gap is for a health department representative with a background to fully appreciate the situation to approach the chief of the obstetrics department with a definite proposal for joint participation in a community-based maternity programme. An ideal person to perform this function would be one of the previously mentioned individuals belonging to both the hospital and public health staff. This reduces the amount of time and resources required and the rewards are great.

There are additional ways to bring the public health staff and hospital staff together. Opportunity to attend hospital staff conferences, ward rounds, etc., can be arranged for the public health staff. When this is done, care should be taken to see that public health staff is met their arrival at the hospital and introduced to the members of the hospital staff, instead of being left to wander around.

Another action plan, with advantages will be to arrange senior or house staff obstetricians from hospitals to visit rural settings. The specialist takes with him his knowledge and experience, and at the same time will gain valuable insight into the many deficiencies existing in small communities. This will eliminate the false concept of the practice of medicine in general and obstetrics in particular if one's entire experience is limited to the four walls of a hospital.

In summary, I have tried to indicate that there are certain practical steps which can be taken by health departments today to produce a real and working collaboration in maternal and child care.

Conclusion

1. Different administrative bodies manage prevention and curative health sectors
2. There is no proper coordination between primary health workers in preventive sector and hospital health workers
3. Lack of proper coordination between preventive and curative sectors negatively effect for the quality of health service provided for the community
4. Proper coordination between hospitals and divisional level public institutions can be achieved by introducing simple strategies
5. Effective referral system is needed to improve quality of maternal and child care.

References

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