MANUAL OF MANAGEMENT FOR PROVINCIAL DIRECTORS

Ministry of Health, Highways and Social Services
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1996

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Management Development
& Training Unit
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FOREWORD

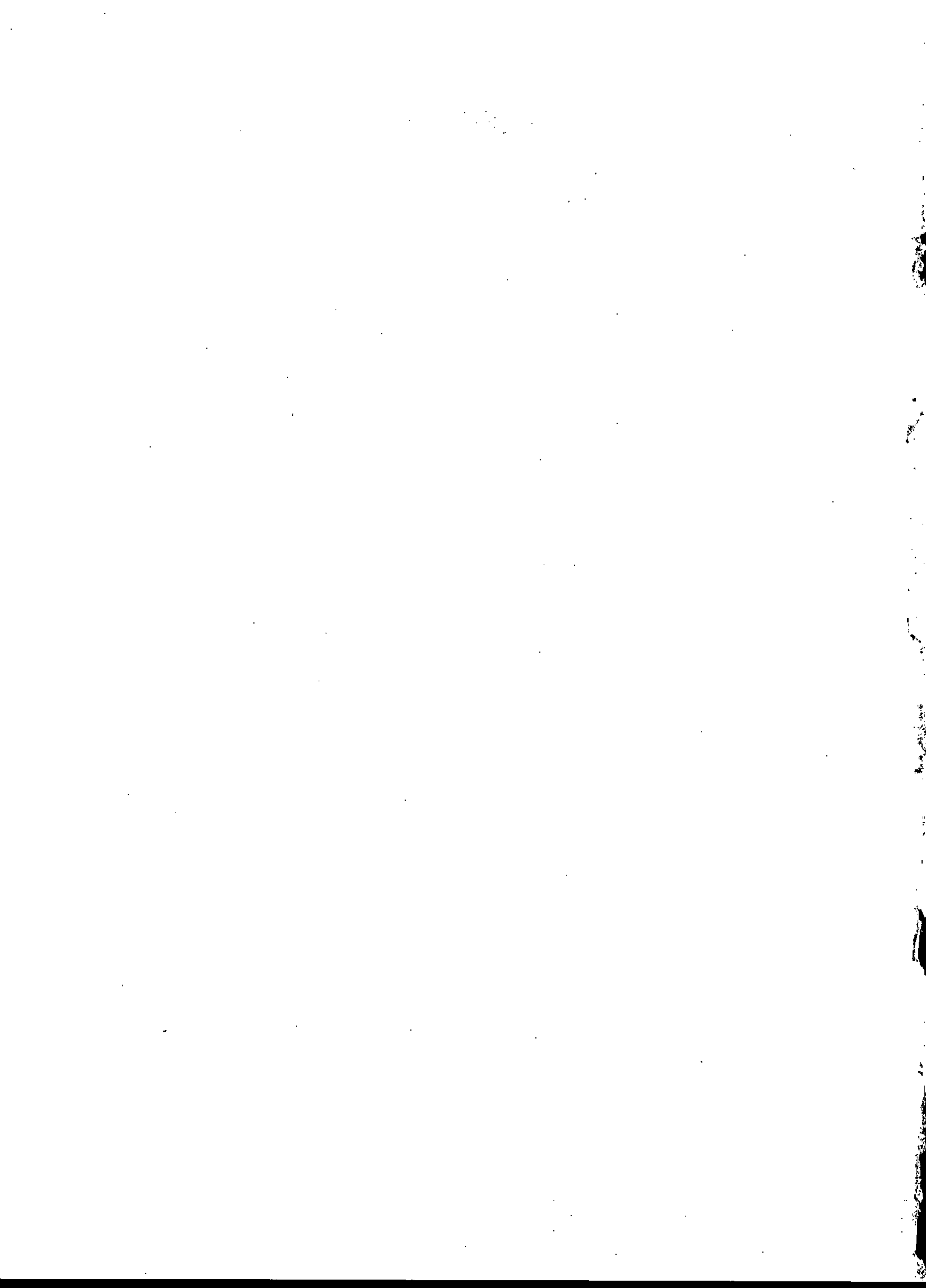
The first in the process of devolution of Health Services was the establishment of the superintendents of Health Services in 1954. Their areas roughly corresponded to Administrative Districts. With the establishment of the District Minister system in 1973, there was closer intersectoral co-ordination at the District level. The devolution of Health Care services to the District level under the guidance of the District Minister was consolidated by the devolution of powers of the Minister of Health to the District Ministers by Gazette notification dated 23.09.1982. By this Gazette notification, the then Minister of Health, delegated 13 functions to each of the 24 District Ministers. The next important milestone in the process of devolution was the establishment of Provincial Councils by the 13th Amendment to the constitution, dated 14.11.1987. The management of the Health Care Services was assigned to the Provincial Councils as a devolved function, with certain areas such as policy, purchase of drugs and equipment, technical education, management of Teaching and Special Hospitals being retained at the centre. The most recent devolution was to the level of the Divisional Directors of Health Services (end 1992). All devolution `exercises in the Ministry of Health have been in step with the general devolution process of the country.

In the landmark year of 1987, the Provincial Directorates of Health Services thus emerged. A whole host of challenges were posed to the Provincial Directors and the then Regional (redesignated Deputy Provincial) Directors of Health Services. Due to the speed of change, there was not much opportunity for capacity building, prior to implementation of this radical alteration to the management process for health development. The natural innovativeness of the PDD & DPDD came into play and they adopted to the change, with the help of the Directorate of Health Services. They also had to work with the Provincial Minister of Health as well as other Provincial Ministers, and non technical Administrators. By and large, these challenges were met, although tentatively at first. The time is now opportune to document the new Managerial Process for Provincial Health Development. For the purpose, a consultative approach was used. A group of experts formulated a format for the manual and the chapters that would be included. Authors' briefs were agreed upon and the authors with experience and the necessary expertise identified and briefed. They diligently put together the chapters. Another round of consultations saw the refinement of the chapters.

The development of the manual marks the fourth instalment of the process to revise the part 2 of the Department manual, which had not been revised since the original publication in the early fifties. The first fledgling step in this exercise was the Manual on Management of Central Dispensaries and Maternity homes. The next, the one on primary care institution. The Third, the one on secondary and tertiary care institutions. Along the way we gathered experience and the successive products gained in quality. I wish to record my deep appreciation to all the experts, who distilled their vast experience into the different chapters with great care and patience. I am very grateful to Dr. C. D. Herat, the hardworking National consultant, who steered the whole process. It is my pleasure to thank Dr. V. Jeganathan, DDG (MS), who led the way and worked diligently to ensure a quality product. Support from the WHO is gratefully acknowledged.

Dr. Reggie Perera

Director General of Health Services.



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ABBREVIATIONS

A.M.O.	Assistant Medical Officer
A.N.C.	Ante Natal Clinic
B.H.T.	Bed Head Ticket
B.M.E.S.	Bio-Medical Engineering Services
B.H.	Base Hospital
C.H.D.R.	Child Health Development Record
D.D.H.S.	Divisional Director of Health Services
D.G.H.S.	Director General of Health Services
D.M.O.	District Medical Officer
D/M.T.S.	Director Medical Technology and Supplies
D.S.	Dental Surgeon
D.P.	Divisional Pharmacist
E.T.U.	Emergency Treatment Unit
E.P.I.	Expanded Programme of Immunization
H.S.R.	Health Systems Research
I.C.U.	Intensive Care Unit
I.E.C.	Institutional Equipment Committee
I.M.M.R.	Indoor Morbidity, Mortality Return
J.I.C.A.	Japanese International Cooperation Agency
J.E.	Japanese Encephalitis
M.C.	Municipal Council
MO MCH	Medical Officer, Maternal and Child Health
M.O.H.	Medical Officer of Health
M.S.D.	Medical Supplies Division
M.T.I.P.	Medium Term Investment Programme

N.H.C.	National Health Council
N.G.O.	Non Governmental Organization
O.R.S.	Oral Rehydration Salt
P.E.R.C.	Provincial Equipment Review Committee
P.H.I.	Public Health Inspector
P.H.N.S.	Public Health Nursing Sister
S.P.H.M.	Supervising Public Health Midwife
P.H.M.	Pubilc Health Midwife
P.N.C.	Post Natal Clinic
P.P.O.	Programme Planning Officer
P.H.C.	Primary Health Care
R.T.C.	Regional Training Center
S.T.D.	Sexually Transmitted Disease
S.P.C.	State Pharmaceutical Corporation
T.A.C.	Technical Advisory Committee
U.N.I.C.E.F.	United Nations Children's Fund
U.N.D.P.	United Nations' Development Programme
W.H.O.	World Health Organization
W.B.C.	Well Baby Clinic

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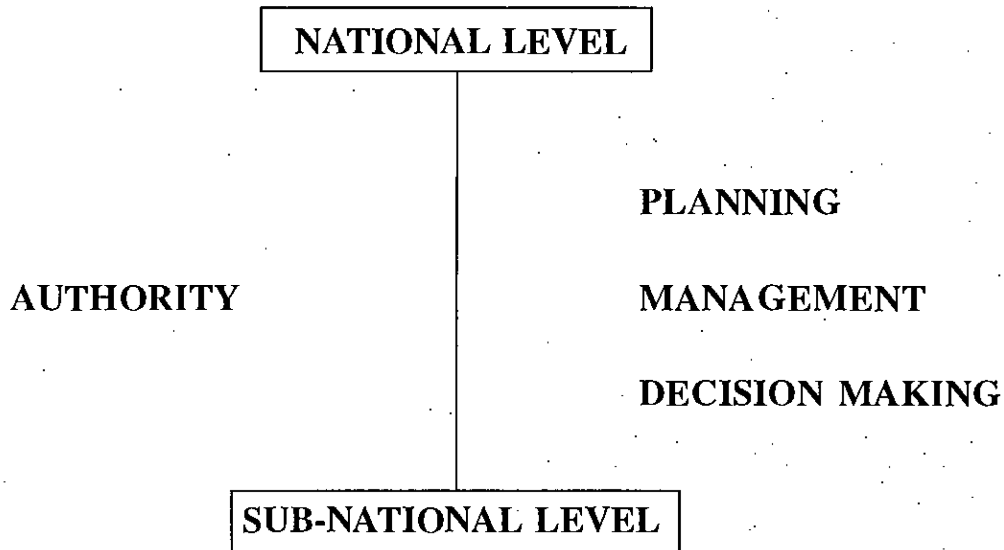
CHAPTER 1

MANAGEMENT PROCESS OF PROVINCIAL HEALTH SERVICES

Provincial Councils were established in 1989. With this the decentralization of health services and development of Provincial Health Department began.



Management is, getting things done through harmonious working of people together, and efficient use of resources in order to achieve certain objectives. The type and nature of objectives to be pursued depend on the type and size of the organization.

Why Health was decentralized?

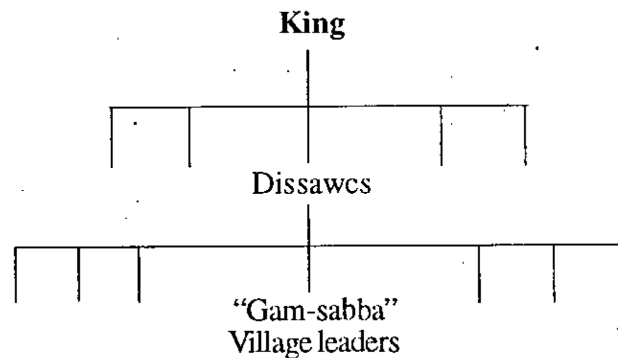
Political independence brought with it a rising tide of increased expectations by the general public with a strong demand for health care, especially for curative services. This led to increased investments in urban hospitals thus giving priority access to defined groups of the population and uneven coverage of the population. Large sections of the population did not have regular access to modern health care. These urban based

curative services consumed increasingly higher proportions of the national budget leaving preventive services especially in rural areas relatively starved of funds.

An effective manager at any level of the organization will be continually on the watch for changes in the external environment; will be aware of the strengths and weaknesses of the objectives of the organization; and will make adjustments so that the objectives are always as effective as possible. The most important component of the effective functioning of the organization is a clear vision of the future and a well considered plan describing the steps that must be taken today, next month, and in the years to come in order to make the vision a reality.

HISTORY OF DECENTRALIZATION OF SRI LANKA

Pre-Colonial era



Colonial era

Decentralized system---------> Centralized

Independence

1948 Health care was highly centralized

Dr. Cumpston (Advisor from Australia)

1949 Suggested decentralization
1952 Necessary legislations were formulated
1954 Decentralization implemented
1972 District political authorities were formed
1981 District Ministers were appointed
1989 Provincial Governments were established

ADMINISTRATIVE STRUCTURE OF PROVINCIAL HEALTH SERVICES

Each province has a Provincial Cabinet Minister to be responsible for the Health Care Services of his/her province. The function of the Provincial Health Ministry is to implement the national health policies and the national and provincial health objectives for the benefit of the people. The Provincial Health Minister has a secretary to his ministry. The Secretary of the Provincial Health Ministry has a Provincial Director of Health Services who is overall in charge of the health services of the province. Under the Provincial Director there are Deputy Provincial Directors to each district. Both curative and preventive services of the district is administered by the Deputy Provincial Director. Each Divisional Secretaries area of the district has a Divisional Director of Health Services. He/She is responsible for the services of his/her area. Divisional Director works under the Deputy Provincial Directors administration.(Table 1).

The health manager should know:-

What is the organization trying to achieve?
Where is the organization now?
Where does the organization want to be in a few years(beyond)?
How are we going to get there?
How will the organization finance this program?

The following are the major issues that commonly demand attention?

1. Equity and coverage
2. Intersectoral action
3. Organization and management of services
4. Selection and use of technologies
5. Financing health care
6. Health information
7. Research.

THE NATURE OF MANAGERIAL WORK

The nature of managerial work is three fold.

* **Managerial roles**
* **Managerial functions**
* **Managerial skills**

1. Managerial roles

Managerial roles are the roles a manager plays in the course of managerial work. It is possihle to learn a great deal about the nature of managerial work hy understanding the various roles that a manager must assume in the course of that work. A manager must adopt certain patterns of hehaviour when a particular managerial position is assumed, those patterns of behaviour often arising out of the necessities of the joh to be done.

Managerial roles are Interpersonal roles, Informational roles and Decisional roles.

a) Interpersonal roles

All managers have authority, either formal or informal. This authority forces them into certain interpersonal roles that are necessary for the successful completion of the managerial task.

1. Figurehead

The first of these interpersonal roles is that of a figurehead and refers to the manager's role as the symbolic head of the organization. In this role the manager is under obligation to perform a number of routine functions of a ceremonial, legal, or social nature to represent the organization whenever it is required.

2. Liaison

Liaison refers to the need for the manager to interact with peers and with other people outside the organization to exchange information and maintain contact. This is different from figurehead role. Liaison is an active role, participatory, communicative role. Figurehead is a passive role.

3. Leader

The manager is the person responsihle for the direction of the organization's total activities. This is an active, essential and internal role. The work satisfaction among health services personnel very often is related to their perceived degree of appreciation hy their leader. The manager must spend time to huild adequate relationships with his hospital staff.

b) Information roles

The manager should he able to gather information, disseminate it, monitor its flow and use within the organization.

1. Monitor

This is the manager's ability to seek and reeeive current, information about the organization and it's functions. The manager thereby has a thorough understanding of the organization, hopefully more complete than anyone clse with that organization.

2. Disseminator

The manager's ahility to transmit factual and interpretational information to memhers of the organization. By the careful selection and dissemination of appropriate information, the manager can guide members of his organization to areas that are felt to be most productive. Keep them away from areas of less interest, and encourage a greater involvement in the organization as a whole.

3. Spokeperson

The manager is responsihle for the transmission of information to outsiders about the organization's work plan and operating status. He is the formal communicator of detailed information to the outsiders.

c) Decisional roles

The third set of roles are the decisional roles. These roles are connected with the manager's ability to make and implement decisions within an organization and to exercise real authority within that organization. Here the manager aets as an entrepreneur, disturhance handler, resource allocator and negotiator.

1. Entrepreneur

This is the manager's ahility to initiate change within the organization, to develop new programs or procedures, and to move the organization into new activities or endeavours that should eventually benefit the organization and enhance its ohjectives. The manager explores continuously ways of making the services available and desirahle to the puhlie, and to encourage the puhlie the scrviees actively.

2. Disturhance handler

The manager has to take corrective action when the organization faces unanticipated problems, either externally or internally.

3. Resource allocator

The manager directs the organization's resources of money, personnel, space and equipment towards the correct institution or unit to achieve the objectives of the organization. This is the manager's real internal power.

4. Negotiator

The manager is responsible for representing the organization at major negotiations with other organizations and groups. This is a more active posturc of putting forward the organization's needs and desires, and seeking to obtain the best deal possible for that organization.

Research has shown that not every managerial position includes the same set of roles to the samc degree. Each managerial position requires a different "mix" of managerial roles, and the same position may require different combinations of roles of different times. The managers should take clear account of the needs of their organization at the time, as well as their own personal characteristics and the characteristics of their immediate colleagues.

Managerial functions

Managerial functions are either future oriented or present oriented.

Future oriented management functions

They are:-

1. Planning and organizational goal setting.
2. Organizational design and development.
3. Leadership and motivation
4. Management of change

Present Oriented Management functions

They are:-

1. Organizing
2. Decision-making
3. Directing
4. Controlling
5. Conflict resolution

Managerial skills

Managerial skills are technical skills, human skills and conceptual skills.

Technical skills

Technical skills are the abilities to use the methods, processes, and techniques of a particular field in managerial work. Example Epidemiological investigation of a disease outbreak.

Human skills

These involve the ability to get along with other people, to understand them and to motivate them towards the organizational objective.

Conceptual skills

This is the mental ability to visualize the complex inter- relationships that exist in the work place- that is among people, among departments or units of an organization.

Difficulties in Health Services Management are:

* multiple and often conflicting goals
* limited resources
* unlimited needs
* political intrusion
* legal requirements - rules and regulations. civil service
* frequent political/management turnover

Financial Management of the Provincial Health Services

Mode of Finance to the Provincial Health Services

Block grant

Block grant consists of the total allocation given to each Province. this includes recurrent expenditure, criteria based grant and medium term investment program.

The Deputy Provincial Director of Health Services send their annual estimates to the Provincial Directors Office. PDHS consolidates the annual estimates of all the districts and through the Secretary of Health submits

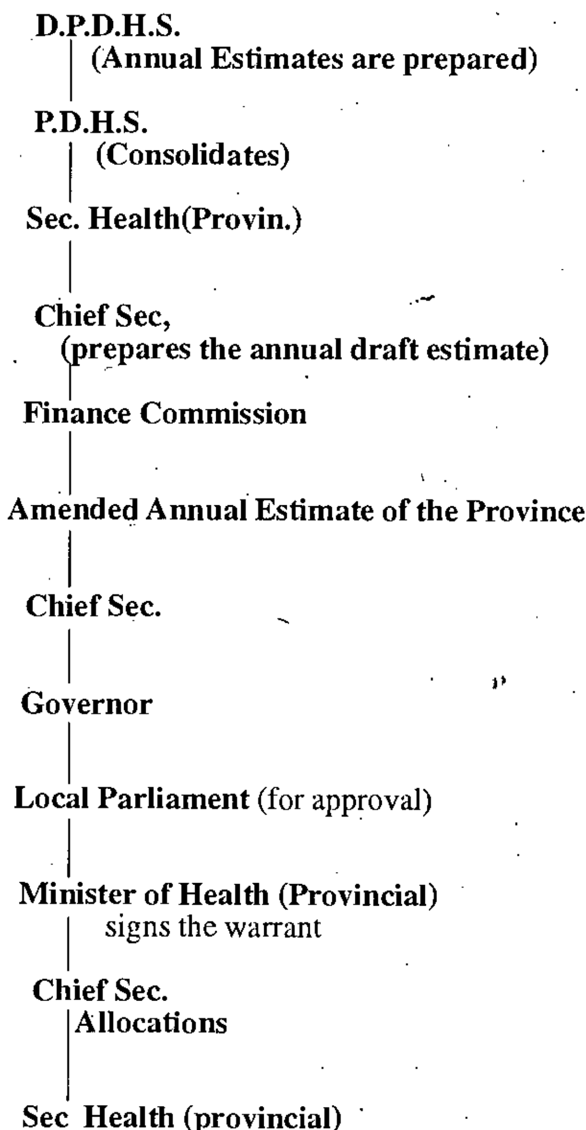
this to the Chief Secretary. The Chief Secretary of the Province is the Chief Accounting Officer. Chief Secretary prepares the annual draft estimates with the data given to him by each Secretary of the Province. He submits the draft estimates to the finance commission.

The finance commission makes the necessary amendments and the approved estimates is returned to the Chief Secretary.

The Chief Secretary after receiving the approved estimates forwards it to the Governor. The Governor places it before the Local Parliament. Once it is approved by the Local Parliament the Hon. Minister of Health signs the warrants and returns to the Chief Secretary for his recommendation for implementation.

The Chief Secretary informs each ministry of their allocations.

