

## Editorial



## Undergraduate Community Medicine teaching in Sri Lanka: past, present and the future

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### Introduction

Sri Lanka has achieved health indicators comparable to those of developed countries despite limited resources. A major contributory factor towards achieving this goal has been the development of human resources in public health. Public health professionals in Sri Lanka comprise a diverse range of categories including doctors, nurses, midwives and other allied health workers. They receive their education in a wide range of disciplines and diverse academic settings. In most of these institutions, public health or community medicine is taught as a discipline. Training future doctors in community medicine is an important component in this context.

### Historical background

The history of public health training for medical doctors in Sri Lanka dates back to 1870 when the Colombo Medical School was established. The curriculum of the then Colombo Medical School was a traditional, discipline-based curriculum which was comparable to a direct transposition of the existing structure of medical schools in Britain at the time. At this time, public health training was carried out by the Department of Medicine. The discipline gained importance with the establishment of a separate Department of Public Health at the Faculty of Medicine, University of Ceylon in 1949. The Department of Public Health was later renamed as Department of Community Medicine. This system was followed by the Faculty of Medicine, University of Peradeniya established in

1962 and the subsequent faculties of medicine, which were established up to 2010. At present, all eight state medical faculties in Sri Lanka have dedicated departments for community medicine or public health training (1-3).

### The changing context and innovations

In 1995, the traditional discipline-based curriculum in the University of Colombo was changed to a more integrated, student-centred and community-oriented curriculum. Early exposure of students to community learning environments was one of the main features of the new curriculum. This change from the traditional to the new curricular format was based on the needs of the community, and the decision for early introduction to community learning environments was directly due to the changing health needs and the disease pattern of the Sri Lankan community (2-3).

The community oriented teaching programme is organized as a whole stream, which spans throughout the five years of the medical course. It involves a wide range of teaching learning activities such as individual reflections, group discussions, fieldwork, student presentations, community and family attachments, and a research project (4). Theoretical inputs on the concepts of health and disease, health promotion and the principles of health education are introduced during the first few terms. As they move forward in the curriculum, students begin fieldwork with groups of 15-20 students attached to selected communities and then 2-3 students attached to selected families. The

Nine-day Residential Community Attachment Programme (CAP) in a rural setting, which was introduced in 2014, is another innovative feature of the curriculum. The objectives of this programme are to promote skills and attitudes required for working in rural sector of Sri Lanka and provide exposure to community health care facilities. The training takes place at selected public health and curative facilities in the area, which is located 200 km away from Colombo (4).

Following the Colombo example, the curriculum of the Faculty of Medicine, University of Kelaniya was changed from a traditional discipline-based model to an integrated organ system-based one in early 2004. The Community Health Strand spans the first four years of the MBBS course. During the first two years, students are familiarized with the various concepts of health and community medicine. At the end of the programme, students are expected to develop skills in using the tools necessary to promote community health, learn about the organization and delivery of healthcare services and develop attitudes appropriate to the practice of public health and community medicine. Field-based training is assessed through reflective writing and a portfolio (5).

In late 2004, the long-established traditional curriculum of the medical faculty in the University of Peradeniya was changed into a more integrated curriculum, and the objectives include improving generic skills and imparting skills necessary to deliver better primary healthcare. Communication skills and research skills are cultivated through community-oriented training, while community-based training and primary care electives provide students a broader vision. Within the curriculum content arranged as streams, the Stream in Hospital and Community-based training spans from the third year to the final year. Community-based training takes place in a rural field practice area located just outside the campus (6).

In 2007, the Faculty of Medical Sciences, University of Sri Jayewardenepura changed into an integrated curriculum with community-oriented content arranged within the Community Strand. The highlight of the community-based medical learning programme of the curriculum was the two-week residential community posting (5).

The Faculty of Health Care Sciences at the Eastern University of Sri Lanka was initiated with the aim of

improving the healthcare services of the Eastern Province, from community health services to the tertiary healthcare. An innovative feature of this curriculum is integration of community-oriented teaching with the Department of Primary Health Care, which is one of the four departments of study in the faculty (2).

The Faculties of Medicine at the Universities of Ruhuna, Jaffna and Rajarata have introduced innovative features within a traditional, discipline-based curriculum. Community-oriented teaching programme of the Faculty of Medicine, Jaffna spans from first years to final and integrated with clinical disciplines. The community attachment at Faculty of Medicine, Ruhuna includes voluntary activities by the students as well. The rural location at Saliyapura of the Faculty of Medicine, Rajarata facilitates community-based teaching.

## Challenges

Even though many medical faculties have implemented more community-oriented curriculums, some faculties find it difficult to implement intensive community-based programmes due to the lack of human and financial resources. Furthermore, many clinicians find it difficult to contribute towards community-based teaching activities due to time constraints. There is room for improvement related to integration of community-based activities with clinical disciplines, particularly in the later stages of the curriculum.

The students themselves need to develop more positive attitudes towards public health. Although the student feedback indicates a degree of discontent regarding community based training, tracer studies suggest that as doctors, they tend to appreciate the importance public health training. There is a need to provide inputs from the beginning of the curriculum in order to reinforce the importance of public health in the clinical settings (7-8).

## Conclusion

The development of health personnel who have the necessary knowledge, skills and attitudes to address the health needs of the community primary healthcare is a challenge in medical education. With the dynamic nature of the health status in the community and rapidly changing healthcare needs, for instance the increasing

burden of non-communicable diseases and the increase in the elderly population, there will be many more challenges to be faced. Community-oriented medical education should be continuously reviewed and updated to suit the rapidly changing public health needs of the country. There should be an energetic attempt to further improve the attitudes towards community medicine and public health. Positive role modelling will play a major part in achieving this goal, and encourage high achieving students to pursue careers in community medicine and public health.

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