Block Grant

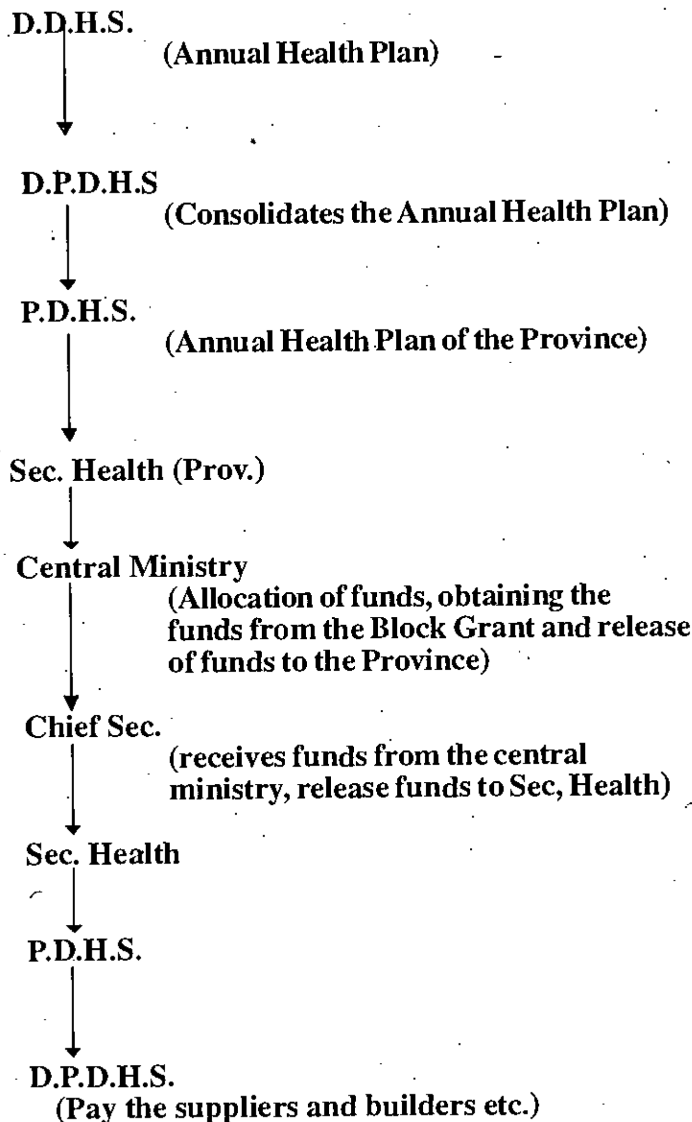


Medium Term Investment Program

The Divisional Directors of Health Services and the Divisional Secretaries develop the annual health plan for their area. This proposed plan is submitted to the Deputy Provincial Director. The Deputy Provincial Director of Health Services discusses this plan with the D.D.H.S. and prioritize the needs depending on the morhidity trends of the area, the request from the people, the needs identified hy the health staff and others and the availability of funds. The consolidated Annual Health Plan is submitted to the Provincial Director of Health Services. P.D.H.S. suhmits this plan to the Central Ministry through the Secretary of Health.

From the hlock grant the M.T.I.P. money is released to the Central Ministry. Central Ministry releases funds to the Chief Secretary and the Chief Secretary sends it to the Provincial Director's office through the Provincial Secretary. Provincial Director releases the funds to the D.P.D.H.S.

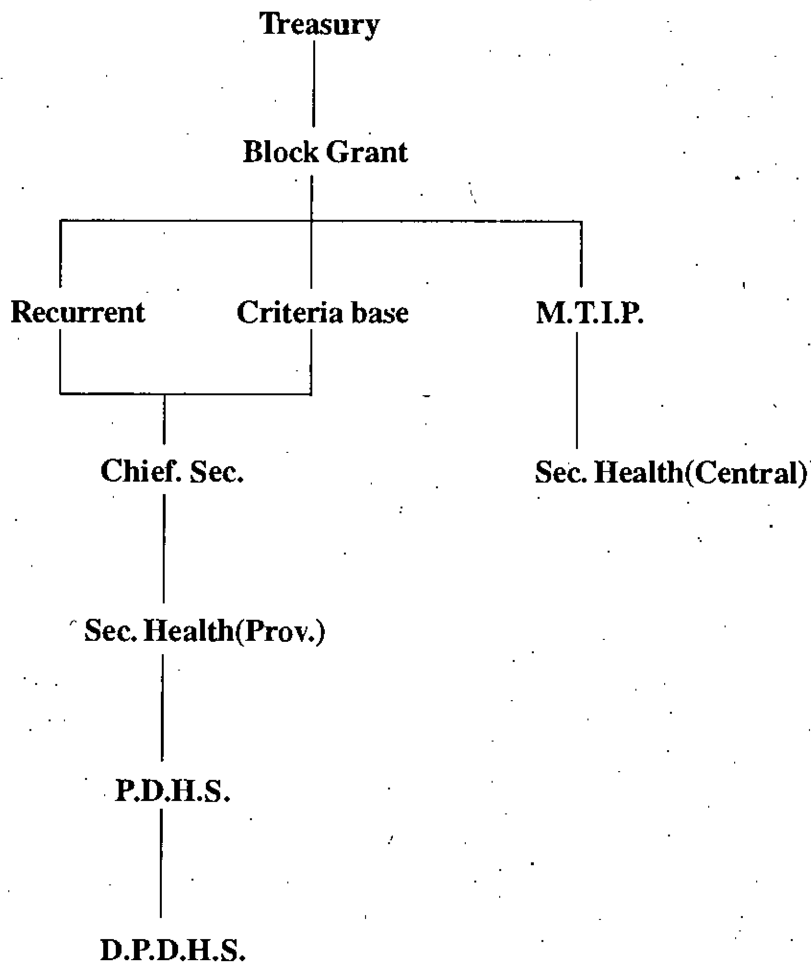
MTIP



Recurrent and Criteria Based Grant

The Chief Secretary receives these funds from the Central Ministry directly. The Chief Secretary gives this to each Provincial Secretary depending on the approved estimates.

Release of funds



Management of information system, In-service training of staff, Monitoring and Evaluation, Supervision and giving a feed back is also important in Provincial Health Development. These areas are described in detail in the relevant chapters in the Manuals on Management of DHH, P.UU and P.HH and R.HH and Secondary and Tertiary Care Institutions.

Table 01

ORGANIZATIONAL CHART OF PROVINCIAL HEALTH SERVICES

DPDHS -Deputy Provincial Director of Health Services
M.S. -G.H.Medical Superintendant-General
DDHS

CHAPTER 2

MANAGEMENT OF PATIENT CARE SERVICES

INTRODUCTION

Health Care is an expression of concern for the fellow human heings. It is defined as a "multitude of services rendered to individuals, families and communities by the agents of health services or professions, for the purpose of promoting, maintaining, monitoring or restoring health". Such services might be staffed, organised, administered and financed in every imaginable way, hut they all have one thing in common; people are being "served", that is, diagnosed, helped, cured, educated and rehabilitated by health personnel. Health care includes "patient care". However many people mistakenly helieve that both are synonymous. Patient care is a subset of health care system.

Concept of patient care services

The basic concept of patient care services is to render an adequate, comprehensive package of quality services either within the Hospitals or in the Out Patient Department.

Objective of the patient care services

The overall objective of patient care services is to either cure the patient or ameliorate the illness to an extent which would enable the patient to continue treatment at home.

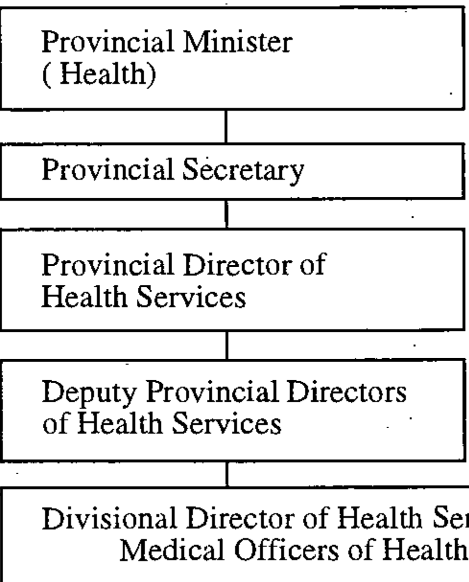
In Sri Lanka patient care services are delivered through three levels of institutions namely,

Primary
Secondary
Tertiary care institutions.

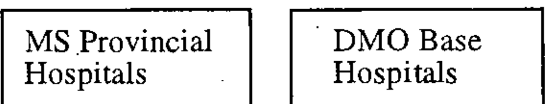
Primary patient care institutions consist of Central Dispensaries, Central Dispensaries & Maternity Homes, Rural Hospitals, Peripheral Units & District Hospitals. Secondary patient care institutions consist of the Base Hospitals. Provincial Hospitals and Teaching Hospitals which provide specialized treatment facilities form the tertiary patient care institutions.

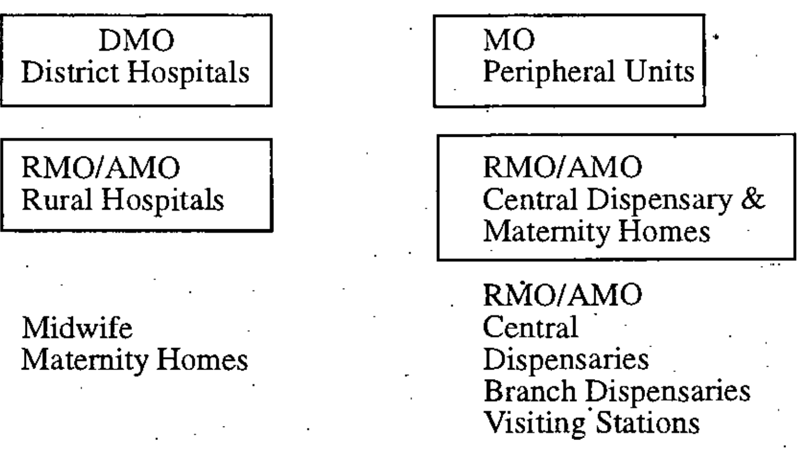
ORGANIZATION OF PATIENT CARE SERVICES UNDER PROVINCIAL COUNCILS

PROVINCIAL LEVEL



REGIONAL AND DIVISIONAL LEVEL





The Teaching Hospitals come under the administrative control of the line Ministry. The services rendered by each level of patient care institutions are described in the manual of management of District Hospitals, Peripheral Units & Rural Hospitals & Manual of Teaching, Provincial, Base & Special Hospitals.

For an efficient and effective patient care management system to operate at the Provincial level, an organizational chart of the Provincial patient care system has to be developed.

For Planning and Management purposes Provincial Director of Health Services shall possess a Basic Data Profile and it should be updated every year.

(A) **Basic Data Profile**:-

Basic data profile shall cover the following broad areas.

1. Geographic characteristics of the Province and a Provincial map. Location of institutions by type/using symbols.

2. Demographic profile.

3. Epidemiological data consisting of -

   Mortality profile
   Morbidity profile

   including the morbidity, mortality trends and emergence and resurgence of new diseases

4. Patient Care institutions by type including bed strength in each institution and Bed Occupancy Rate.

5. Service facilities available at different institutions

6. Utilization of service facilities by various patient care institutions

7. Human Resource by categories - (computerized)
   Institution - Cadre No. available No. Requircd
   Man hour planning exercise will have to be carried out to get optimum human resource utilization.

(B) Logistics and other utility services

(C) Equity of services & resources. (Norms to he developed). More often than not major institutions are generally over crowded, hecause of the availability of better services. However, it leads to inequity of services. Therefore attempt should be made to bring down this disparity to a minimum. It is also observed that there is pooling of staff in major institutions, so that peripheral institutions are under staffed though the total cadre position is correct for the District/Province. Therefore action has to be taken to avoid this situation through a continuous transfer scheme.

(D) **Supervision**

Vide chapter 20 of manual on the management of DHH, PUU & RHH.

(E) **Monitoring & Evaluation**

Services rendered by the patient care institutions to he monitored quarterly. Utilization of funds under various programmes, projects to be monitored every month. Physical & Financial progress of developmental activities may be monitored every month.

Gross progress made may be interpreted graphically in respect of each district.

Annual Evaluation may be made preferably under following Parameters.

1. Input Evaluation
2. Output Evaluation
3. Process Evaluation
4. Outcome Evaluation

(F) **Landscaping & Beautification of Patient Care Institutions**

(a) Survey plans to be prepared in respect of Government land belonging to patient care institutions and boundaries of such lands to be well demarcated. A copy of the plan may be filed with the Head of the Institution. Prompt action to be taken in the events of encroachment.

(b) Preparation of contour plans

(c) Preparation of sketch maps showing the Location of
- medical building
- sewerage system
- water supply system
- approach roads
- power lines - both above the surface and underground
- telephone system

(d) Location of Future buildings to be earmarked.

(e) Preparation of Master plans for each & every patient care institution with periodic amendments, in terms of equipment, human resources etc.

(f) Preparation of an annual plan for the province

(g) Preparation of a Master Plan for the whole province.

Roles and Responsibilities of the Provincial Director of Health Services

Provincial Director of Health Services shall:

1. Ensure and organise the hospitals to provide outpatient treatment, in ward treatment, emergency treatment and laboratory services of standard quality.

2. Ensure timely referrals/transfers of patients from Peripheral Hospitals to secondary and tertiary level institutions.

3. Ensure implementation of a forward referral and back referral system in the province.

4. Improve clinical training facilities in District, Base and Provincial Hospitals.

5. Take steps to update clinical knowledge of the staff of all categories by regular staff training.

6. Identify the problem areas in patient care services and ensure the quality of services rendered, by implementing quality assurance programme and establish medical auditing units.

7. Organize visiting clinics in Base & Provincial Hospitals in finer specialities and establish visiting clinics in basic specialities in other Hospitals wherever necessary.

8. Ensure the availahility of Drugs, Dressings and other medical supplies, equipment and printed forms in adequate quantities.

9. Develop a system to promote thc Hospitals to involve in community health activities.

10. Strengthen the Intersectoral coordination to develop patient care services by active participation in District Coordinating Committees, District Development Councils.

11. Assist thc Judiciary services by providing a standard medico legal services in all Hospitals manned by M.B.B.S. qualified doctors.

12. Develop the supervisory skills of thc middle level supervisory grades of staff of Hospitals.

13. Visit patient care institutions periodically in the province and send feed back.

14. Organize periodical performance rcviews in patient care services.

15. Maintain the regular flow of information pertaining to patient care services, i.e. collate, process, update, computerize, analyzc, evaluate and maintain graphs, charts and send feedbacks to all those concerned.

16. Conduct/encourage/and assist in research pertaining to patient care services.

17. Coordinate with policy makers at the Provincial level and formulate a Provincial consultative committee on Health and provide technical assistance in making decisions.

18. Link the Provincial Ministry with the Line Ministry and coordinate activities.

19. Assist the N.G.O.O. in the improvement of patient care services by mutual support and concerted effort and avoid overlapping and also raise funds wherever neccssary according to existing regulations for health developmental activities of the province.

20. Liaise between Government and thc Private Sector in order to provide more opportunities for the private sector to expand with a view to reduce burden on the part of the Government in providing patient care services.

21. Establish emergency treatment units in patient care institutions on a phased out basis to cover the entire province.

22. Ensure the implementation of disaster preparedness plan in the best possihle manner even in the smallest patient care institutions.

23. Provide patient care services in Estate Sector.

24. Ensure advocacy and coordination with Hospital Development Committees and liaise with National Health Development fund.

25. Deal with trade unions, for the betterment of services while preserving the rights/responsibilities of the employer/employee.

26. Ensure cost consciousness/and carry out cost benefit analysis and probe into health Economics; with a view that both the health care provider and the user are quite cost conscious. It is also recommended that cost centres be established wherever possible and display unit cost per patient in respect of every category of patient care institution.

27. Attend to public complaints promptly and ensure that preliminary investigations are carried out immediately.

28. Give leadership and provide expertise and negotiate appropriately in conflicts.

29. Act as the nucleus for team building and look into comfort and welfare of the employees and boost up the morale of the workers.

30. Develop a high degree of public relations.

31. Organize ways and means of Inventory control and ensure periodic Board of surveys at least once a year.

32. Organize disposal of unserviceable and obsolete items and grant write off authority.

33. Assess the total assets and update assets annually and keep records. Probe into audit queries.

34. Possess a sense of public accountability.

35. Shoulder all the responsibilities as the Head of the Department.

CHAPTER 3

THE ROLE OF THE HOSPITAL IN PUBLIC HEALTH

1. INTRODUCTION

For many decades the health services of Sri has developed more or less as two distinct and parallel components: the curative(or medical) services; and the preventive (or public health) services, with varying degrees of integration at different levels.

Accordingly health care is provided through:

a) a network of **medical institutions** ranging from teaching hospitals, provincial hospitals and base hospitals providing secondary and tertiary curative care services, to district hospitals, peripheral units, rural hospitals, central dispensaries and maternity homes providing varying levels of services at the primary health care level; and

b) a network of **health units(now corresponding to Divisional Secretariat areas) providing public health services** covering the entire extent of the island.

The Health Unit System which was initiated in 1926 by the establishment of the first health unit at Kalutara for the provision of preventive health care has expanded over the years to cover the entire extent of the island. Each unit was designed to serve a population of 40-80 thousand and was responsible for providing comprehensive preventive and promotive services in a well demarcated area.

These Health Units are designed to provide promotive, preventive, curative and rehabilitative services which include:

1. **Maternal and Child Health Services** including Family Planning and Nutrition.

2. **School Health Services** including School Dental Services

3. **Prevention of Communicable and Non-communicable diseases**

4. **Epidemiological Surveillance**
   - The collection, analysis and interpretation of data for ACTION
   - Epidemiological investigation.

5. **Environmental and Occupational Health Services** which includes:
   - Safe water supply and sanitation
   - Solid waste disposal
   - Good housing
   - Food safety
   - Estate health
   - Disaster control

Health Education

Enforcement of Public Health Legislation

Intersectoral Collaboration with the following agencies in the provision of services:

- Divisional Secretariat
- Local Authorities
- Schools
- Agricultural Sector
- Estate Sector

In 1992, with the abolition of the district (regional) level administration and the establishment of a divisional level administration under Divisional Secretaries, Medical Officers of Health who were in charge of the Health Units were appointed Divisional Directors of Health Serviccs(DDHS) to meet the health needs in the division and to function on par with Divisional Secrctaries. The functions performed by the Regional Director of Health Services at the district level were transferred to the DDHS. Thus the administration of both the public health services and curatives at divisional level is now assigned to the DDHS.

The administration of the public health serviccs continues to be the chief function of the DDHS, who is assisted by public health inspectors(chiefly responsible for environmcntal health, control of communicable diseases, food safety, school health), public health nurscs and midwives(chiefly responsible for matemal and child health care, family planning, nutrition) and school dental therapists(responsible for preventive dental care of school children). However, hospitals and other curative care institutions have a vital role to play in the provision of some of the important aspects of preventive health care. Some of the more important areas in which they could make a significant contribution in the provision of public health services are:

1. **Provision of Service** - Maternal and Child Health, Family Planning, Immunisation, School Health

2. **Epidemiological Surveillance**

3. **Health Education**

4. **Support for field activities**

5. **Referral Services**

SERVICE PROVISION

Maternal and Child Care

The provision of MCH Services provides one of the best examples of the need to maintain a close link between the public health field services and the hospital. The outcome of a pregnancy as well as the birth of a healthy child depends not only on effective antenatal care, which is largely provided through the public health services, but on the natal and immediate post-natal care provided in medical institutions. Hospitals play a major role in ensuring safe confinement and prevention of immediate post-partum complications in the mother, and the well-being of the newborn infant. They also should play a supporting role in the provision of antenatal care to mothers. Specialists clinics would obviously support the field services by undertaking the care of mothers referred to them, particularly those at risk; and smaller institutions should conduct hospital antenatal clinics for mothers living in the vicinity. This helps to relieve the workload of the DDHS/MOHs enabling them to improve the quality of services provided to the public.

Child Welfare Clinics conducted on the same lines would not only help in improving the health of children living in the vicinity of the hospital, but would also serve as centres providing immunisations and nutritional supplements. These clinics ANC, PNC, WBC conducted at hospitals are the responsibility of the Head of that institution and field health staff has only a supportive role.

Family Planning

The strengthening of family planning services has been recognised as a matter of national importance. Whilst the health sector is largely concerned with its effects on maternal and child health, the need for maintaining a manageable population growth makes this activity one of national importance. Insertion of IUDs, and male and female sterilizations are some of the methods best provided through medical institutions. Hospital staff could conveniently participate in the provision of these services by establishing Family Planning Clinics and providing services for sterilization and family planning counselling.

Maternal Death Investigation

Rationale for investigation. Head of institution is responsible for conduction/ initiation of investigation and follow up and feedback. With the reduction of maternal mortality to levels below 0.5 per 1000 live births it is considered possible to bring ahout a further reduction in maternal mortality through the investigation of all maternal deaths, and utilising the findings for taking remedial measures. These deaths are investigated by the DDHS. Since many of these deaths occur in hospitals, it is essential that hospital staff cooperate in providing all available information to him on these deaths. It is important to emphasize that this is not a fault finding exercise but an educational one. The lessons learnt will be useful for future planning of maternal health services.

Maintenance of Records

Public health workers maintain records in respect of hoth mothers and children under their care for monitoring their progress. The importance of these records cannot be over-emphasised. Two important records that would come to the attention of hospital staff are the Mother's Card and the Child Health Development Record(CHDR). The Mother's card provides important information on the progress of pregnancy and also indicates, by the use of a red sticker, whether the mother is 'at risk'. A blue sticker identifies a primigravida. The importance of this card should be recognised by hospital workers as it is a useful tool in the management of the pregnancy.

The CHDR is a vital record maintained for the purpose of monitoring the child's progress through the early years. It provides information from hirth up to three years. Children horn in hospital would, therefore, have their initial records pertaining to the child at the time of hirth filled in by the hospital staff. Hospital staff should take a special interest in providing this information as it is necessary for monitoring the future progress of the child by the public health staff.

Referral

Due attention is often not given in hospitals to mothers and children referred to hy the public health staff, particularly to those requiring specialised attention. It is necessary that specialised clinics give priority attention to those persons referred by public health staff. The provision of adequate information when persons are referred back after attention will assist in guiding field staff in their further care.

EPIDEMIOLOGICAL SURVEILLANCE

Hospitals play a major role in providing information to the public health sector on diseases that come to their attention. Such information is utilised to prevent transmission of communicable diseases and to plan health programmes.

Notification of Communicable Diseases

The notification of communicahle diseases by doctors is a statutory requirement under the Quarantine and Prevention of Discases Ordinance of 1987. All doctors should comply with this requirement as the information provided is of immense value for early investigation and institution of appropriate action to prevent spread of the disease.

Every doctor who treats a paticnt suffering from a notifiable disease should notify the Medical Officer of Health of the area in which the patient resides in the notification card provided for this purpose(Form Health 544). It is desirahle to maintain a ward notification register and an institutional notification register for recording all cases notified. This is particularly important in large hospitals where notifications may originate from several wards.

It is regrettahle that reporting of notifiable diseases from hospitals is extremely unsatisfactory. Every effort should, therefore, be made to strengthen this activity through frequent supervision.

Providing regular feedback on notification received, classified hy wards from where they originated, has been found to improve notification in larger hospitals. a similar feedhack comparing reports from smaller hospitals could probably he equally effective in improving notification.

Hospital Indoor Morbidity and Mortality Returns

Of equal importance are the Indoor Morbidity and Mortality Returns that are required to be submitted quarterly from all hospitals to the Medical Statistician. These returns depend on information recorded in Hospital bed Head Tickets. Investigations reveal that incomplete records are maintained in most hospitals and that many diseases remain undiagnosed even at the time of discharge of the patient from hospital. It is important to ensure that accuracy of records as these data are utilised for monitoring disease trends, which are of value in planning health services.

Data for the Indoor Morbidity and Mortality Return are obtained from an Inpatient Register which should he maintained for this purpose. Information ohtained from the Bed Head Ticket is recorded in this register. Therefore, the need for ensuring the recording of an accurate diagnosis on the Bed Head Ticket.

Special Surveillance

Surveillance of diseases such as poliomyelitis and STD/AIDS is conducted through reporting from selected centres. As poliomyelitis has not been reported in Sri lanka after 1993, Sri Lanka has now embarked on a programme of eradication. It is now necessary to report all cases of acute flaccid paralysis(AFP) with view to excluding poliomyelitis as the cause, and to enahle the DDHS/MOH to take appropriate action. The

index case should also be subjected to appropriate clinical and virological investigation. Hospital staff should be made aware of the correct procedures that should he followed when these diseases are detected.

As the regional level sentinel surveillance is carried out hy the Regional Epidemiologists(REs) in respect of selected diseases, and for this purpose a large hospital is selected by the RE to he visited every month. All notifiable diseases are monitored at these sentinel sites. The following diseases are monitored to obtain detailed information:

Acute flaccid paralysis
Neonatal tetanus
Pneumonia
Dysentery
Diarrhoea

A special report is sent by the RE to the Epidemiologist on the active surveillance carried out at these sites every month.

HEALTH EDUCATION

The sick, reporting at hospitals for treatment, are more receptive to advice and guidance regarding prevention of illness from which they suffer. They are easily amenahle to attitudinal and behavioural change. Thus the hospital environment provides ideal opportunities for health education. Every member of the staff should endeavour to find time for educating patients and their guardians. Person to person communication affords the best means of imparting health messages to people.

All hospitals should set up organised health education units which utilise electronic audio-visual eqiupment such as public address systems and televisions for conducting health education programmes. Patients and relations awaiting treatment at Outpatients' Departments and clinics where they often remain for a considerable period of time have been found to provide a very receptive audience. These facilities could very profitably be expanded to all institutions.

It is imperative that trained staff be provided for conducting this activity and held responsible for its implementation. They should preferably be selected from amongst the existing staff. Many hospitals utilise the services of nurses

Training of all categories of staff in the use of proper techniques of health education is important. Uniform health messages should be provided to prevent confusion. It is necessary to realise that patients often consult members of the staff of an equal social status for advice. Thus, there is a need to train even the minor grades of hospital workers to respond to patients' queries by providing them with the correct information.

PARTICIPATION IN FIELD HEALTH ACTIVITIES

The DDHS/MOH often requires assistance in conducting field-based MCH and FP Clinics, School Medical Inspections, and training programmes for staff, volunteers and other community members. Hospital staff should participate in these programmes when called upon to do so. Attendance at the monthly conference at the DDHS office of officers in charge of all medical institutions will greatly assist in coordinating these activities.

IMPLEMENTATION OF PUBLIC HEALTH MEASURES IN HOSPITALS

Infection Control and hospital sanitation are two important preventive activities that deserve attention in hospitals.

Infection Control

Prevention of nosocomial infections and transmission of Hepatitis B and HIV/AIDS require special consideration. Trained Infection Control Officers should be appointed to hospitals and given the responsibility for infection control in their institutions.

Hospital Sanitation

Sanitary facilities should be properly maintained and cleanliness of hospital toilets ensured. This will not only prevent disease transmission but would serve as an example to patients on the proper maintenance and use of these facilities.

Refuse disposal especially the disposal of infective material and sharps requires special measures. The use of incinerators is advocated for disposal of infective material and sharps. DMO should ensure to obtain PHI to visit hospital. GH should have a PHI Register for PHI - log book.

CONCLUSION

Hospitals have an important role to play in the implementation of public health programmes. They serve as referral and service centres to complement some of the facilities provided in the field. Through the participation of their staff, they assist the public health sector to implement some of their important activities. Participation of hospital staff in planning and monitoring public health programmes should be encouraged. This could be effected by ensuring the attendance of hospital staff at monthly public health conferences held at the DDHS/MOH office. This is likely to bring about a better coordination of activities and an optimum utilisation of human resources.

CHAPTER 4

MANAGING DIAGNOSTIC SERVICES

1. Introduction

In an era of rapidly advancing technology, the medical world is flooded with high technology equipment. It is the affluent country which can afford the best and the most.

Sri Lanka is a developing country which has to accommodate its need of medical equipment within a limited low budget. The Health Ministry invested Rs.30 million annually, during the late 80's and it has risen to 600 Million for equipment. This increase in expenditure is partly due to the increase in prices of medical equipment world wide.

Earlier, medical equipment to the different levels of health care institutions were supplied on past experience and demand. With the introduction of the standard lists of medical equipment, the limited resources available have been put to maximum use. Nevertheless these lists can serve only as a guide.

The Ministry of Health has the formidable task of providing medical equipment to the various health institutions in the country and with the setting up of the provincial councils in the recent past, there has been a change in the hierarchy of the medical administrative set up. As such it is pertinent that the administrators at the provincial level play an active role in the management of medical equipment.

The objective is to rationalise both the purchase and use of medical equipment so as to ensure the availability of basic, cost-effective and safe medical equipment to all the health institutions throughout the country, using the funds the country can afford to invest in such equipment.

As such cost consciousness in the selection of medical equipment and the availability of facilities for the repair and maintenance are of paramount importance in the management of medical equipment.

2. Supplies Under Laboratory Services

1. Theatre equipment
2. ETU equipment
3. ICU equipment
4. Radiology equipment
5. Physiotherapy equipment
6. Transfusion services equipment
7. Paediatric, PBU equipment
8. Oncology equipment
9. Equipment for all specialties in the curative services
10. Laboratory glass ware and chemicals(Path, Hae. Microbe, Histopath)
11. Supplies from MSD other than drugs dressings and X-ray films (where a separate manual is available)

3. Legal Provisions

The Cosmetics, Devices and Drugs Act. No.27 of 1980(as amcnded by Act No. 38 of 1984) provides the legislative framework to control the procurement and use of health care equipment in Sri Lanka. The regulations under this Act have been gazctted in Gazette Extraordinary No.378/3 of 02.12.1985.

A Technical Advisory Committee has been set up by the Honourable Minister of Health & Women's Affairs to advice the Hon. Minister on this subject. Three Sub-committees have been set up by the Technical Advisory Committee, of which the **Sub-committee on Devices** recommends the equipment for registration.

4.1 Management Process

The management process commences with the estimation of annual requirements of equipment in the institutions based on their real needs.

For implementation of these activities, thcrc is an organization consisting of:

i) Bio-medical Engineering Services(BES)
ii) Medical Supplies Division(MSD); and
iii) Surgical Equipment Stores of the Institutions.

The Bio Medical Engineering Services is responsible for procurcment, storage and distribution of major capital equipment. The MSD is responsible for procurcment, storage and distribution of low value capital equipment.

However, Provincial health Ministry can purchase certain items in consultations with the BME engineer following the tender procedure laid down in FR.

At the provincial level to assist in the management the following committees should be established.

Provincial Equipment Committee
Sub Committee of PERC in District
Institutional Equipment Committee
For their reference see Annex 1.

4.2 Selection of Equipment

The General Circular No.1726(MF/4/91) of 16.10.91(Annex 1) provides the guidelines for selecting health care equipment. It is very important to select equipment of quality, taking into account the cost.

5. THE ESTIMATION OF ANNUAL REQUIREMENTS OF EQUIPMENT

This should be done based on the guidelines specified in General Circular 1726. In summary, the ordering of equipment should ensure that; the equipment ordered is within the list of equipment for the institution; within the estimated cost; and is within the annual budgetary allocation.

The estimation of the annual requirement of equipment is primarily the responsibility of:- the Director/ MS/M.O.I.C of the Institution.

"Equipment Review Committee" at institutional, District and Provincial level will examine the lists, and make amendments, if any with the concurrence of the end users.

The final list of capital items thus prepared at the provincial level should be forwarded to Director(MT&S) by end July of each year for items to be supplied for the following year.

A similar estimate for surgical instruments/consumables for medical equipment and other consumables, dental and lab items should be prepared and sent to the Director MSD, according to the funds allocated.

5.1 Procedures for Requisition of Equipment

For items to be supplied by MSD, all requisitions should be forwarded in Form Health 166 duly signed by the Head of the Institution, approved by the relevant PDHS/DPDHS indicating the availability of funds, in the case of institutions coming under Provincial Councils.Further the PDHS should consolidate the estimates of the institutions and submit to D.(MSD).

6. Receipts.

The reeeipt orders from the institutions should be forwarded to BES/MSD within three days of receipt of thc equipmcnt by OIC/RMSD, without which bills cannot be sent to the particular institutions.

7. Accounting and Stores Procedure

7.1 Keeping Ledgers:

On receiving new equipment, thc details of the cquipment should he entered in the stock book or ledger. Usually there is a page for each item stoeked. There should be two ledgers, one for eapital equipment and another for consumahle equipment.

7.2 Balancing the Ledger.

Whenever an itcm of new equipment is received, it is added to the total in stock. Each time an item is issued, it is subtracted from the total stoek and the ledger should be balanced immediately.

7.3 Payment for purehases.

Payment from all provinces should he made to MSD for the purchases of equipment and lahoratory itcms. This should be done no sooner the provincial officers receive the bills from MSD. This is the responsibility of the PD/Dy. PD.

7.4 Storage of Equipment

Proper storage of equipment(surgical, medical, dental and laboratory items) is essential for:-
ensuring the sterility of single use items, easy reach to those responsiblc for stores management; and ensuring quality during use.

Dental and lahoratory consumables which require refrigeration should be stored under specificd low tempcratures. Refrigerators should be defrosted at weekly intervals.

The PDHS/Dy. PDHS should makc periodic inspeetion of the store, preferably onee a month.

7.5 Issuing of Equipment

The items are issued to different units in thc Institution from the main stores.

During issue, there are procedures to be followed.
Maintaining a Ledger Record - i.e. writing the issue in the stock ledger
Issuing a voucher to he signed; and
an Inventory Record of the unit receiving the equipment
No equipment should be issued on verbal requests, on "Chits" or on "a friendly basis".

Use of equipment

User should be trained in effective use of the medical equipment. The trained staff only should be allowed to operate complicated and expensive equipment.To this end, the development and a user manual is essential.

Maintenance of Equipment

Capital equipment should be properly maintained (to be kept in good working condition) and the use of consumables should be controlled to prevent wastage, misuse and pilferage.

A Log Book should be maintained for each item of major equipment.

Few carefully selected staff should be trained in each hospital for preventive maintenance, with adequate tools in consultation with D/BMES. All expensive machines should have at least two years of maintenance contract. The maintenance contract should be drawn up in consultation with D/BMES.

Servicing.

In order to obtain maximum service from the equipment purchased, the equipment should be regularly serviced. To facilitate this, clear instruction on servicing should be given to the user by the supplier, agent or the BME.

A log book

should be maintained with respect to each major piece of equipment. It should state the details of the frequency and type of repairs, cost of the repair, person doing the repair and the like. Surgical consumables, laboratory glassware and chemicals, dental consumables and non consumables to all institutions are procured by MSD through SPC. The MSD also makes local purchase of accessories, chemicals etc. that are urgently required by the institutions.

9. Monitoring of Availability and Use of Equipment

Preventive and corrective maintenance and continuous monitoring of the use of equipment are the best safeguards against premature malfunctioning or breakdown of valuable equipment and the consequent interruption in services due to their non-availability.

10. Annual Survey of Surgical Equipment

In terms of FR 756, all stores held in each institution, MOH's office, Offices of the decentralised Units have to be verified during the early part of every financial year. The Boards of Survey appointed for this purpose will also be responsible for verification of surgical equipment.

The Boards of Survey for verification of all stocks of surgical equipment at the institutions under the Provincial Councils will be appointed by Provincial Directors. These Boards will consist of three responsible officers. The senior most officer of the three, will function as the Chairman of the Board. The Board should have at least one officer competent or qualified in the field of the equipment being surveyed.

10.1 Condemning of Unserviceable Equipment

The condemning of unserviceable equipment should be done regularly(at least once in three months) to prevent their accumulation and occupying valuable space. All stores found to be unserviceable should be separated and placed in charge of another officer.

A list of unserviceable articles should be prepared in form Gen 47[1]* in quadruplicate.

The list should be examined and unserviceable articles condemned by a Board of Survey appointed by the appropriate authority. Institutions under thc Provincial Councils, Dy. Provincial Director of Health Services will appoint a Board of Survey to institutions which have beds below 100. In other cases, Provincial Director of Health Services will appoint the Board.

11. RADIOLOGICAL SERVICES

Please refer to chapter 14 of Manual of Management of Teaching, Provincial, Base and Special Hospitals.

The problems encountered in this area is to obtain the required items on time.

The Provincial Equipment Review Committees should identify the requirements in generic names and not in trade names and inform DMSD in time so that he can order the same with SPC. Any specific product required to the department should be communicated with DMSD well on time before the usual ordering so that it could be included in the estimate. Very occasionally some items come to a stock out position at MSD due to prolonged lead time and it is recommended that the PDs and Dy. PDs should local purchase the item following the tender procedure. Change in specifications of any items in their department should be communicated with DMSD so that some thought could be given to it during the process of ordering.

12. Pathological Services

Reference Chapter 15 of the Manual of Management of Teaching, Provincial, Base and Special Hospitals. The main areas in this field where problems arise is due to the storage conditions of the items used and also the short shelf life some of the items have, and radioactive substance used in the laboratory. The annual estimate has to be done with the Pathologist giving due consideration to the space available for storage, consumption patterns and change of procedure in methods of testing.

13. Other Services

All other services the PDs and Dy. PDs should communicate with the Directors of the particular campaign or services and get instructions.

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[1]*Value under Revision

ANNEXURE 1

Provincial Equipment Review Committee(PERC)

should be established in the office of the PDHS. Its composition should be:

P.D.H.S.
Dy. P.D.H.S
Heads of major institutions(PH/BH/DH)
One Consultant from PH/BH
Regional RMP
Divisional Pharmacist
Regional D.S.
Officer in charge of Surgical Store - BH/PH, O.I.C of R/MSD.

The PERC should meet quarterly. The minutes of such meetings should he conveyed to all the memhers and the D(MT&S), D/MSD

Sub-committee of PERC

should be appointed consisting of the following members:
PDHS - Chairman/Dy. PDHS
D/RMP, D/Pharmacists, Two Consultants;
O.I.C. of the Base and Provincial Hospitals in the Province;
DDHS of the Division whose institutional requirements are to he considered.

The Sub-committee will;

Scrutinise and prioritise requests so that estimates conform to the limits of the allocation;
Monitor supply of equipment to institutions, prophylactic maintenance and repairs to the same;
Ensure economical use of surgical consumables, X-ray films, ECG paper and the like;
Ensure availability of basic essential equipment to all institutions in the Province.
Transfer of under-utilised equipment to other institutions inside or outside the province; and
Monitor condemning of unserviceables and dispose them.

Institutional Equipment Committee(IEC)

should be established in each Base Hospitals and District Hospitals.

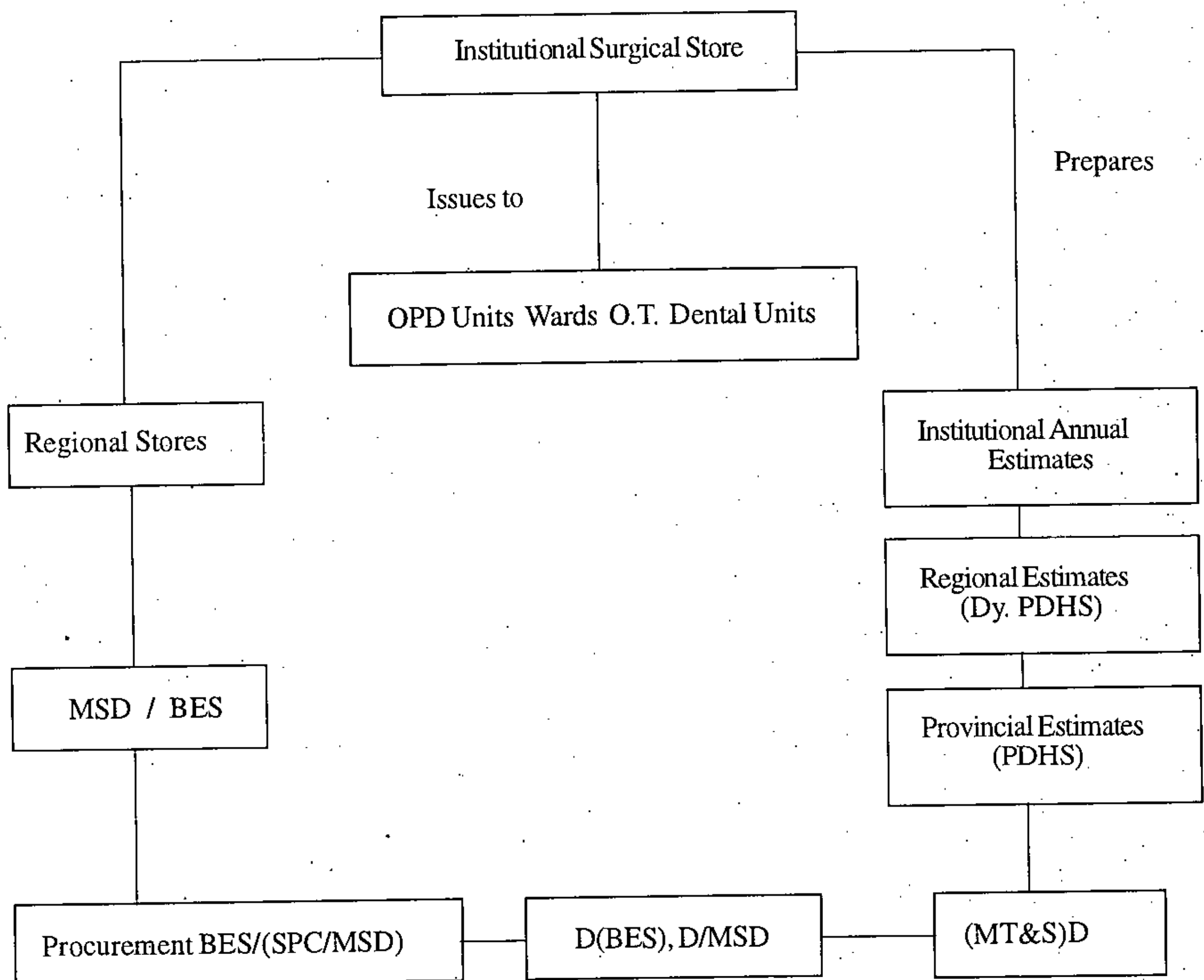
The membership of the committee should he:
Dy. PDHS - Chairman;
Director/MS - Vice Chairman;
RMP/Pharmacist i.c. of Surgical Stores - Secretary;
All Consultants;
SMO-OPD;
Matron/Theatre Sister;
Dental Surgeon; and
Heads of Units such as Physiotherapy not represented hy consultants.
This committee should meet bi-monthly. The minutes of the meeting should be sent to all the members, and PDHS.

Annexure 2

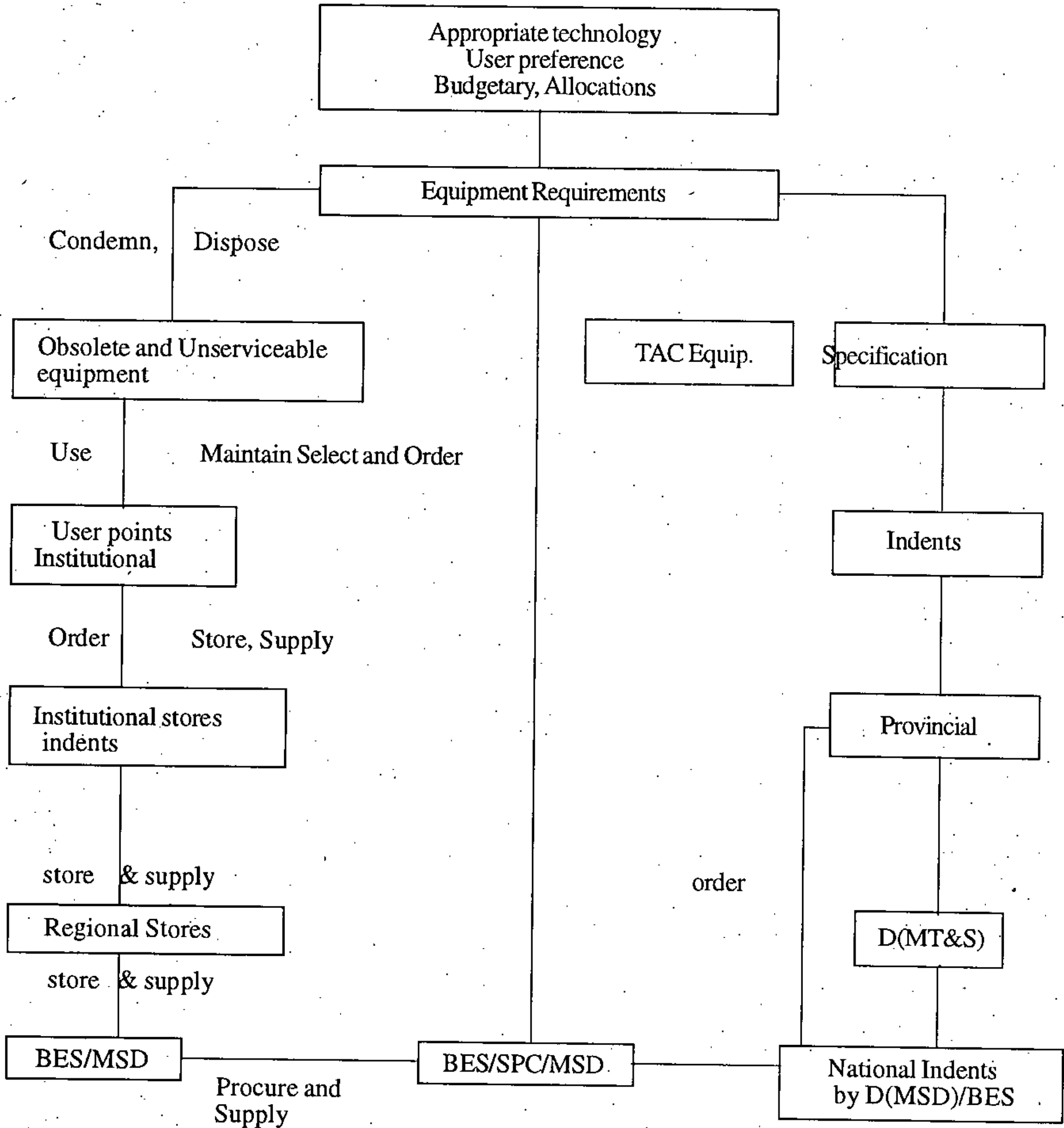
ORGANIZATIONAL STRUCTURE, MECHANISMS AND FUNCTIONS

Organizational Structure

To ensure continuous availability of health care equipment in the institutions, the Ministry of Health & Women's Affairs has an organizational structure and the following procedure.



EQUIPMENT MANAGEMENT CYCLE



Annexure 4

MANAGERIAL CALENDAR

Date/Month	Activity	Responsible Officer
Mid March to Mid April	Selection of required equipment	O.I.C./Institutions, Consultants and Users
End April	Price list to be sent to institutions	D/BES for capital equipment and D/MSD for consumable equipment
Mid May Committee	Preparation of Institutional requirements	Institutional Equipment
End June	Review and Synthesis of equipment list of Institutions for the Province	PDHS and PERC
Mid July	Posting cumulated lists of Provinces toPDHS D(MT&S) and DMSD	Dy. PD/Directors
Mid August	TAC meeting	DDG(LS)/D(MT&S)/DMSD
End August	Inform the TAC decisions to PDHS/ Directors	D(MT&S)
September	Preparation of national forecasts	D(BES)/D(MSD)
October	Transmission of national forecast to SPC/ Tenders by D(BES)	D(MSD)
Mid December at institutions	Stock Verification	PDHS
Annually	Stock of institutions	Dy. PDHS
Quarterly	Provincial Equipment Review Committee meetings	PDHS
Bi Monthly	Institution Equipment Committee meetings	Directors
Quarterly	Inspection of Institutional equipment	Dy. PDHS/DP DRMP/O.I.C

CHAPTER 5

FINANCIAL MANAGEMENT

Introduction

The Ministry of Health, Highways and Social Services had deemed prudent to prepare guidelines for better financial management for the benefit of the Health Sector of Provincial Councils. These are based on the financial regulations and circular instructions issued from time to time. This is only a brief note and the officers are advised to refer to the relevant sections and circulars for details.

01. Estimates

Annual estimates reflects the financial expression of the Government Policies and programmes of activity. Annual Estimates comprise of Revenue estimate, estimate of expenditure and advance to Public Officers account.

1.1 The preparation of the annual estimate commences with the issue of the Treasury circular in respect of the ensuing financial year.

1.2 Capital Expenditure

In this connection, your attention is drawn to FR 3 - Planning of expenditure.

Any Capital Project costing not less than Rs. 10 million should be approved by the Cabinet of Ministers. Your special attention is invited to the process of Project.

Planning and Two Stage approval procedure referred to FR 3(2) (i) (ii) and (iii). Capital Projects should be included in the Public Investment Programme approved by the National Planning Department of the Treasury before making budgetary provisions in the Annual Estimate.

1.3 Project Planning

The following stages should be passed through in the preparation of Medium Term Investment Programme.

a) Identification

b) Preliminary appraisal

c) Preliminary approval(Approval in principle)

d) Preparation of the Project

e) Full appraisal

f) Final approval

g) Inclusion in the Public Investment Programme

Thereafter, the budgetary provision will be made in the annual estimate and action will be taken to implement the project.

1.4 Capital expenditure is provided in the Annual Budget and implementation of the project should commence.

Regular evaluation should be done in the course of the implementation of the project to ascertain whether there were any constraints/hindrances in the implementation of the project and remedial action taken. Any project costing not less than Rs.10,000,000/= should receive the approval of the Cabinet of Ministers.

1.5 The capital projects may be classified as follows under the relevant Programme.

101 - Rehabilitation and Improvement of capital assets

102 - Acquisition of equipment

103 - Construction of Buildings

104 - Contribution to Public Institutions etc.

1.6 The object code under which budget has to be prepared is as follows.

Project 101:-

Object code: 2601-Rehabilitation and Improvement, Buildings

2602- - do - Plant & Machinery

2604- - do - Vehicles

2609- - do - Other capital assets

Project- 102 -**Acquisition**

2101 - Furniture for office, Household equipment

2102 - Plant and Machinery

2103 - Implements Tools Instruments and apparatus

2104 - Vehicles

2107 - Communication outlay etc.,

1.7 Recurrent Expenditure

Recurrent expenditure may be classified under the following programmes:-
Programme

1 - Administration
2 - Patient Care Services
3 - Community Health Services

1.8 Running expenses of the department are accounted under recurrent expenditure under following captions.

These are:

1. Personal Emoluments
2. Travelling expenses
3. Supplies
4. Contractual Services
5. Other recurrent expenses

These are shown in annual estimates object Nos.

1101 - Salaries and Wages
1102 - O.T. and Holiday Pay
1103 - Allowances
1201 - Travelling
1301 - Stationary and office requisites etc.

1.9 Advance Account Activities - Advance to POO.a/c

The estimates relating to Advance Account show three types of limits viz.

a) Maximum limit of Debits
b) Minimum limit of Credits to the Account
c) Maximum limit of debit Balance

Control Over Limits

It is the responsibility of the Chief Accounting Officers/Accounting Officers to ensure that the Advance Account Activities are managed economically, and efficiently whilst the financial outlays are kept within the prescribed limits. These are prescribed by parliament and any variation of these limits should also be approved by Parliament. Any application for variation of limit should be made to the Treasury before 31st December of the financial year in the form of a cabinet memorandum.

1.10 Revenue

It is necessary to prepare revenue estimates by the different sections of departments to be included in the annual estimates.

Revenue Heads which come under PDHS's in Provincial Councils are indicated below.

Revenue Head	Sub Head	Item	Sub Items
5	1	1	- Rent
5	2	4	- Interest
6	1	4	4 Miscellaneous income
6	2	4	1 Apothecary and Midwifery charges

02. DELEGATION OF AUTHORITY

2.1 It is not possible for the Accounting Officer to perform all the financial duties personally. He has therefore to delegate some of his duties to his subordinate officers as follows:

2.2 The scheme of delegation generally follows four distinguishable stages in execution viz:

2.2.1 Prior Authorization(F.R. 136) Officers delegated with authority under F.R. 135 has to initiate action by authorising the provision of certain supplies and services. By this act the State is committed to certain expenditure which may become necessary immediately or a few months later - F.R. 136.

2.2.2 *Approval.* After the supply is made or service is performed an officer delegated with authority under F.R. 135 has to approve the supply/service as performed in accordance with the requirements of the Department - F.R. 137.

2.2.3 *Certification.* On a report by the officer responsible for "approving" that the service has been performed an authorised officer of the Department certifies that the supplies/services were duly authorised and performed and that the payment is in accordance with regulations or contract is fair and reasonable - F.R. 138.

2.2.4 *Payment.* On the strength of the cretificate in (2:2:3) above, the Paying Officer will make/payment F.R. 139.

03. Maintenance of Records

i. Departmental Appropriation(Votes) Ledger FR447

A Departmental Appropriation (Votes) Ledger must be kept in every department on Form General 138, in order to enable the Head of a Department to control his expenditure under the various Ohjcct Code/ of each project. The account must show not only the amount expended hut also the liahilities incurred, in order that the exact amount available for expenditure at any time may be known. It is preferablc if a running balance of available funds is maintained.

ii. Classification Register

Every month all the payments should be classified according to the Programme, Project Ohject, and it should tally with the totals for the Votes ledger under the relevant object code. The total receipts and payments arrived at the classification should tally with the Cash Book.

iii. Cheque and Money Order Register

A register of cheques, money orders etc. should he maintained on Form Hcalth 214 at all offices to record remittances received by post for crediting to Govenment Account. The particulars of receipts should be entered by the officer in-charge of the Institution/office or by the officer delegated hy him for the purpose. The officer so delegated should not be other than the officer opening thc tappal. Particulars of disposal should likewise be entered giving all the information under the various columns-Headings of this register and authenticated by a responsible officer.

The delegation of such duties by the officer in-charge will not ahsolve him of responsibilities for the accounting of all such remittances received. He should pcriodically examine these registers and satisfy that the officers are performing their duties according to the requirements.

iv. Cash Book

A cash book shall be maintained at the Provincial Director's Officc and Deputy Provincial Dircctor's Office. In this will he recorded every cash transaction and, in the cross entry columns part of sum payable not paid out in cash but appropriated.

Progressive totals should he taken daily and daily halancc recordcd in the cash hook. On the last day of the month the cash book should be halanccd for the month and thc halance carried forward to thc following month.

Full details shall be given for every receipt transaction, thus where recovery has been made on account of Travelling Advance from a Travelling claim, the original date of advance and the original amount paid shall he recorded with the name of every officer from whom recovery has been made. Where a sum has been recovered as a result of over payment, the month of payment and the Blue Voucher No. should be noted. Paying-in-slips or vouchers should be written out by the Subject /clerk concerned and passed to the Cashier maintaining the Cash Book. The number of each cheque issued shall be recorded on the payment side with the name of the party. Abbreviated description of the service or supply and the Institution affected shall be recorded. On receipt of the Bank Statement the date of credit of each sum banked shall be noted in red ink on the left hand side. Cash book should be reconciled with the Bank Statement.

v. **Audit Query Register FR452(i)**

An Audit Query Register must be kept in every department, showing the date of receipt of all letters and queries received from the Auditor General, and the date on which a reply was sent. The queries received from thc Auditor General should be filed along with copies of replies sent. Seperate files should be opened for each query.

vi. **Deposit Ledger** F.R. 592, 593

A deposit ledger should be maintained at each Provincial Director's office/Deputy Provincial Director's office in form H569/G.69. All entrics should be authenticated by Chief Clerk and the superior officer. Where appropriate, separate ledgers should be kept to record different types of deposits such as Security deposits, Contract deposits and miscellaneous deposits.

Withdrawal of deposits can be made only on a requisition on Form G.70 certified by two Authorised Officers.

This ledger should be balanced every month and shown in a control account. Annual chcck should be carried out to ensure that the balance tallies with the total of the individual balances of unpaid deposits.

vii. **Register of FR 66 Applications**

A register shall be maintained in the Provincial Director's Office to record all applications submitted for approval. On reccipt of the Authority of thc Chief Secretary of the Province, a rccord shall he made in thc Register maintained and the authorised FR 66 application will be returned to Dy. Provincial Director.

04. **Rendition of Returns/Statements**

i. Statement of Actual Receipts and Payments of thc previous month and anticipated receipts and payments for the following month(Imprest Application/Flash Report)

This monthly statements should be sent by the Provincial Director to the Chief Secretary of the Province on or before the 3rd of every month, to enable him to submit his consolidated application to Secretary, Ministry of Provincial Councils on or before the 5th of every month.

ii. **Monthly Summary of Accounts**

The monthly Summary of Accounts shall be prepared from thc Paying in Vouchers (in respect of receipts) and paid documents (in respect of payments), (after reconciliation with the totals in the Departmental Appropriation(Votes) Ledgers and Classification of Receipts and Payments) and sent to the Chief Secretary of the Province by the Provincial Director on form Treasury 174 on or before the 10th of the following month.

iii. **Monthly Statement of Committed Expenditure**

The monthly statement of committed Expenditure shall be preparcd in respect of the allocation granted under each of the objects under the various Projects of Programmes. Monthly committee Expenditure statements by object are due at Provincial Directors office from Deputy Provincial Directors on or before the 15th of the following month. Adequate reason should be given for any variation.

iv. **Statement of Audit Queries Outstanding**

Provincial Director of Health Services should advice his Deputy Provincial Directors to reply Audit Queries promptly and he should obtain a monthly return of Audit Queries outstanding and see whether that the officers responsible reply all the Audit Queries.

v. **Annual Appropriation Account**

Provincial Director of Health Services should furnish Appropriation Account annually to the Chief Secretary of the Province in quadruplicate, in form, DGSA 1 to 9 - vote state accounts circular no. 49/95 of 25th of July 1995 in Sinhala and English with a Tamil translation.

The following should be incorporated in this statement:-

i. Amount in the Annual estimates

ii. Supplementary estimate/FR 66 application Total (A)

Less Expenditure

Consolidated Fund	(11)
Special Funds	(21)

Foreign Aid

FA Loan	(12)
FA grant	(13)
Reimbursable Loan	(14)
Counterpart funds	(15)
Reimbursable grant	(16)
Total	B
Excess/Savings	A + B

05. Reconciliation

(i) Appropriation(Vote) Ledger

At the end of every month total expenditure under each object code in the appropriation ledger should be reconciled with the total of classification of payments under the respective object code.

ii. The Monthly Classification of Receipts and Payments with Cash Book

Monthly total expenditure according to classification should be compared with the total expenditure recorded in the cash book, and tallied.

iii. Figures of Monthly Summary of Account with the Treasury Book

Figures included in monthly summary of accounts should be tallied with the provincial treasury books. If any discrepancies are detected, action should be taken to rectify errors by a Journal.

iv. Bank Reconciliation

Bank statement to be obtained from the bank at the end of every month or if required weekly or fortnightly as the case may be and prepare a Bank Reconciliation Statement. One copy should be forwarded to Auditor General and another copy should be pasted on to the cash book and another copy to the summary of accounts. This procedure will facilitate to detect any fraud or error early and remedial action could be taken.

v. **Reconciliation Deposit Ledger**

Any amount deposited in the General Deposit Account should be shown according to the dates of the receipt side of the deposit ledger and following particulars should he shown.

1. Date of Deposit
2. Name of the depositor
3. No. of the cash receipt
4. Reason for depositing the money and the amount

Following particulars should be shown when making payment from the General Deposit Account.

1. The date of payment
2. The name of the person who receives the money
3. No. of the cash receipt and the amount.

Receipts and payments should be authenticated by the Chief Accounts Clerk and by the Superior officer. When the repayment is made cross reference, to be noted in the following manner.

1. Date of repayment to be mentioned against the date of deposit.

At the end of each month the receipt and payments should be separately totalled and should he compared with the classification of expenditure and monthly summary of accounts. Control account has to be maintained by entering the debits and credits of Deposit Account every month and the balance carried over the end of the year should be tallied with the individual halances unpaid from General Deposit Account.

vi. Reconciliation of payments and recoveries of Loans-Public Officers Advance account.

1. When the Loan/Advances are paid to government officers a register to be maintained with the following details. Name of the officer, the date of payment and amount.

This has to be authenticated by a staff officer when the voucher is certified for payment. The monthly recoveries also be entered against their names. The total payments and recoveries should.be compared according to the classification of receipts and payments. These figures have to be included in the monthly summary of accounts.

vii. Reconciliation of individual halances of loans with the Control Account.
A control account should be maintained in respect of advances to Public Officers Account. Monthly

debits and credits(to be reconciled with the monthly summary of accounts) should be posted and the balance in the Control Account should be reconciled with the individual balances.

06. Tender Procedure

Tenders should be invited for the selection of contractors annually by the Provincial Director of Health Services/Deputy Provincial Director of Health Services for the following objectives;

i. Supplying food for the non paying patients and hospital employees.
ii. Laundry services
iii. Transportation of Oxygen Cylinders, Drugs, Thriposha etc.
iv. Burying of unclaimed dead bodies

6.1 General Procedure of calling Tenders FRR 685-799

Adequate publicity should be given for procurement of supply or services or work. So as to allow many tenderers to compete, notices should be published in government gazette and/or newspapers.

A period of not less than 3 weeks should normally be allowed from the date of publication of the Notice for the suhmission of Tenders.

Tenderers could be bound with the following conditions to enable only the suitable tenderers who have an ability to do the contract satisfactorily, to submit their tenders.

i. -Obtaining a worth certificate, issued by the Divisional Secretary of the relevant division.
ii. Charging a non refundable tender fee.(To cover the cost of documents).
iii. Charging a refundable tender deposit.
iv. Obtaining a certificate of experience.
v. Calling for Bid Bond wherever necessary.

6.2 Information to Prospective Tenderers

All intending tenderers shall he supplied with full information regarding the supply of service for which tenders have been invited.

(a) In the case of diet contracts the estimated numbers of diets to he ordered during the year or the estimated quantity of raw provision to be ordered, as the case may be.

(b) In the case of laundry contracts the estimated number of linen to be washed during the year.

(c) In the case of Transport - Thc Railway Stations from which goods should be transported to institutions, the distances there to and the period within which the transport should be completed and weight of goods to be transported.

(d) In the case of unclaimed bodies Number of estimated unclaimed bodies buried during the previous year.

6.3 The tender conditions shall make it clear that information so supplied is purely for the guidance of prospectivc tenderers and the Department reserves to itself the right to accept or reject any tender, part of a tender.

6.4 A sealed tender box must be kept in the room of a responsible officer for collecting the tenders.

6.5 If tenders are permitted to be submitted under registered post they must be received before the closing time.

6.6 Tenders should be opened in the presence of the Tenderers and testified the date and the signature. Tenderers or their agents authorised by a letter should be allowed to be present at this time. Original tender should be referred to the Project Officer for evaluation.

6.7 <u>Preparation of Tender Schedule and Report on Tenders</u>

The tenders rccorded shall be scheduled in the appropriate form under the supervision of a responsible officer.

The schedule shall be checked carefully by another officer. Tender evaluation committee should study the tenders and make a recommendation to the appropriate Tender Board. In making this recommcndation, TEC shall pay due regard to the rates quoted, current contract rates, if any, the capability of the tenderer to carry out the service or supply, and other factors relevant to the contract.

The lowest tender should normally be recommended. If a tender other than the lowest tender is recommendcd full reasons for such recommendation of every tendcr overlooked should be recorded.

6.8 If there are no successful tenders tender board may decide to recall the tenders. Where the invitation of fresh tenders involves delay and is likely to result in a service or supply not being arranged at the commcncement of a contract period, the Tender Board may direct either that thc previous year's contractor be allowed to continue the service or supply on a temporary basis until a permanent contractor is appointed or failing that, the other arrangements be made at rates not exceeding those approved by the Divisional Secrctary of the area.

6.9 Letter of Acceptance

Once the Tender Board has accepted a tender, a letter of acceptance in the approved form shall be addressed to the successful tenderer, under registered cover with copy to the Auditor General.

07. Capital Expenditure monitoring with the Plan

The action plan for Medium Term Investment Programme is generally prepared during the 4th quarter of the preceding year by the Provincial Director of Health Services based on the proposals submitted by the DDHS and DPDHS and in consultation with the Provincial Secretary of Health.

For this exercise assistant Directors(Planning) and Planning and Programming Officers of the Provincial Ministry, PD office and DPD offices and other members of the respective planning units are involved. Once the action plan is prepared the Provincial Secretary of Health submits it for the approval of Secretary of Line Ministry.

For the implementation of the plan estimates are called for construction and repairs of huildings from the Director of Provincial Engineering Department and thereafter the construction is carried out either by following the tender procedure or through the approved societies. In addition to this all acquisitions and purchases are handled by the Deputy Provincial Director of Health Services.

The imprest to implement the action plan is provided by the Line Ministry through the Chief Secretary of the Provincial Council. A report regarding the monthly expenditure is suhmitted by the Provincial Director to the Line Ministry through the Chief Secretary. The Ministry provides the necessary funds in accordance with the requests.

Every month a progress review meeting should he held attended by the relevant staff.

Besides, the physical inspections of the progress are carried out by the Provincial Secretary, Provincial Director, Deputy Provincial Directors and Divisional Directors in a planned sequence in association with the Assistant Directors(Planning), Accountants, Planning Officers and Administrative Officers, and monthly reports are submitted to Provincial Director/Provincial Secretary. Finally Provincial Director/Provincial Secretary submits monthly and quarterly reports to Secretary of Line Ministry.

If there were any constraints that hinder the progress of the appropriate performance of the contract, appropriate action should be taken to rectify the situation.

A Budget cell should be established to monitor the recurrent and capital expenditure.

08. Loss of Stores and Write off authority FR 102-113

8.1 Losses are divided in to two groups.

a) Shortages or breakages, of consignment, damages on transit, accident losses due to shortages detected at handing over or at a verification.

b) Other types of losses such as losses by negligence, carelessness, misappropriation, theft etc.,

8.2 All losses should be reported to Provincial Director of Health through Deputy Provincial Director of Health by the Head of institution.

8.3 Summary of action to be taken when losses occur

a) The loss should be reported where necessary to the appropriate authorities - FR 104

b) Report to the police in case of losses by theft, frauds,accidents etc.

c) Inquiries should be held and responsibility fixed.

d) Adequate security arrangements should be taken regarding the books, records etc. involved.

e) The loss should be recorded in the relevant Register of Losses - FR 110.

f) The amounts the officers responsible will be called upon to make good, should be fixed and action taken to recover them.FR 105.

g) Adequate steps should be taken to avoid a recurrence of the loss.

h) Disciplinary action, where necessary, should be taken independently - FR 105(4)

i) Preferring of claim on bank, Company Guarantor etc. where appropriate.

j) Accounting procedure, where applicable should be adopted
- FRR 106 , 107 supplementary provision only be necessary.

k) Order of write-off has to be made-FR 109(i)

l) An order of waivers has to be made when the full amount under (f) cannot be recovered
- FR 109(2)

8.4 Authorities to deal with losses in Provincial Councils

a) Provincial Director of Health Services - Losses not exceeding Rs.25000/= in value in terms of F.R. 105(1).

b) Chief Secretary of the Province - Losses not exceeding Rs.250,000/- or a higher amount as fixed by the Ministry of Provincial Councils/Treasury.

In all cases where the Chief Secretary has no authority to deal with losses, the full facts of the case should be reported to the Treasury through the Ministry of Provincial Councils.

8.5 Order of Write-off - FR 109

The term "Order of Write Off" is used to indicate the final order relating to losses.

A copy of every order of write off should be sent to the Auditor General.

Reference to the order of write off should be made in the inventories etc.,

09. Establishment of Internal Audit

Provincial Secretary of Health in each Province must establish an Internal Audit team. Internal Auditing is an independent appraisal activity established within the Department as a service to the Department. It is a control which functions by examining and evaluating the adequacy and effectiveness of other controls.

Internal Auditing is a systematic, objective appraisal hy Internal Auditors of the diverse operations and controls within the Department to determine whether;

i. Financial and operating information is accurate and reliable.
ii. Risks to the Department are identified and minimized.
iii. External regulations and acceptable informal policies and procedures are followed.
iv. Satisfactory standards are met.
v. Resources are used efficiently and economically.
vi. The departmental objectives are effectively achieved.

CHAPTER 6

MANAGING INFORMATION

Information provides the basis for decision making, in the managerial process for health development. Since different types of decisions are made in different levels, the information requirement varies from one level to another. Information must therefore be relevant and appropriate to the particular decision making points. In addition, information should be reliable and timely.

Information is used for;

a) Health planning and intervention strategies
b) Identification of problem areas
c) Monitoring of activities; and
d) Evaluation in relation to objectives

In district planning and management, information is needed to answer the 3 important planning questions;

- Where do we want to be in future? - **"There?"**
- Where are we now? - **"here"**
- How do we get from **"here"** to **"there?"**

1. INFORMATION IN THE DEVELOPMENT OF HEALTH PLANS

The first question - **where do we want to be? -**

requires the development of **national health policies and plans**, by the ministry of health stated in operational terms, based on clear goals, specific objectives and targets. Based on these long-term goals the ministry of health will have to develop realistic medium term plans which need a substantial input from the provinces. The annual health plans which should be developed at the provincial level should contain the analysis of the present situation and the health priorities that need to be tackled to help developing the medium term plans. Health information is necessary for this activity.

2. ASSESSING PRESENT HEALTH SITUATION

To answer the second question -**where are we now?** needs an assessment of the health status of the community, based on information about health prohlems and diseases.

Information gathering and analysis are expensivc. Therefore it is very important to identify clearly what kind of information is necessary and feasible to collect at the provincial level that will he most useful for the work in the districts. At this level information might be required for decision making, for education and training of health personnel, for people involved in health matters in other sectors, to communicate with the ministry of health, research workers and to give a feed back to the lower levels who provided the information so as to know their status.

3. INFORMATION NEEDS

3.1 Demographic information

Description	Source	Uses
population size and distribution in terms of births, deaths and migration	Registration of births, deaths and diseases- Registrar's return, population census, sample surveys and population projections	for calculation of different rates and trends-births,deaths, diseases, still hirths, preterm, neonatal deaths and maternal mortality.

3.2 Health services information

a) Curative health service information
b) Preventive health infonmation
c) Campaigns

As hospital is the first point of contact between community and formal health services in this country, it is also the main source of information. However, infonmation received from health care institutions may not be representative in many instances. Sizeable numbers do not attend the government health care institutions due to various reasons. Private sector and department of indigenous medicine (government and private) also

contribute for the health care service in Sri Lanka. However, these sectors are not well organized yet to provide the local health planners with necessary information as the government (western) sector. But this could be improved. The concept of "iceberg phenomenon" which emphasizes that the mass of health problems lies helow the surface should be borne in mind.

a) **Curative service information**

i. **Quarterly Indoor Morbidity and Mortality Return**

The main source of information of disease pattem is the hospital Indoor Morbidity and Mortality Return (see manual on Management of Teaching,Provincial, Base and Special Hospitals for hospital management chapter 17). A well maintained BHT providc information to complete this form after extracting information to the in-patient disease register. IMMR provides a quarterly summary of the in-patients disease register. It also provides information on total admissions, patient days for the quarter and deaths that occurred within 48 hours of admission to hospital. Therefore, study of this return before forwarding it to the Medical Statistician will provide the health managers with vital information mentioned earlier. This information could be made use of for reallocation of heds, indenting of drugs and further inquiring into deaths.

It is also important to check the accuracy of data hy randomly checking the data recorded in the IMMR with the entries made in the In-patient Disease Rcgister. All government hospitals providing inpatient care services, other than Maternity Homes must preparc thc IMMR quarterly and should forward this return to DPDHS. The IMMR with facilities to record information of all four quarters in the same form should be kept in the institution as the "office copy". The number of patients remaining at the beginning of the quarter and ending of the quarter and the patient days required to complete the summary page of this return should be obtained from the mid-night census.

This return is expectcd at the Deputy Provincial Director's office hy 25th of the month following every quarter. Although this does not reflect the morbidity and mortality that occurs in private institutions/others in the district, it provides a fairly good vision of the disease pattern of thc district/province. After extracting necessary information DPDHS should forward the retum to the Medical Statistician. This information is used in the preparation of Annual Health Bulletin at the central level.

Uses -
1. prioritize problems
2. age/sex distribution
3. seasonal variation
4. geographical distribution - spot map

ii. Notification of Communicable Diseases

This is a requirement under the Quarantine and prevention of Diseases Ordinance of 1987 and its subsequent amendments(refer to manual on hospital management). Notification from hospitals should be sent to MOH of the area. Here it is again under-reporting due to various reasons.

- lack of knowledge of the reporting requirement
- negative attitude towards reporting
- misconceptions that result from lack of knowledge or negative attitude

It should also be borne in mind that patients who seek other type of treatment other than western do not get into this system. Provincial Directors will be able to organise this system even in private and other institutions in his province if he is interested in control of communicable diseases in the area.

Uses- early information on impending outbreak
planning of control measures

iii. Quarterly Outdoor and Clinic Return

Information received at the DPDHS office. Programme planning officers are responsible to consolidate these data. Information received here are limited to total number of treatment days, first visits and subsequent visits and average daily treated. No infomation about age, sex, morbidity and seasonal pattem of the outpatients are received here. Short surveys will help the managers in getting this information if necessary(refer to manual on hospital management).

iv. Monthly Maternity Return

Received by the DPDHS monthly and Programme Planning Officers(PPOs) are responsible for consolidation of these statistics. This gives vital information such as number of births(live and still), birth weight of infants born in hospital, maternal deaths reported from the matemity wards, number of cesarian sections etc. It is helpful in studying the trends of birth weight and still births, investigate and initiate intervention programmes.

v. Annual Bed Strength and Staff Return

Information is useful in the reallocation of beds and hospital staff, both medical and paramedical(preparation of the return refer to Manual on Hospital Management). Programme Planning Officers consolidate these information and use in the preparation of Annual Health Plans for the district.

$$\text{Bed Occupancy Rate} = \frac{\text{No. of bed days}}{\text{No. of Beds}} \times \frac{100}{365}$$

b) Preventive Service Information.

- Quarterly maternal and child health return (H 509)
- Quarterly family planning return(H 1159)
- Quarterly immunization return(EPID/EPI/2/91)
- Quarterly sanitation return (H 631)
- Quarterly school health return (H 797)
- Weekly return of communicable diseases(H 399)
- Quarterly dental statistics

H 509, H 1159 and H 797 returns should be received at the DPDHS office before the 25th of the month following the quarter and consolidate and analyzed by the Medical Officer Maternal and Child Health (MO MCH) at the DPDHS office. Majority of the MCH information are consolidated into these 3 returns by the MOH and the rest of the details received by the MOH by various returns are available at MOH offices(Annexure 1).

Quarterly immunization return EPID/EPI/2/91, Weekly Return of Communicable Diseases H 399, Quarterly sanitation return H 631, expected before the 25th of the month following the quarter and consolidate and analyze by the Regional Epidemiologist, Supervising Public Health Inspector.
Special Surveillance diseases;

Cholera
Acute Flaccid Paralysis
Neonatal Tetanus
Measles
Japanese Encephalitis
Dengue Haemorrhagic Fever and
Rabies
Information about these should also be available at the Regional Epidemiologist (Annexure 2).
Quarterly Dental Statistics should be available at the Regional Dental Surgeon.

c) **Campaigns** - Monthly statistics on
- Malaria
- Filaria
- Leprosy
- Rabies
- Sexually transmitted Diseases
- Respiratory diseases - TB

received at the DPDHS office. Programme officers provide the information and Regional Epidemiologist is responsible for coordinating these activities. These statistics are useful for monitoring and evaluation of these programmes, replanning of activities.

3.3 Vital Statistics

- Birth Rate
- Death Rate
- Maternal Mortality Rate
- Infant Mortality Rate
- Still Birth Rate
- Neonatal Mortality rate

Most of the information necessary for calculating these rates could be obtained from the previously mentioned returns and records for the districts and also from Kachcheri. In addition Department of Census and Statistics also publish these information annually. But the information lags behind the schedule for 3-4 years. The same information is available in the Annual Health Bulletin published by the Ministry of Health.

3.4 Socio-economic Information

Many of these information should be available at the Medical Officers of Health(MOH) for their areas. MOH is expected to carry out an area surveys every five years. Information may also be available at the Programme Planning Office of the Kachcheri.

4. HEALTH INDICATORS

Health indicators are essential for analysing the present situation in the district/s and province, for expressing specific targets and for assessing whether these targets are being met or not. Also to measure changes or trends over a period of time and to make comparisons.

Indicators provide a means of comparing different districts in the country and measuring their progress in raising health status. Indicators can bring out the difference in health status between particular sub groups in the population, such as the privileged and the poor, or between rural and urban areas. Health and nutritional indicators are also indirect measures of overall development and direct indicators of quality of life.

Quarterly performance reviews at the provincial level based on the analysis of the information received at this office using these indicators will help in orienting the lower level staff in achieving district as well as national targets.

For the provincial health team health status indicators are more useful as regional planning is more operational in nature. It is important to select the relevant indicators.

4.1 Basic health status indicators:

- **Morbidity indicators**
  - leading causes of morbidity in the districts
  - disease specific incidence and prevalence rates for the common and severe diseases eg. malaria, diarrhoea or TB
  - analysis of the pattern of disease incidence/prevalence for all age groups and major age groups separately

- **Mortality indicators**

  - leading causes of mortality
  - crude mortality rate
  - infant mortality rate
  - 1-4 year old child mortality rate
  - maternal mortality rate
  - disease specific mortality rates
  - and the rates mentioned in section 3.3

- **Nutritional status**

  -the percentage of new borns with low birth weight
  -percentage of children with different degrees of malnutrition

Keeping the district health profile up to date should be a continuous activity. The information should be analyzed, displayed and widely communicated. Visual displays showing progress in the indicators should be given wide publicity.

4.2 Information support in developing district priorities

The next step in provincial/district health planning is to answer the question: **How do we get from "here" to "there"?** An analysis of the present situation, as shown by the district health profile should provide the basis for this.

In selecting priorities for developing PHC in the districts choices will have to be made regarding the following: which population groups, diseases or underlying health problems should be given priority? Which health programmes should receive more attention and more resources? Good epidemiological health information is necessary to help answer these questions. Making choices is a difficult process. Each district will have its own special problems. However, many important decisions on priorities that must be made at the district level could be made if a proper analysis of the health information is made at the provincial/ district level.

The analysis should identify the following:

- Main health problems
- High-risk groups
- Access to and coverage by health programmes
- Organization and management of these programmes

Analysis by age, sex, socio-economic, ethnic groups, occupational groups, any seasonal or climatic changes, access to health facilities will help in prioritising health problems.

4.3 In developing district health plans

Epidemiological information system should be used for health planning process as follows:

- Analyze the present situation, including health status, in the districts.

- Develop the priorities for the next annual and medium-term plans.

- Decide on which high-risk groups should receive priority.

- Make plans to improve access and coverage for the priority health programmes.

- Decide on the objectives and indicators to evaluate progress.

4.4 In evaluating progress

Implementation of the district health plan for primary health care can be evaluated in two main ways. The first is to assess what **programme activities** have heen achieved compared to what was proposed in the district health plans. The second is to determine if the indicators of health status have improved or if the frequency of disease or underlying health problems have been reduced. The health indicators will help for charting progress.

The main steps in undertaking an evaluation as part of district health management are:

- Select the necessary indicators for the health activities.

- State the objectives to be achieved in terms of the indicators.

- Collect the necessary health information.

- Judge the extent to which the targets have been met.

- Review the strategy and district health plans and make new annual plans for the next year.

5. Summary

A list of indicators for use in compiling information to be used in health planning, management and evaluation is as follows:

District population

Total
By age group
Births
Fertility

Health resources

Facilities
Personnel
Finances

Health status

Nutrition
Morbidity
Mortality

Health programmes

Maternal care
Child care
Environmental health
Hospital care

District health status and health planning profile

		Year 1	Year2	Year3	Year4	Year5
1.	**District population**					
A.	Total estimated					
B.	Total by age group					
	0-11 months					
	1-4 years					
	5-14 years					
	15-45 years					
	45+					
C.	Tot. births estimated					
	Crude birth rate					
	General fert. rate					
2.	**Health status**					
A.	**Nutritional status**					
	Infants					
	% with low birth wt					
	Children					
	Wt. for age					
	% between 3rd & 50th centile					
	% below 3rd centile					
B.	**Morbidity**					
	Selected specific diseases by number of new cases diagnosed					
	Diarrhoea					
	Measles					
	Neonatal tetanus					

	Year 1	Year2	Year3	Year4	Year5
Diseases with special control programmes					
Tuberculosis					
Malaria					
Leprosy					
Epidemic diseases					
JE					
Dengue					

C. Mortality

Total deaths

Total deaths estimated for the district.
Crude estimated Mortality rate
Estimated age specific death rates
Maternal mortality
Disease specific mortality - malaria
pneumonia
TB

	Year 1	Year2	Year3	Year4	Year5

3. Health programmes

A. Management of pregnancy

Total no. of expected deliveries in the province by districts

No. of pregnant women who received pre natal care

% receiving prenatal care

No. of deliveries attended by trained personnel

Estimated no. of couples using FP services

No. of couples accepting FP for the 1st time

% of couples continuing FP(women aged 15-45)

Similarly indicators should be used to assess the following;(which are already available and in use).

	Year 1	Year2	Year3	Year4	Year5
B. Child care					
infants					
Immunization					
Nutritional assessment					
C. Environmental health					
Water supply					
Excreta disposal					
Refuse disposal					
D. Hospital care					
Clinic visits					
OPD visits					
Hospital admissions					
Maternal deaths					

The improvement of information systems should be regarded as an integral part of a comprehensive strategy to improve management.

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FLOW OF MCH INFORMATION

ප. සෞ. සේ. නිලධාරිනියගේ ක්ෂේත්‍ර කටයුතු
Field Activities* PHM.M

මාතෘ සහ ළමා සෞඛ්‍ය සායනික කටයුතු
MCH clinic* Activities

පාසැල් සෞඛ්‍ය කටයුතු
School Health* Activities

ආයතනික මාතෘ සහ ළමා සෞඛ්‍ය කටයුතු
Institutional* MCH Activities

ප. සෞ. සේ. නි. මාසික වාර්තාව (සෞ: 524)
PHM Monthly Statement (H 524)

ත්‍රෛමාසික මාතෘදරක සායනික වාර්තාව (සෞ: 527)
Quarterly MCH Return (H 527)

ත්‍රෛමාසික පාසැල් සෞඛ්‍ය වාර්තාව (සෞ: 797)
Quarterly School health Return (H 797)

සෞඛ්‍ය වෛද්‍ය නිලධාරී
Medical Officer of Health

ත්‍රෛමාසික ප්‍රතිශක්තිකරණ වාර්තාව (ඊ 86)
Quarterly Immunization Return (E 86)

මාතෘ සහ ළමා සෞඛ්‍ය වාර්තාව (ත්‍රෛමාසික) (සෞ: 509)
Maternal & Child* Health Return (Quarterly).

ත්‍රෛමාසික ප්‍රතිශක්තිකරණ වාර්තාව (ඊ 86)
Immunization Return (Quarterly) (E 86)

මාතෘ සහ ළමා සෞඛ්‍ය වාර්තාව (සෞ: 509)
Maternal & Child Health Return (H 509)
ත්‍රෛමාසික ප්‍රතිශක්තිකරණ වාර්තාව (ඊ 86)
Immunization Return (E 86)

ප්‍රාදේශීය සෞඛ්‍ය සේවා අධ්‍යක්ෂ
Regional Director of Health Services

මාතෘ සංඛ්‍යාලේඛණ මාසික වාර්තාව (සෞ: 830)
Maternity Statistics Return (Monthly) (H 830)

Immunization Return Consolidated
ත්‍රෛමාසික ප්‍රතිශක්තිකරණ වාර්තාව (සම්පිණ්ඩිත)

- මාතෘ සහ ළමා සෞඛ්‍ය ත්‍රෛමාසික වාර්තාව (සම්පිණ්ඩිත)(සෞ: 509)
- Maternal & Child Health Return Consolidated (Quarterly) (H 509)
- මාතෘ සංඛ්‍යා ලේඛණ වාර්තා (මාසික) (සෞ: 830)
- Maternity Statistics Return (Monthly) (H 830)

FAMILY HEALTH BUREAU
පවුල් සෞඛ්‍ය කාර්යාංශය

EPIDEMIOLOGY UNIT
වසංගත රෝග විද්‍යා අංශය

MEDICAL STATISTICAL UNIT
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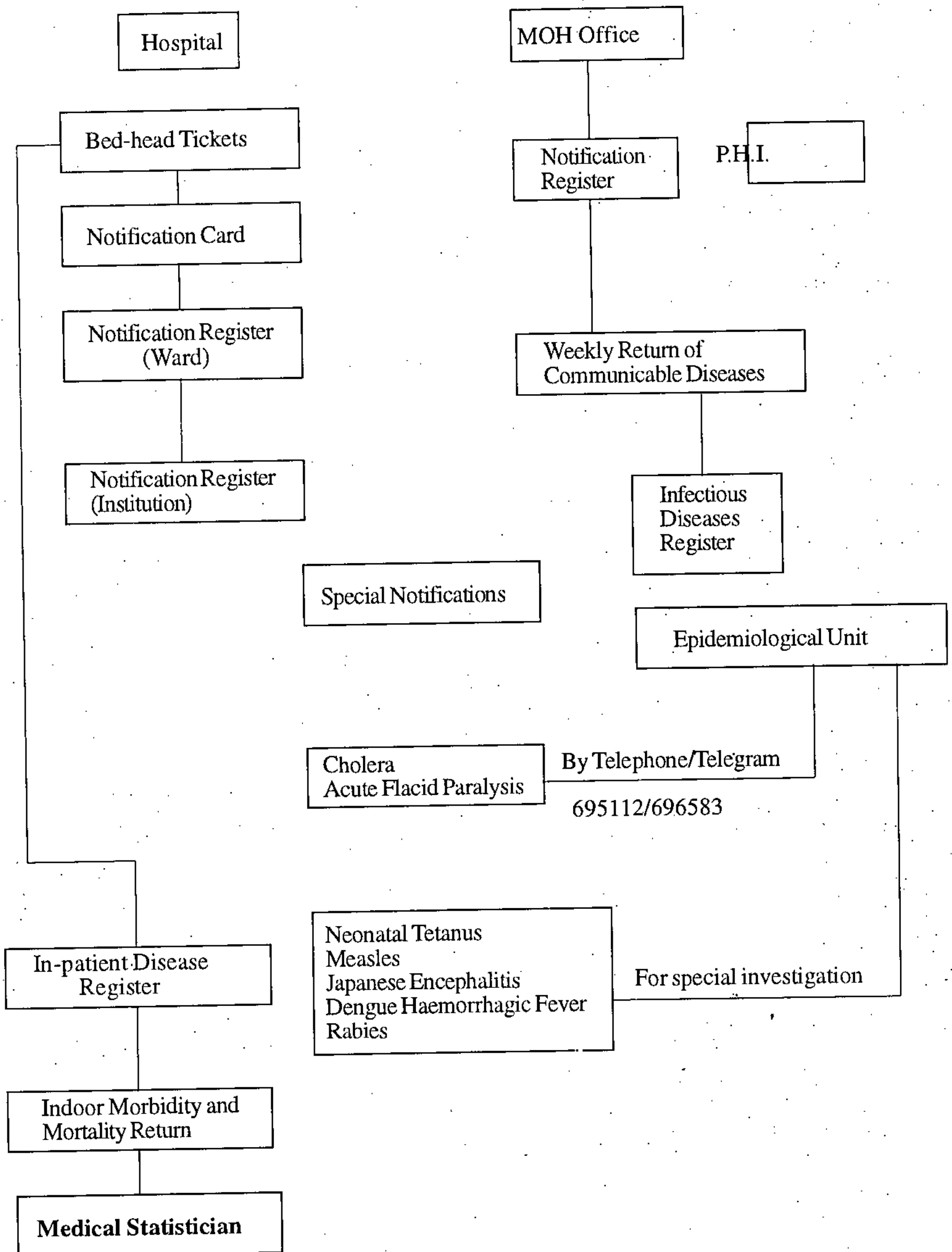
MECHANISM FOR COLLECTION OF DATA



CHAPTER 7

MANAGEMENT OF HUMAN RESOURCES

Organizations have realized that human resources are the most important of all resources. All managers in organizations are concerned with human resource management(HRM). This is in order to achieve the organizational goals through the efficiency of its employees. In certain organizations such as in large private sector firms, there are separate units to look after its human resource management activities. But in the public sector in Sri Lanka there are no such organized units responsible for HRM. Therefore the human resource management has to be undertaken by all the managers as part of their role in managing employees.

In human resources management, the aim of the manager should be to develop and realize the full potential of each employee under his or her supervision, in order to assure maximum benefit to the organization.

There are no universal techniques, or formulae in the management of Human resources. Organizations have to attract, select, train, motivate and retain qualified people. At the same time, employees satisfaction should be ensured by fulfilling there personal needs. In the Government Sector(including Health Sector) the managers of a Ministry/Province do not have the same freedom as in private sector managers to get involved in all these areas. In the case of Government sector, managers have less freedom in attracting, selecting and recruiting the employees.

Provincial health organizations deploy large numbers of various categories of health personnel to deliver health care in the community. The provincial managers will have to generate higher commitment as well as greater involvement on the part of employees of the organization in order to achieve the organizational goals.

This chapter highlights some of the key issues a Provincial Director should draw his attention to:-

i) the deployment of competent manpower in adequate numbers

ii) the development of required manpower by proper training

iii) resolving the factors responsible for poor staff performance

Planning for Human Resources

The health care institutions need different types of skills and competencies, and it is necessary to develop a plan to ensure that proper personnel are obtained for the organization when required.

Provincial directors will be asked to provide their cadre requirements for various categories of health personnel. In preparing their cadre requirements it is very important to do it methodically and scientifically.

Human resources planning analyses likely influence on the supply of and demand for people with a view to maximize the future performance of the organization. Human resource planning also can be viewed as an attempt to balance the requirement of employees with the numbers available. HRP looks not only on the quantity of manpower but also on the quality.

First of all it should be clear on the organizational objectives and its strategies. Next it is essential to forecast on the services going to he provided by the organization. then the manager should plan and request the cadres accordingly.

This is a process which ensures that sufficient number of employees possessing appropriate skills are available for achieving the goals of an organization. It involves in obtaining the **right people in right numbers** with **right knowledge, skills** and **experiences** in the **right jobs** in the **right place** at **right time** at **right cost.**

Provincial Director may not be in a position to decide on certain aspects on the above areas. Selection of certain categories of staff is done at the central level. Once they get appointed to particular provinces the Provincial Director will utilize them according to the needs within the province.

Decisions on cadre requirement

Cadre requirements generally have to be based on the future demands. In this aspect the design of cadre requirement is mainly based on the demand for the services. So before deciding cadre requirement the manager has to assess demands for different categories of staff based on the future demand of the services.

Also it needs to estimate the demand of requirements for each different professional group annually over the planned period.

Demand for manpower depends on

i) Health care demands
consider - likely future health service utilization
ii) Health needs based on demographic as epidemiological characteristics
iii) Health care, Personnel to population ratio
iv) Service targets

In deciding the requirement managers will have to use the above approaches and the suitable approach is based on the type of services to be provided. Also it may not have to follow a single method mentioned above, instead it is preferable to use a mix of such methods to develop the manpower requirements.

Some of the Factors influencing the Staff Performance

Motivation

Motivation refers to goal directed behaviour of individuals. First of all in order to motivate the employees the management has to provide the proper organizational culture and the climate in which the employee behaviour could be directed constructively towards better performance. Performance can be considered as a product of the capability and the motivation of a person.

There are several underlying factors for Motivation. According to Maslow"s theory there is a hierarchy of needs. Once the lower order needs are fulfilled, the individual become motivated by needs which exist at the next level of the hierarchy.

Although many people believe salary as the main motivating factor, there are several other factors which motivate people to work more efficiently.

Some of the factors which will be helpful to motivate a person are :-
a) Salary
b) Promotional prospects
c) Job security
d) Interest of the work performed
e) Working environment
f) Status
g) Recognition and appraisal of good work
h) Fringe benefits
i) Challenging work

Some action to Motivate Subordinates

i) The Manager must set an example
He needs to he a role model.

ii) Assess the strengths as well as weakness is of his/her suhordinates and place them in suitahle jobs

iii) Ensure their participation in managerial process. This enables sharing of ideas and bettcr dialogue with staff.

iv) Appraise of performance and appreciation of good work.

v) Provide leadership and promote team concept among its membcrs

vi) Provide them with additional knowledge

vii) Develop good personal relationship with the staff

lt is also important to design jobs to encourage efficiency and commitment.

i) By allowing a person to be involved in a variety of tasks within their capabilities

ii) To rotate thc placc of job
eg. by changing a nurse from one unit to another unit. By allowing a labourer who is in the theater to work in OPD etc.

iii) Get staff involvement in the decision making process

Conflicts and Conflict Management

Possible underlying causes for a conflict are:

i) When individual or groups feels that he or the group is treated unjustly by the superiors

ii) Lack of recognition or appraisal of work

iii) Lack of opportunity for skill development

iv) Lack of involvement in organizational decisions

v) Personal problems

vi) Personal weaknesses

These could be broadly categorized in to the areas of conflicts that take place between individuals or groups wherc they perceive

i) Goal incompatibilities(goal conflicts)

ii) Interfere with the goal accomplishment

Conflict situations are common in the health sector due to the following reasons.

i) The difficulty in deciding what is the right thing to do and how to do it, as it is difficult to measure the performance of the organization by outcomes

ii) Employees of several categories of staff from different disciplines leads to differences in perceptions and expectations

iii) No clear demarcation of authority

Managing a Conflict Situation

There is no perfect way of managing conflict situation. Management of the conflict situation will depend on the circumstance under which the conflict has occurred. Different situations demand different solutions. The provincial manager will have to face the prohlem with the best fitting solution for the problem.

Different styles may be adopted in managing conflict situations.

Common styles adopted are:

i) Avoiding
ii) Forcing
iii) Accommodating
iv) Collaborating
v) Compromising

The **Avoidance style** is used by the managers to stay out of conflicts, to ignore disagreements or to remain neutral. **Forcing** style reflects a win-lose approach where the forcing person feels that one side must win and the other loose. But the regular use of this style develops lack of respect and dissatisfaction. The **Collaborating Style** is a win-win approach which it tries to represent a desire to maximize joint outcomes. The **Compromising style** is adopted a give and take policy leads to partial satisfaction to the parties concerned.

Of the different conflict management styles the **collaborative style** and the **compromising style** will be advantageous for the organization, but again the manager will have to decide which of five management, styles is best suited for the problem in question.

In dealing with conflicts the manager must consider the following.

i) Conflict should be accepted by the manager as a normal occurrence.
ii) Need to develop trust in the parties involved in conflict in order to resolve it.
iii) Need for flexibility of each party is required towards compromising for settlement of the conflict.

In order to resolve a conflict

i) Collect all the underlying facts that lead to the conflict
ii) Take early action - Delay may develop into a series of conflicts
iii) Provide opportunities for each person or party to voice the opinion on possihle methods of resolving the conflict
iv) Provide your suggestions accordingly and arrive at agreement

Prevention of Conflict Situation

The manager should
i) Develop cordial relations with the staff
ii) Play a supportive role by guiding them in working situations and in personal problems
iii) Encourage the staff members and get them involved in decision making on the related areas
iv) Be impartial in dealing with any issues

Alcoholism

Alcoholism is a significant prohlem faced hy the health care managers. This is characterized hy compulsive and uncontrolled drinking which interferes with normal living pattern.

According to the rules available the government employee should not consume alcohol while at work. If the person is found to he smelling of alcohol he cold be disciplinary dealt with. There are standard procedures to deal with such prohlems.

But the manager should look into the problem of alcoholism in a broader way than this. It is very important to identify and correct a person who is addicted to alcohol early hecause of the destruction it could create on the person's carrier. Also it will decrease the productivity of a person as well as of the institution. There will be instances that he will have to be disciplinary dealt with. In such instances manager may have to decide on the circumstances and act accordingly.

Some of the **warning signs** of alcoholism are

i) Absenteeism
ii) Leaving the work place early
iii) Borrowing money from other workers
iv) Public complaints
v) Co-workers complaints
vi) Ineffectiveness of the job
vii) Unexplained absence from work
viii) Over reaction to criticism
ix) Avoidance of supervisors and managers
x) Unpredicted and inappropriate behaviour

Specially in larger institutions like in major hospitals the manager may have to look into this type of prohlem broadly as there are several employees working in it. Alcoholism is an illness and should be treated accordingly. At the same time it is important to note that majority of the employees who develop alcoholism can be helped to recover. The condition should be diagnosed and treated early.

In this exercise the manager must try to:-

i) arrange programs to tackle this problem
ii) supervisors have to be trained to cope with this issue
iii) train the supervisors to identify the problem early
iv) arrange programs with the consultant physician/consultant psychiatrist to treat those affected
v) maintaining confidentiality is very important
vi) may have to identify and train counsellor to conduct counselling on those affected

Staff Welfare

The management of an organization has a responsihility to look after its employees. There are economic as well as social reasons for this. Some of the reasons why an organization should provide welfare services for its employees are:

i) By providing welfare services it will help to ensure the productive capacity of the employees

ii) In some of the instances it is a legal responsibility to provide such welfare measures for the employees

iii) It is a social responsibility of the employer to provide such services to its employees

The effects of stress on joh performance is a recognized feature. The stress is an individual reaction to certain aspects of work. Most of the employees in institutions face different levels of stress during their work. Also different stress levels are experienced by different people. The provision of welfare services is also oriented towards the prevention of such stress-related issues. This will help the employees to cope with their efficient work performance.

Welfare services provided for the employees may be grouped in to two hroad categories.

1. Personnel welfare services
2. Group services

1. **Personal Welfare Services**

Personal welfare services deals with counselling and advisory services. This will be helpful in:-

a) Carrier development of the employee
b) Help in case of sickness
c) Obtaining legal advise in need
d) To have good working relationship etc.

Although a counselling system is not existent in the public sector, introduction of such a system will help to motivate the employees in any organization. Manager may not have adequate time to get involved in counselling. But he can appoint a responsihle officer for it.

2. **Group Services**

Some of the welfare issues considered in relation to groups of employees are:

i) Provision of canteen facilities
ii) Provision of rest rooms
iii) Provision of social and recreation facilities
iv) To provide assistance in transport, housing, shopping etc.
v) Pension issues and
vi) Granting of loans etc.

Also, it will be much helpful if a welfare officer is appointed for these activities. Specially it will be helpful in the larger institutions such as the provincial hospitals.

Also it need to train the managers and supervisors to enable them to cope effectively with counselling and provide support for the employees in need. It is necessary to train the managers and supervisors for them to become more efficient and effective counsellors so as to support the employees who need such counselling.

Absenteeism

Absenteeism is one of the commonest problems faced by the health care organizations. There are number of reasons why people cannot get to work. But there may be special reasons for them to get chronically absent. Absenteeism costs a lot for the Government departments in Sri Lanka; including the Health department. Some of the common areas related to staff absenteeism are:

i) Social attitudes
ii) The nature of the work
iii) Working conditions
iv) Job satisfaction
v) Alcoholism
vi) Social activities
vii) Family responsibility and
viii) Travelling difficulty etc.

Some of the key factors that need to be considered by the manager to prevent and to control absenteeism are:

1) Develop a proper working climate at the place of work.

2) Keep attendance records accurately. This will help to spot the absenteeism much early before it becomes a major issue.

3) Supervisors will have to be accountable for the behaviour of its employees.

4) Keep an observant eye and it will help to identify this problem early.

5) Closely observe the conditions of working environment.

6) Set time period limits for activities wherever possible.

7) Train the supervisors in absenteeism control methods.

BASIC TRAINING

At present, the Provincial Health System is responsible only for the basic training of the Public Health Midwives, Part II course. However, in future it is proposed that the provincial council will also undertake the basic training of Public Health Inspectors.

Training of Public Health Midwives

Introduction

During the early years of the nineteenth century midwifery services were confined to the medical care institutions in the urban areas. Untrained midwives, the so called Traditional Birth Attendants were responsible for home deliveries in the rural areas. Since the establishment of the first Health Unit at Kalutara in 1926 midwifery services was introduced to rural areas through a trained midwife. A good health infrastructure which included Maternity Homes and Rural Hospital etc. paved the way for safe institutional deliveries in the periphery. Domiciliary services were provided by the team of health workers headed by the Medical Officer of Health(MOH). In areas where the muslim community is concentrated for example Eravur, Beruwala, Weligama a "Woman Medical Officer"(WMO) was appointed to work with the MOH to guide and assist the Public Health Midwives(PHMM) working in these areas.

Midwife training was increased from three months to six months and at present it is eighteen months. Part one training which is of twelve months duration is conducted in the nine(09) Nursing Training Schools(NTSS) and the part two training is done in the nine part(II) PHM training centres including the National Institute of Health Sciences(NIHS) Kalutara.

All part II PHM training centres come under the provincial set up except the NIHS which comes under the administration of the Central Government.

At present the 8, part II PHM training centres in the provincial set up get the resources and other facilities through the Provincial Director(PD).

As there is a shortage of PHMM working in the periphery to provide Primary Health Care Services(PHC) it is necessary to train more PHMM.

As such PDD of the provinces where part II PHM training is conducted have a big responsibility to ensure training of adequate number of PHMM and also to improve quality of the field based training programme.

Distribution of Part II PHM training Centres

Unfortunately part II PHM training centres are not scattered evenly throughout in Sri Lanka. Of the nine centres four are situated within the Western Province, two within the Central Province, one each in Southern, North Western and Northern Province.

Western Province

1) National Institute of Health Sciences
2) DDHS/Panadura
3) DDHS/Moratuwa
4) DDHS/Homagama

Central Province

1) RTC/Kadugannawa
2) DDHS/Werellagama

Southern Province

1) RTC Galle

North Western Province

1) RTC/Kurunegala

Northern Province

1) RTC/Jaffna

The last batch of PHM trainees were given part II training at Batticaloa.

Functions

It is important to note that of the 8, part II PHM training centres, 4 are upgraded and are now called regional training centres(RTC).

The RTCC in addition to functioning as part II PHM training centres, conduct inservice as well as other continuing education programmes for different categories of health workers.

As there is a proposal to decentralize training the RTCC may have to start training Public Health Inspectors(PHII) also. At the moment National Institute of Health Sciences is the one and only centre conducting basic training of PHII.

There is the necessity to open up at least three more part II PHM training centres in the country. The most suitable locations will be Badulla, Batticaloa and Vavuniya.

If Sri Lanka is aiming to reach the goal 'Health for all by the Year 2000' it is necessary to take serious and prompt action to strengthen the health infrastructure in the periphery with the provision of adequate number of PHC workers.

Resources required for part II PHM training

Students who are sent for part II PHM training have completed twelve months training at a NTS. One of the main objectives of part I training is to provide knowledge, skills and develop attitudes for conducting safe delivery at the institutional set up.

During part II training they are exposed to the community set up and two thirds of the training programme is field based. In fact the trainees live in the community with the PHM of the area.

They attend classes at the MOH office(DDHS office as it is called now) twice a week during the six months period. In addition they are attached to a Maternity Unit in the DDHS area or a nearby place to get experience in working in a maternity unit and also to learn management of a maternity unit.

If quality training is to be ensured it is necessary to provide trainees to the DDHS office and to the field practice area served by the DDHS. In other words the staff requirements for the DDHS handling part II trainees must be fulfilled.

2 special grade nursing tutor
1 PHM per 3000 population
1 PHI per 15-20,000 population
1 PHNS per PHI area
1 SPHM for every 5 PHMM etc.
Clerical staff
Labourers etc.

A proper building should be made available for the facilities for training. In other words the DDHS office must have a separate section for training. In that section there should be adequate space for classroom facilities, and other basic facilities, like toilets, library, storeroom, common room etc. As far as possible a twenty four hour water supply on tap should be available. In addition the environment of the DDHS office should be clean and healthy with minimum extraneous noises that may disturb the teaching learning sessions. The DDHS office should be easily accessible to trainees and the community. Facilities for garbage disposal is a must to keep the DDHS office and garden clean.

Furniture

In the classroom there should be a table and chair for the teacher and adequate number of chairs for trainees. The chairs should be specially designed to provide facility for writing.

Other facilities

Magiboard/greenboard, slide projector, overhead projector and side tables etc. are the minimum facilities needed for any training programme. There are other special requirements for PHM training. For demonstration purposes certain special items are needed

ex.
a) Midwifery kit
b) Post partum box
c) Urine testing equipment
d) Blood pressure apparatus
e) Thermometers
f) Stethoscope
g) Basins
h) Mackintoshes
i) Kidney trays & surgical items
j) Weighing scale

are some equipment that must be made available.

In addition samples of clothing which a lactating mother may require, clothes that a new born baby requires etc. should be available for training.

Library facilities

Every training centre must have a reasonable stock of library books which are relevant for the type of training conducted in the centre. In addition to the text books, there should be current literature made available, journals, magazines, papers etc.

If possible each training centre should be provided with computer facilities. Students will be misfits if they are not computer literate in the twenty first century.

As PHMM have a big role to play as Health Educators it is good to have a small facility for production of Health Learning Materials. PHM trainees should be taught to prepare low cost health learning materials.

Financial allocations for training

The field trainees need to travel more when students are attached to them. As such the commuted travelling allowance for PHMM in the part II PHM training should be increased.

As an incentive the field trainees should be paid a reasonable allowance when trainees are attached to them.

The DDHS must be allowed an additional sum of money for fuel. Otherwise he/she may not be able to monitor, supervise and evaluate the training activities conducted in the field.

Allocation for chemicals, drugs, vaccines, non consumables and consumable items etc. should be more for training centres than for other DDHSS.

If these facilities arc not made available quality of training may suffer. Once the students complete their training they have to work alone in remote far off places. Therefore skill training is an important task for the trainers of the DDHS office and field.

Financial allocations should be made available for training of trainers as this is a very important activity to improve quality of training.

Skill development of Trainers

Those officers who accept the responsibility to perform duties as trainers need special skills apart from the technical skills they possess. Whatever the category of trainee they handle the trainers must have the following skills.

a) Communication skills

b) Interpersonal skills

c) Skills to select and use different teaching methods correctly under different circumstances

d) Decision making skills

e) Management skills

f) Counselling skills

g) Skills to prepare lesson plans, teaching learning aids etc.

h) Skills to plan teaching sessions

i) Skills to evaluate training programmes, trainees and trainers

j) Skills for curriculum development etc.

If possible all trainers should be given the opportunity to undergo a training on educational technology for a period of one month at least, ideally three months. Careful planning is necessary to release officers and to cover up their work during that period.

INSERVICE TRAINING

Inservice training is one form of continuing education. All health workers are given a basic training to provide the minimum competencies to fulfill their job functions during their period of work, but they do not get opportunities to make use of all the competeneies they acquire, and also they will be confronted with activities which need new skills of competencies. In the former instanee it is natural that they forget or feel insecure to perform such activities which are not routinely done. Inservice training will provide opportunities to renew their knowledge and skills.

The new skills they have to aequire(for example with scientific, technological advances, new surgical instruments, new equipment etc. has to be handled) depend on the work plaee and the type of work they are confronted with. Very often under such circumstanees on the job training is given but short courses(5-10 days) of Intensive Training may be useful and produetive.

Similarly new health problems arise from time to time. For example HIV/AIDS, ebola virus etc. Close monitoring of the emerging health problems could be made to deeide what subjects to be covered during inservice training.

Planning for Inservice Training Programme

Unless Inservice Training Programmes are planned properly they can be of no use to the participants or eommunity. Therefore it is essential that well planned Inservice training programmes are conducted.

What are the basic, important vital steps a planner must follow when plans are to be drawn for inserviee training.

Steps to be followed

a) Identify the health problems of the area
b) Seleet the target group
c) Do a proper needs assessment
d) Prepare eurricula for training
e) Identify resources
f) Discuss with relevant authorities

- administrators
- trainers/resource personnel
- other officers who have done similar programmes
- community leaders etc.

A master chart should be prepared indicating the order of selecting the participants. A decision has to be made as to the frequency of conducting Inservice Training for a particular group of health workers. For example -

Staff nurses every three years

Public Health Nursing Sister - every two years etc.

Another important issue is to decide on the number of participant per programme and also to decide whether it should be a multi disciplinary type of training.

It is very important to plan out the practical sessions and field training if there are any in such a way that students do not idle.

Further if courses are conducted simultaneously in two or more places the trainers should be given a training in how to conduct each session so that there is uniformity of training.

Method of monitoring and evaluation should be planned ahead of the training programme. Very often training activities are not evaluated properly. During the planning stage one must decide in:-

a) continuous evaluation

b) The method of evaluation

c) impact evaluation or follow up.

Cooperation of the participants and trainers must bc sought for effective evaluation of any inservice training programme.

Evaluation of trainers too has to be planned to ensure quality of training. Customarily this is not an activity that is carried out regularly in Sri Lanka.

DISTANCE EDUCATION

Distance education is one method of continuing education that is bccoming popular among workers. Those who find it difficult to leave their work place or home to attend inservice training programmes have accepted distancc education as a practical and efficient method to improve knowledge.

Thus establishing a unit or cell in the provincial set up will be useful to help health workers who are interested in gaining new knowledge.

Further the problem of releasing health workers and arranging for covering up duties, providing transport for participants of training programmes, making available facilities for accommodation etc. will not arise. Some authorities who have used distance education as a method of continuing education claim that it is less costly and therefore cost benefits are higher. However very close monitoring and supervision is necessary at the peripheral level.

When using distance education as a method of continuing education considerable amount of time must be spent on planning, and organising the activity. Teaching learning materials have to be available in sufficient quantities to make the distance education programme effective.

Library facilities must be available to those who are engaged in preparing the teaching learning materials. A group of dedicated teachers have to be identified to make this activity a success, apart from having students who are interested and eager to learn.

Buildings and other facilities for duplicating forms, printing, storage and distribution are other issues that need to be looked into.

Pre and post evaluation of the group of trainees identified (the target group) must be inbuilt into the distance education package.

(* the teaching learning materials used must be checked and reviewed regularly.)

Workshops and Seminars

These methods can be used to for continuing education of Staff/Health workers.

Limited number of participants should be selected for a workshop but large numbers may be invited for seminars.

Workshops

This is a very good method for continuing education because it leaves room for interaction of participants and hence active learning process ensured.

Availability of adequate resource personnel is a must to make the outcome of the workshop a success. The resource personnel should be subject specialists and well trained trainers.

Teaching learning materials also should be made available to them to enhance the Teaching Learning process.

A proper evaluation of trainees, trainers and the programme should be done hased on the objectives of the workshop.

Difficulties and Limitations of a workshop are as follows:

-selection of the participants

-making available adequate resources

-selection of a suitable venue for conducting a workshop

-time needed for planning a workshop is quite considerable when compared to other methods of continuing education like seminars.

Seminars

This is a good method of education to give opportunity for large number of health workers to improve knowledge. Selection of the target group for a seminar on a specific subject should be carefully done.

When the availability of time is limited and participants cannot be released for days or weeks, the seminar is useful because it can be limited even to a couple of hours.

CHAPTER 8

PLANNING OF DIVISIONAL HEALTH SERVICES

1. Introduction

1.1 Development of Divisional Health System

After independence in 1948, the Government launched a massive development programme, inclusive of health infrastructure development. The Department of Medical and Sanitary services was thus estahlished in 1948, to spearhead this developmental programme. This was a highly centralized organization with very little coordination between the two sections. In 1949, the Govemment commissioned Dr. Cumpstan, an Australian, to undertake a study of the health services and to recommend a suitable structure. He recommended decentralization to improve management, better supervision, intersectoral cooperation and community involvement. The Government accepted the recommendations and enacted the Health Services Act No. 12 of 1952, which provided for the framework of the Department of Health Services. The first step in the process of devolution of Health Services was the consequent establishment of the Superintendents of Health Services in 1954. Their areas generally corresponded to Administrative Districts.

With the establishment of the District Minister System in 1978, there was closer intersectoral coordination at the District Level. The devolution of health care services to the district level was consolidated by the devolution of powers of the Minister of Health to the District Minsters by Gazette notification dated 23.09.1982.

The next milestone in the process of devolution was the establishment of Provincial Councils by the 13th Amendment to the constitution, dated 14.11.1987. The management of Health Care Services was assigned to the Provincial Councils as a devolved function, with certain areas such as policy, purchase of drugs and equipment, technical education, management of Teaching and Special Hospitals being retained at the centre.

The most recent devolution was to the level of the Divisional Directors of Health Services (1992). All devolution exercises in the Ministry of Health have been in step with the general devolu-

tion process of the country. The district (regional) level administration was abolished. To meet the health needs in the division and to function on par with the Divisional Secretaries, the Medical Officers of Health were appointed Divisional Directors of Health Services(DDHS). The functions performed by the Regional Director of Health Services at the district level were transferred to the DDHS. Thus the administration of both the public health services and curative services was assigned to the DDHS(fig.i).

This system is expected to provide:

-better integration of the preventive and curative services;
-a means for better plan formulation hased on the needs of the community;
-effective implementation and close monitoring of activities;
-improved coordination of health related sectors and NGOs; and
-better community mobilization.

Although the district administration was abolished the services of thc Regional Director now redesignated the Deputy Provincial Director has been retained to effect a smooth transfer of functions from the district to the divisional level.

1.2 Services at Divisional Level

The Divisional Health Organization headed by Divisional director of Health Services will ensure:- Provision of comprchensivc, Promotivc,Curative and Rehabilitative Primary Level Hcalth Carc to all the people in the division. It will include, among others, the following services:

1. Collection, analysis and interpretation of hasic vital and health data;
2. Basic Epidemiological investigations with focus on micro-epidemiological work;
3. Essential maternal health services (Prenatal/Natal/Postnatal care);
4. Family Planning Services;
5. Essential Child Health Services(Infant/Preschool);
6. School Health Services;
7. Immunization against vaccine preventable discases;
8. Essential Environmental Hcalth Services;
9. Prevention and control of Communicable discases such as Rahies, Malaria, STD, Leprosy, Filariasis, Tuhcrculosis, HIV/AIDS, Japanese Encephalitis, Dengue Haemorrhagic fever etc;
10. Prevention and Control of Non-communicable diseases;
11. Nutrition;
12. Health and Nutrition Education;
13. Primary Level Medical Care Services including early diagnosis and prompt referral.

1.2 Roles and Responsibilities of DDHS

The Divisional Directors of Health Services are expected to perform four major roles. These are:

1. The role of a Health Manager responsihle for the administration and technical control of all government health institutions and the field services;

2. The role of a Community Physician - which includes the administration of the public health services;

3. A Leader of Health Development; and

4. A Teacher of Health Development.

The DDHS is assigned certain responsibilities, under each of the above mentioned roles. A detailed description of the roles and responsibilities of DDHSs issued by the Ministry of Health is given in annex. 1.

2. Role of the Provincial Director in Planning Divisional Health Services

This will require the assessment of needs of the community in each division through the study of:
-the demography
-morbidity, and mortality patterns
-the quality, coverage and range of services provided hy the puhlic as well as the private sector
The information necessary for this purpose may have to he ohtained:
-by conducting periodical surveys and
-by designing, establishing and operating a management information system (MIS) and an epidemiological surveillance system.

The Provincial Director should guide the Divisional Directors in the preparation of a plan of action utilising the information obtained from the assessment of needs to hridge the identified gaps and deficiencies in the quality and range of services and coverage of population groups.

The PDHS may set up a Planning Unit or cell in his office to assist him in planning the health services. This should provide the guidelines and the necessary training for the Divisional Offices to prepare the Divisional Health Plans.

The plans will include:

a) Annual Health Development Plan
b) Medium Term Plan
c) Perspective Plan
d) Project Plans

The PDHS should coordinate the preparation of this plan by conducting meetings with the DDHSs periodically. He should also monitor the implementation of these plans by regularly reviewing the progress.

3. Management Information System

The Provincial Director of Health Services should design, establish and operate relevant and need-based management information system and epidemiological surveillance system, including data bases which will include among other plans, health status, health problems including trend analysis, and forecasting of epidemics, health needs, service provision, manpower, equipment, supplies, finance, health related agencies and individuals including private practitioners.

Mechanism for collection of data

ROUTINE DATA

A. Hospital Data

i) Hospital returns
   Indoor morbidity and mortality return - quarterly
ii) Notifications
iii) EPI/CDD return - quarterly
iv) Vaccine/ORS stock return - monthly

B. MOH Data

C. Demographic Data

D. Data from Laboratory surveillance

SPECIAL DATA

i) Surveys

ii) Outbreak investigation reports

4. Resources for Divisional Health Services

Divisional Directors of Health Services will receive funds as follows:-

i) Funds from the Provincial Council

ii) Funds from the Line Ministry

The Provincial Councils will prepare a budget under Head, Programme, Project and Object Code and the funds will be provided to the Divisional Directors of Health Services under Head, Programme, Project and Object Code.

The Line Ministry will allocate funds under the Medium Term Investment Programme to the Provincial Councils who in turn will distribute the allocation to the Divisional Directors of Health Services.

Preparation of Budget

Annual Divisional Health Plan should be prepared for recurrent expenditure. Action should he taken to prepare Medium Term Investment Programme for each Division and it should be forwarded to the Provincial Director of Health Services who would consolidate and transmit same to the Ministry of Health, Highways and Social Services on due date.

Allocation of funds to Divisional Director of Health Services

Provincial Directors will allocate funds for recurrent expenditure under their Head, Programme, Project and Object Code under advise to the respective Deputy Provincial Director of Health Services who would continue to make payments. Similarly allocation under Medium Term Investment Programme would be made by the Provincial Directors.

Authorization of Expenditure

A scheme of delegation of functions in terms of FR 135 should be formulated by the Provincial Directors of Health Services under the four district functions viz. Authorization, approval, certification and payment. However, the functions that should be delegated to the Divisional Director of Health Services may be as follows:

1) Authorization of Increment of all staff attached to the Division
2) Authorization of O.T. up to 40 hours
3) " Holiday Pay
4) " Travelling

5) Supply and requisites
6) Repairs
7) Transportation, communication and utility and other serviccs

Tender Board

A Tender Board may be set up as follows:
1) Divisional Director of Health Services
2) A representative from the Divisional Secretariat(Preferably Accountant)
3) Representative from the Provincial Office

5. Coordination of Divisional Health Services

Structural and functional relationships of DDHS

i) First level Supervisor : Provincial Director of H.S.

ii) Second level Supervisor : Secretary(Health)of the Province
Director General of Health Services

iii) Typical contacts required at immediate work environment of DDHS
- i) Divisional Secretary;
- ii) Heads of health related sectors;
- iii) Chairman and Members of Pradeshiya Sabha
- iv) Members of the Parliament and Provincial Council in the Division
- v) Social, religious and political leaders in the division
- vi) Heads of NGOs, Private health and health related agencies and private practitioners
- vii) DDHS of adjoining divisions

6. Supervision of Divisional Health Services

The Provincial Director should supervise and motivate the Divisional Directors of Health Services in the province such that the maximum work performance, commensurate with their potentials, is obtained. In doing this, the PDHS will:

i) make regular supervisory visits to all DDHSs according to a planned monthly programme and a standard check-list of content of supervision.

ii) promote, assist and ensure that each DDHS develop a monthly work(servicc) performance targets and monthly advance programme.

iii) promote, assist and ensure that each DDHS identified levcls of accomplishment and pro poses measures/actions that minimises shortfalls.

iv) give due recognition to the good work done hy the DDHS; and also discourage his/her unsatisfactory work performance.

7. Evaluation of Divisional Health Services

It is proposed to evaluate the work of the DDHSs utilizing:

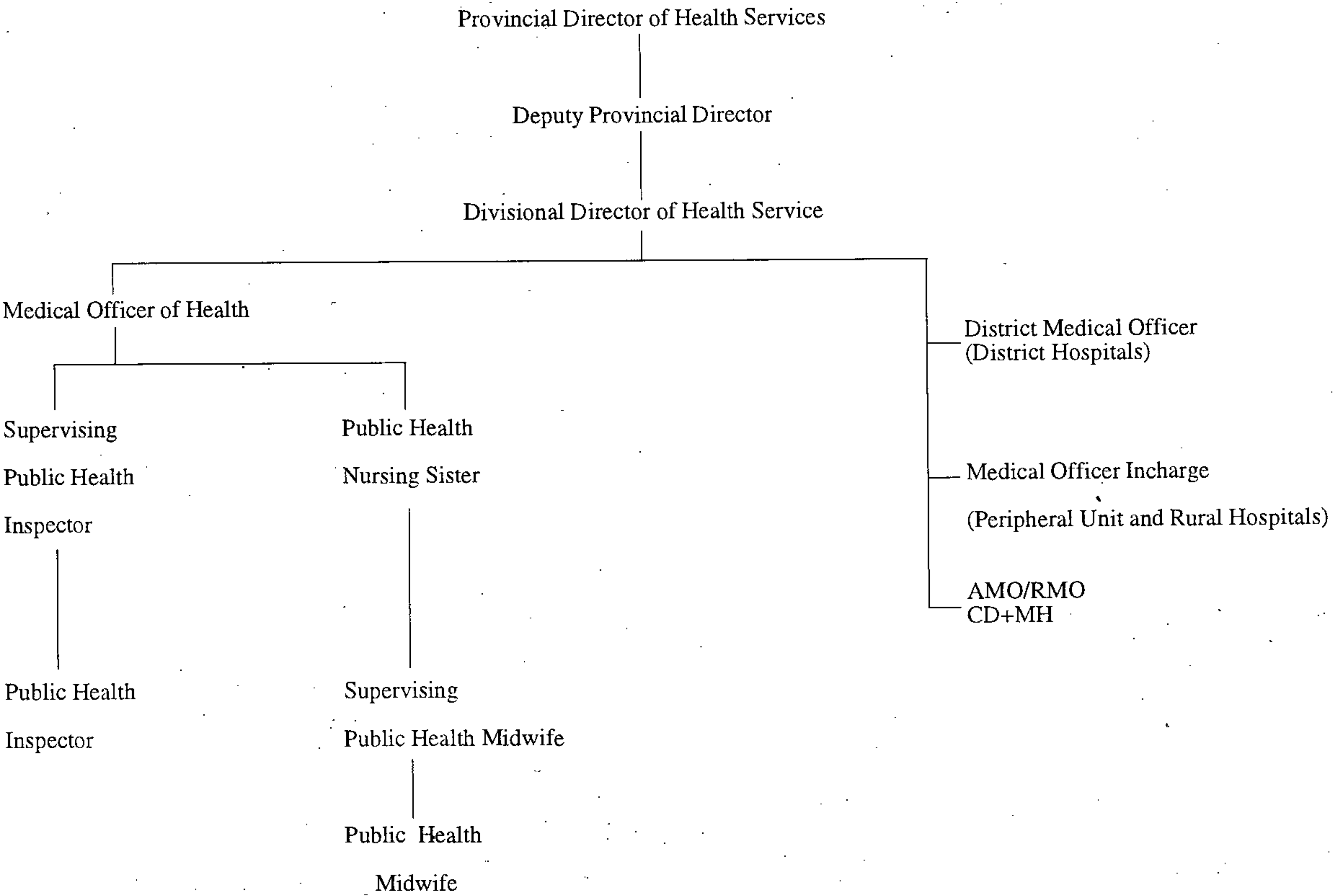
i) The Annual Work Plan prepared by DDHS

ii) The quarterly performance reports submitted hy DDHS

iii) Reporting of periodical supervisory visits and discussions of supervisory officials of Pro vincial and National levels.

iv) Annual performance appraisal reports

Format 1



Divisional Director of Health Services (DDHS)
Job Description

The DDHS is the alter-ego of the Provincial Director of Health Services in the division. He/She is responsible for total health development of the assigned division.

Roles and Responsibilities

1. He/she is the chief health manager of the division. All government health institutions and field services in the division (Annex-1) will be under his/her administrative and technical control. Management of Health services, health resources and health development at large will be his principal managerial responsibility. He/she will coordinate with health - related sectors, NGOS, Private Practitioners of all systems of medicine; develop and maintain good public relations with all concemed mobilise community resources etc.

2. He/She is the principal community physician of the division. In this capacity, promotion of health prevention and control, early diagnosis and treatment of diseases and disabilities; rehabilitation of the needy will be his/her principal technical responsibilities. A list of services envisaged to be provided under his/her technical guidance and supervision is at Annex-2

3. He/She is the Leader of Health development in the division, He/She will provide guidance, support and leadership for all health development efforts, present and future, in the division. He will be member of the divisional coordinating committee.

4. He/She is a teacher of "Health and Development" in the division. He/She in this context will be responsible for educating public, leaders, personnel of Health-related sectors and such others who have a role in health development and b) training and developing health personnel.

5. Any other roles and responsibilities assigned from time to time based on local needs and the needs of health administration of the country.

Functions

I. Plan health services development in the division. It will include, among others, the following:

I). Conduct periodical survey (s) on Health and health-related aspects and assess

(a) The patterns of morbidity, cause specific mortality and disabilities etc. and the service needs.

(b) The quality, coverage and range of services being provided, sources of care, Patterns of use etc; and

(c) Gaps and deficiencies between (a) and (b)

II.) Prioritise and schedule actions to bridge the identified gaps & Deficiencies in quality and range of services and coverage of population groups.

III.) Prepare a Plan of Action every year for health development in the assinged division. The plan of Action will incorporate among others, actions for.

a) Better provision of comprehensive promotive, preventive, curative, and rehabilitative services with referral links;
b) Measures to prevent and control epidemics;
c) Better use of currently available resources;
d) Identification, mobilisation and effective use of additional resources likely to be available;
e) Increasing the quality and coverage of services within the range of services defined to be provided in the division; and
f) Integrating budgets for the year both of capital and recurrent.

iv) Involve in the planning process the representatives of other government health-related sectors, NGOS, Private practitioners of all systems of medicine, elected representatives of people, prominent citizens etc. and ensure that the plan is need based, realistic and acceptable to all shades of opinion.

v) Establish and operate viable mechanisms at divisional level and below to effectively support the process.

vi) Obtain approval of the plan of Action from the Provincial Director of Health Services well in advance of implementation.

2) Organise the health resources available in the division in a way that support effective implementation of the actions and services specified in the plan of action & within the framework of all relevant guidelines and directives issued by the provincial health administration. In doing this, the DDHS will

I) Periodically review the current use of various health resources available:
II) Identify areas of under-use, non-use, misuse, abuse;
III) Take steps to enhance effective use of the available health resources; and

IV) If organising the resources involves any major changes such as redefining the joh descriptions of health workers, reallocating population groups and/or areas etc. the approval of the PDHS will be sought prior to enforcement.

3. Ensure that the health services of defined quality and range are provided equitably to all the population in the division. In this context, he/she will also provide directly promotive, preventive, curative and rehabilitative services in divisional hospital, other institutions and in the field during his/her schedule of visits, as per his/her interest, expertise, health prohlems, and the needs of the people.

4. Supervise and motivate the health personnel in the Division such that the maximum work performance, commensurate with their potentials, is obtained. In doing this, the DDHS will:

1) Make regular supervisory visits to all institutions and field according to an approved monthly programme and a standard check-list of content of supervision;

11) Promote, assist and ensure that each health worker and his/her supervisor develop a monthly work(service) performance targets and monthly advance programme of work (service) in tune with the specified job description and in consonnance with the plan of Action of the year:

111) Promote, assist and ensure that each health worker and his/her monthly work performance, identifies levels of accomplishment and proposes measures/actions that minimise short falls;

iv) Recommend and/or initiate such measures in consultation with PDHS and based on approved criteria,
a) That give due recognition to the good work done by a health worker and his/her supervisor and
b) That also discourage his/her unsatisfactory work performance.

5. Ensure that requisite knowledge and skills of both technical and managerial nature, for effective performance of assigned jobs, are available with all health workers and their supervisors. In doing this, the DDHS will:

I) Assess and identify the deficiencies, if any, in the knowledge and skills of all health functionaries;

II) Organise in-service and continuing education/training programmes, whether formal or informal, on-the-job or distance education, at the local/divisional lavel;

III) Liaise with and seek support from training institutions, local NGO's eic. that could assist in this function;

IV) Procure such educational/training materials which are suited to local needs and/or prepare such materials based on local conditions and distribute to all concerned personnel of health and health-related sectors and also GP's as relevant.

6. Coordinate and maintain good public relations with all concerned officials in the divisional Secretariat and other government agencies, non-government agencies, private practitioners and such others including teachers, community leaders, (social, religious and political) women's organisations, charitahle and voluntary organisations, etc.at divisional level and levels below and elicit their cooperation and collaboration in health divelopment. In doing this, he/she will:

I) Prepare relevant documentation that descrihes their potential roles, responsibilies and functions as complementary and supplementary to the health sector functions, mechanisms, processes and procedures established to facilitate better and more effective coordination etc.

II) Prepare information booklets on services available, their nature, content and source; procedures, and such other rcgulations governing services provision, patients rights to know etc. and widely circulate;

III) Support preparation of plans of action of activities to be implemented by other agencies, and individuals;

IV) Estahlish mcchanisms for sharing of experiences, performance, problems and future perspectives and also monitoring of services provision, implementation of plans of action etc.

V) Provide feedback to all concerned of achievements and failures, underlying causes, corrective actions to be taken and responsibility thereof etc.

7. Ensure that -

(a) Rcquisite quantity of right type and quality of drugs, vaccines, chemicals, equipment and such other supplies are indented, received and distributed on right time within the framework of procedures in the manual of managment of drugs, supplies,equipment etc. made available; and

(b) The available equipment, buildings, vehicles are in good working conditions through proper servising, preventive maintenance work and repairs etc. within the contours of the budget available, policies, procedures, rules and regulations governing it.

8. Ensure effective implementation of various provisions and statutory powers vested in him/her in the legislation enacted to protect and preserve the health of the public. Also, recommend licensing of practitioners of different systems of medicine, owners and managers of pharmacies, medical establishments, hotels, restaurants and such othcr eating houses; moniter their performance-irregularities and abuses; apprehend those that practice without liccnce and delicence those that do not conform to the set standards.

9. Design, establish and operate relevant and need-based managment information systems(s) and epidemiological surveillance system(s) dealing with different functions, including data base(s) therefore which will include among others plans, health status, health problems, including trend analysis and forecasting of incidence of diseases(epidemics) health needs, services provision, manpower, equipment, supplies, financing, health related agencies and individuals including private practitioners.

10. Design and implement appropriate processes and procedures for periodical monitoring of health services provision (quality, range, coverage, accessibility, efficiency and effectiveness) in the division at different levels. Further, based on such a monitoring process:

    (1) Prepare and submit periodical progress reports to different organisations as mutually agreed; and;

    (11) Prepare and submit periodical feed back reports to all those concerned.

11. Undertake periodical evaluation studies and analysis for example, of health status, health problems, use of resources, quality of services, emerging health problems and their epidemiology, cost analysis; operations research(field action research) of innovative ideas and interventions.

12. Plan and operate system for disaster preparedness and response.

13. He/she shall be responsible for all financial, administrative and establishment matters relating to his office and range within limits of delegation.

14. Report with regular periodicity to provincial Director of health services of various developments, progress, problems, proposed action etc. in the division as per the requirements, stipulations, guidelines issued from time to time and also comply with the directives issued by PDHS from time to time on various aspects of health services administration in the country.

15. Any other function(s) which is not specifically listed above, assigned whithin the framework of development of health of the people and in fulfilment of the needs of health administration in the country.

CHAPTER 9

LOGISTICS

1) INTRODUCTION

Buildings and Logistics

It is very essential to have an efficient system of supplying goods and services in the health institutions to maintain satisfactory patient care services. Most of the government departments may be able to afford some sort of breakdown of these services but not the health institutions such as hospitals.

1.2 The responsibility of the PDHS will be to ensure that the health institutions under him have sufficient accommodation and an efficient logistical services. These will include;

Logistical Services of Institutions under PDHS

1) Construction and maintenance of buildings.
2) Maintenance of service systems such as water, electricity and gas supply.
3) Maintenance of communication system.
4) Maintenance of sewerage, drainage and waste disposal systems.
5) Maintenance of cleaning and security services.
6) Establishment and management of diet and linen service.
8) Maintaining a transport service.
9) Supplying and stock controlling of drugs, blood, medical and non medical supplies.
10) Supply of uniforms.
11) Disposal of unserviceable items, and clinical waste and sharps.
12) Maintaining a landscaping system.

2. BUILDING CONSTRUCTION

2.1 All health institutions should have their own future plans for development to cater to the ever increasing demands in this sector.

2.2 Any building planned for, has to be a part of the development plan of the institution. Design of the building should not be tailor made to suit the limited financial resources. Instead it is more appropriate to construct the building in stages depending on the availability of money for the actual requirement.

2.3 In designing a building or any construction the end users of the project has to be consulted and their requirements have to be accommodated wherever possible. The advantage of this is that they will use the building with more satisfaction and need for modification of the design at the stage of construction will be minimized.

2.4 Wherever land space is limited and expensive, especially in urban areas, steps should be taken to put up multi storied buildings. If funds are inadequate for this purpose at least the foundation should be designed in such a way, that in later stages additional floors could be added to the building.

2.5 In designing a building, services of a proficient architect should be obtained wherever possible. This will help to get a building not only strong and spacious but also beautiful and more convenient, which will harmoniously match the landscaping of the premises. PDHS has to ensure that in designing a building, proper consultation has been carried out with the officer in charge of the institution. Each and every copy of the design drawing plan of the building can be signed by the head of the institution stating that he has been adequately consulted and plans and drawings are satisfactory.

2.6 After awarding the contract the design and the estimate should be made available to the officer in charge of the institution and also a meeting should be held with the engineer, consultant(if any), contractor, officer in charge of the institution and the future users wherever it is appropriate. This will help the close relationship among these parties which will help to monitor the performance of the construction in a healthy atmosphere. (Tender procedure to be followed for the award of the contract is given in the annex.)

2.7 It is the responsibility of the PDHS that the constructions are carried out according to schedule for which a program has to be obtained from the contractor and performance has to be monitored regularly till the building is completed and handed over.

3. Important items which have to be considered in constructing a building.

-Feasibility and justification
-Proper approval and availability of money
-Availability of services such as electricity, water, telephone, sewerage etc.
-Easy accessibility and proximity to service centres and central administration and end users.
-Ownership of the land.

-Approval of the plan by the local authority.

-Security of the premises

-Environmental effects

-Taking over the completed building with a list of fittings which can be removed

4. Logistical Services

4.1 The responsibilities of the head of the institution in attending to services listed in para 1 are explained in the 'Manual of Management of Teaching, Base and Special Hospitals'. (Chapters 18, 31, 34, 35, 36, 38, 39 and 40) The responsibility of the PDHS is to ensure that these systems and services are effectively operated under these guidelines.

4.2 In obtaining items, facilities and services tender procedure has to be followed. This procedure with the authority vested over at different level of positions is given in the annex "Tender Procedure."

SUPPLIES, SERVICES AND DISPOSAL - TENDER PROCEDURE

1. The formal procedure for deciding prices and for selection of persons or organization under normal circumstances to:

-to carry out construction, repair or maintenance

-to procure supplies and services

-to sell or rent out goods and services

within area of authority is called tender procedure.

1.1 Pre-requisites for Tenders

1. Financial Provision
2. Approved estimates/ assessments/lowest bids
3. Supply of samples
4. Plans specifications, Bill of Quantities and standards
5. Supervision facilities
6. External provisions
7. Treasury approval for Customs - Exchange - imports - exports

2. Provincial Director will function as a tender officer Head of Department of an "A" grade Department in the work services and repairs to vehicles. The limits of expenditures provided under Financial Regulation and powers given to the Provincial Councils and to the Line Ministry are as follows:-

2.2	1. F. R. 686 A - Rs.50,000/-	-	The maximum that could be authorized as Head of Dept. without a Tender Board.
2.	F.R 686 B - Rs.500,000/-	-	Maximum that could be authorized by the Departmental Tender Board when dealing with tenders.
3.	FR 785(3) Rs. 25,000/-	-	Maximum that could be authorized for repairs to the Motor Vehicles and Machineries.
4.	FR 799(1) A Rs.25,000/-	-	Maximum that could be authorized for works and supplies by Head of dept. (Personal)
5.	FR 799 1(b) Rs.100,000/-	-	Maximum for work and supplies deviating from the tender procedure, subject to the approval of the Head of Department. Departmental Tender Board.
6.	FR 796 (i) Rs.1500/- -	-	Maximum that could be spent for small scale supplies for a day.
7.	FR 797(i) Rs.250/-	-	Authority that could be delegated to officers for small scale urgent work and supplies deviating from the tender procedure.
8.	FR 72 Rs.25,000/-	-	Authority to revise expenditure estimates subject to the 10% percent of the estimate.

3.1 **Tender Board Tender Procedure**

The Provincial Secretary will decide the make up of the tender board of the Provincial Council.

1. Provincial Director of Health Services (Chairman)
2. Accountant
3. Administrative Officer

3.2 Documents to be submitted to the Tender Board

1. Certificate of Financial Provision
2. Tender Notice
3. Tender Condition
4. Tender Forms
5. Draft estimate/assessment/Bid

3.3 (b) Tender Notice - FR 688

1. The designation of the person who invite tenders
2. Subject/from whom
3. Date of issuing notices
4. Issuing time of tender forms/closing time and opening time of tenders
5. The person from whom further details could be obtained.

3.4 (c) Tender Forms

1. Subject place and nature of work
2. Name and address of the person to whom forms were issued
3. Number and date of the receipt for payment of security fees
4. Signature and designation of the person issuing tender forms
5. Date/time of issuing forms
6. Declaration of tender/description of work

3.5 Matters to be considered by the tender board/officer

(a)

1. Whether pre-requisites of tender have ben fulfilled
2. Security fee/tender fee
3. Whether call for limited tenders/tenders with pre qualification/or public tenders
4. Bid Bonds/Security Bonds/Guarantees
5. Time intervals(minimum of 3 weeks)
6. Appropriation of conditions
7. Concession of taxes and fees
8. Publication of notice (FR 693)

(b) Notices published locally/general

1. Station and office publication
2. Paper Notices
3. Gazetting
4. Posting to the registered contractors

3.6 **Forwarding and accepting tenders**

1. Should be submitted to the authorized person/Tender Board.
2. By registered post/putting to the tender box/or by handing over to the person named in the notice.
3. (a)Tenders should be placed in covers separately in two copies.
   - (b) Covers should be sealed(sealing wax can be used .... if necessary)
   - (c) Should indicate whether original or the duplicate
   - (e) Tender box should be kept in a safe place in charge of a staff officer
   - (f) After closing tenders, the slot of the tender box should be covered with a paper sealed, and signed on it. If necessary the tenderers too should be allowed to sign on it.
   - (g) After closing tenders, the Chairman of the Tender Board should:-
     - i. Open tenders
     - ii. Categorize tenders according to the subjects
     - iii. Put serial numbers
     - iv. Announce tenderers name and prices
     - v. Place date stamp
     - vi. Initial on the date stamp before the tenderer or their representatives

3.7.1 **Scheduling, Inspection and Evaluation of tenders(FR 696-699-**

a) Tenders should be scheduled immediately after opening

b) The originals and the schedules should be handed over by the Head of Institution/Head of Unit(as the case may be) for evaluation.

c) Evaluation Committee/Inspecting Officers shall look in to the :-
   1) Correctness of adding, multiplication, and adjustments in tender forms
   2) Amendments to be made
   3) Conformity with the tender conditions and
   4) Compare with the lowest bid or the estimate.

3.7.2 Thereafter they should sign the schedule, indicating, what tender should be accepted and with what amendments the tender should be accepted.

3.7.3 The evaluation committee/inspecting officers should recommend in respect of construction work and services the lowest tender and in respect of selling, leasing and renting on line the highest tender. If the committee is not recommending these tenders the reasons for not doing so should be indicated separately by the committee.

3.8 The decisions that could be taken by a tender board

The tender board after considering observations of the evaluation committee/inspecting officers, together with the schedules, and originals of tendering can decide to;

a) accept the tender as a whole, or to accept part of a tender
b) accept parts of more than one tender
c) reject all tenders or part of them
d) call fresh tenders, when the prices of all tenders exceed the amount in estimate
e) recommend to follow departmental procedure

3.9 Special matters on accepting tenders

i. Local products can be purchased although their prices exceed 10% of the prices of foreign products.

ii. If the specification sent by the tenderer is better than the specification of the tender, such tender can be accepted irrespective of their slight differences.

iii. Prices of recognized societies can be accepted although their prices exceed by 10% percent of the prices of the lowest bid(Treasury Circular No.240)

iv. Tender Board can discuss with the tenderer about the corrections, additions and conditions of tenders.

v. Tender Board can obtain consultative guidance before arriving at a decision.

4. Recognised Societies

a) Samurdhi Task Force - Samurdhi Task Force accepted by the Samurdhi Bala Mandalaya
b) Registered Cooperative Societies
c) Labour Cooperative Societies

d) Rural Development Societies

e) School Development Societies

f) Farmers Organizations

g) Socictics approved by the Treasury from time to time

4.1 The contract should be cancelled forthwith, if the recognized socicties transfer the contract to any sub contractor. The maximum value of the works that could be assigned to a society within a year should not exceed Rs. 750000/-.

4.2 A certificate about the resources and skills of works of a society should be obtained before awarding a contract.

5. <u>Deviation from the tender procedure</u>

5.1 Purchases (FR 794)

1. From registered suppliers Rs.500/-
2. Open market Rs.50/-

5.2 Work and serviccs (FR 797)

1. Authorized officer Rs.300/-
2. Deputy Provincial Director in case of an urgent requirement Rs.5000/-
3. Provincial Director(Head of Department)Rs.50000/-
4. Departmental Tender Board Rs.500,000/-

5.3 <u>Necessities</u>

1. To provide urgent services
2. To make purchases which are not applicable to the normal procedure
3. Services and works which require special skill or speciality
4. Additional works which were not anticipated.

(Reasons should be indicated and a copy of the decision should be sent to the Auditor General)

6. <u>Preliminaries on Tenders</u>

a) Financial Regulations

1. 685 -705 Tenders and contracts
2. 715-745 Supplies
3. 750-763 Board of Surveys
4. 767-779 Selling

5.	78--793	Work and Services
6.	794-801	Deviation from the Tender Procedure
7.	802-807	Miscellaneous
8.	72	Revision of estimates
9.	237	Refunding retention money

b) Treasury Circular (Finance)

1)	T.C. Finance 221 - 03.05.84	Assigning work on Gramodaya Mandalayas
2)	T.C.Finance 222 - 12.05.84	Payment of Advance
3)	T.C.Finance 228 - 11.10.84	Concession to approved societies
4)	T.C.Finance 234 -	Assigning works on Gramodaya Mandalas
5)	T.C.Finance 252-20.05.87	Accepted societies
6)	T.C.Finance 255	Assigning works on accepted societies
7)	T.C.Finance 260-29.11.88	Repairs to vehicles and equipment
8)	T.C. Finance 282-11.07.90	Assigning work on accepted societies, deviating from the tender procedure.
9)	T.C.Finance 296 -	Purchase of P.V.C. pipes
10)	T.C.Finance 298-09.08.91	Contract Bonds
11)	T.C.Finance 308 - 27.07.92	Arbitration of contracts disputes
12)	T.C.Finance 311 -05.10.92	Rejecting tenders
13)	T.C.Finance 315 - 08.06.93	Increasing prices
14)	T.C.Finance 316- 23.04.93	Services and work Bonds
15)	T.C.Finance 324 - 18.10.93	Purchasing at minor scales

16) T.C.Finance 327 - 15.12.93 Consultative Services

17) T.C.Finance 329 - 21.04.94 Bid Bonds

18) T.C.Finance 331 - Payment of Advanccs

19) T.C.332 - 18.01.94 Government Supplies

b) Provincial Councils Finance guidelines 01.1995 to 04.1993

c) Gencral Contract Agreement Act No. 3 of 1987 for construction over Rs. 5 million

d) Inland Revenue Act No. 69 of 1981 for recovery of BTT from contracts and stamps duty act No.43 off 1982 for stamp dutics on agreement.

CHAPTER 10

COMMUNICATION AND PUBLIC RELATIONS

Transmission, Message, Reception

1. Introduction

No organization can exist without communication and public relations. Human progress has been achieved through cooperative action which depends upon effective communication and puhlic relations. Our daily lives are filled with one communication experience after another. It is through **communication** and **public relations** people understand each other, learn to like each other, influence one another, build trust, form and terminate friendships, learn more about others and oneself and how others perceive oneself. These two are indispensable parts of management.

2. Definitions

1) Communication is defined as sending a message to another individual with the conscious intent of evoking a response.

2) Communication is a process by which two or more people exchange ideas, facts, feelings or impressions in ways that enable each to understand the meaning and intent of messages used for this purpose.

3. Objective of Communication

The main purposes of communication are for:

3.1 Conveying the right message to the right person/audience - so that the receiver should understand it and translate it into action.

3.2 Coordination- Communication is a tool for coordinating activities. Coordination without communication is a remote possibility.

3.3 Good organizational and public relations.

3.4 Development of managerial skills - Communication is a learning process. Facts, Information, Ideas etc. enrich the knowledge of the executive. When he communicates with others his knowledge and skill improves.

3.5 Effective translation of policies into action.

3.6 For planning development, implementation, monitoring and evaluation of services

4. **Fundamentals**

Chester I Bernard has laid down five fundamentals of communication. These are:

4.1 Specific purpose

4.2 Study of the receiver

4.3 Organization of an idea

4.4 Interesting transmission - Communication is an art to be practiced. The interest of the receiver has to be aroused, sustained and assured.

4.5 Personal touch

5. **The Principles**

There are eight principles of communication. These are:

5.1 **Clarity** - The message should be clear. It should be communicated in simple, easy and commonly understood language.

5.2 **Attention**- The recipient's attention must be drawn to make communication effective.

5.3 **Consistency** - The communication should be consistent with the plans, policies, programmes and objectives of the organization/enterprise.Inconsistency creates confusion.

5.4 **Adequacy** - Inadequate communication, delays action and spoils good relations and leads to confusion.

5.5 **Timeliness** - Information should be communicated at the proper time.

5.6 **Integration** - Communication is a means and not an end in itself. It should help in achieving a genuine interest and spirit of cooperation among the personnel of an organization.

5.7 **Informality Vs. Formality** - It is good to be informal and friendly but formal communications are generally practiced in government offices.

5.8 **Feedback** - Communication is a two-way process.

6. Methods

There are four broad categories of communication observed in large organizations.

6.1.1 Formal and Informal -

Formal communication the scaler system of tbe organization is taken into account. It establisbes the beirachieal relationship of the organization.

In every organization there is informal communication. It is generally known as Grapevine system. It is more indirect, less explicit but more interesting. Gossip and rumor are examples. But the manager has to take precautions to minimize grapevine communication.

6.2 Oral and Written

Oral communication with face to face conversation increases the personal touch, understanding becomes better and widens good relations in the organization.

Circulars, bulletins, manuals, bandbooks, notes, orders, letters and instructions are the common form of written communication. These are often comprehensive and produce definite and lasting effect.

6.3 Downward and Upward -

In line organizations like the Ministry of Health communications flows from superiors to sub ordinates.

6.4 Horizontal -

This takes place between two subordinates of tbc same status or two superiors of the same status. At conferences and seminars too borizontal communication takes place.

Communication may be viewed as a pattern of interconnecting networks varying from simple direct, one direction network to star circular and serial radial networks etc.

7. Non-verbal Communication(Silent language)

Sometimes a smile, a nod and a glance would be more effective than a load of words. A glance across or moving across the office can convey an important meaning. Silent language helps supervision.

8. **Communication Skills** depend on:-

8.1 Credibility of the sender

8.2 Sending understandable messages

8.3 Ensuring optimal feedback

8.4 Developing close relationships

8.5 Listening closely and responding relevantly

8.6 Ensuring two way communication

8.7 Always using decent, polite and gentle language.

9. Important Areas in Communication

The PDHS will have to get his ideas across, gain confidence and become persuasive in some specific areas. Some of these are discussed in detail.

9.1 Making a Presentation

Great speakers are made, not born. They have become great speakers by years of developing and practicing their speaking skills. Once, one masters the basis of organization, preparation, delivery and the skill of overcoming nervousness one becomes an effective speaker.

a) Planning the Presentation

When the PDHS has to make a presentation to a group of managers or administrators/staff, he has to think of a two-tier process - developing objectives and assessing the audience.

Step 1. **Develop Objectives** - In an informative presentation the PDHS will have to deliver the facts and figures to educate the audience. In a persuasive presentation the PDHS has to inspire changes in the audience's behaviour, attitudes or beliefs. In a majority of situations the PDHS has to make persuasive presentations in professional settings.

Step 2. **Assess the audience**

The PDHS has to place himself in the shoes of the audience who will be listening to him. So the PDHS has to be aware of these features of the audience.

1. Values, needs and constraints
2. How well informed is the audience and
3. Arguments and evidence that the audience accept/reject

b) Organizing a Presentation

Effective speakers build their speech/presentation from the centre outwards. Some suggestions that help to organize your thoughts are:-

1. Brainstorm the main ideas - either by writing ideas or using index cards etc. generate as many ideas as possible.. Eliminate some and retain a few - 2-5 main ideas. If there are finally more than five ideas make subpoints.
2. State the subpoints.
3. State the benefits - In persuasive presentations like making a new proposal or asking for increased finances or staff etc. the audience would like to know of the specific benefits of such a proposal.
4. Prepare handouts - Handouts are useful to a) reinforce important information b) summarize action items for the audience to follow up and c) supply supporting information.
5. Develop visual aids - Visual aids are useful to:

   a.) Focus the audience attention
   b.) Reinforce your verbal message
   c.) Stimulate interest and
   d.) Illustrate factors that are hard to visualize

When constructing the visual aids follow the KISS principle(keep it short and simple).

6. Main idea, preview and review sentences.
   In the preview, the main idea of your presentation is stated. In the review sentence you examine the main idea stated in the preview sentence.

7. Develop the introduction - The introduction is important to:-
   a) get the audience's attention and make them concentrate on you.
   b) Provide background information on the subject
   c) Introduce yourself -

   Some speakers use anecdotes, humour rhetorical questions(a question with an obvious answer - eg. How many of you wish to become rich?) or a shock statement (e.g. the victims of road traffic accidents in Sri Lanka/per year will fill this auditorium).

8. Develop the conclusion - Good conclusion always return to material in the introduction. In persuasive presentations sometimes we see "call to action" statements:

C) **<u>Preparing for your Presentation</u>**

You must practice and rehearse as much as possible viz-
(1) make key notes; (2) mentally run through the presentation; (3) Repeat (1) and (2) several times (4) practice answers to questions you anticipate from the audience; (5) Control the presentation environment(overhead projector, microphone, handouts etc.)

Suppose you are drawn to a situation of impromptly speaking, then don't panic as you know how to organize your thoughts and you know your job. Any topic can he split into components such as :-

A - Past, present and future
B - topic 1, 2 and 3 eg. production, storage, distrihution of drugs
C - The pros and cons of an issue - eg. generic prescribing
With this background knowledge you can make a successful speech presentation:-

a - Give a few introductory remarks
b - Develop a clear preview sentence of your main points
c - Deliver the body of the presentation
d - Summarize the main points
e - Conclude the presentation - end with a strong positive statement

D) **Delivering the Presentation**

If you stand stiffly, with little animation in your body and speak in a monotone voice without facing the audience, the speech would be dull. Non verbal action have to be used to show your feelings. Use a natural, conversational style in a direct and friendly manner. How to say is as important as what to say.

Deliver your presentation in the following sequence.

1. Introduction
2, Preview sentence(Tell the audience what you are going to tell them)
3. Main ideas and sub points
4. Benefits - in persuasive presentations
5. Summary
6. Conclusion

During the presentation your posture should be erect but relaxed. Don't stay frozen at one spot. Learn to gesture in front of the audience. Use gestures for emphasis as in normal conversation. Eye contact with the audience is extremely important. It opens the channel of communication hetween you and the audience and makes the presentation more personal and builds confidence in you.

Avoid monotonous voice, talking too fast, and control your volume. It is usual to ask 'Can you hear me at the back?' to tune the volume of your voice.

After thc presentation you might wish to encourage the audience to ask questions some questions you have already anticipated. When answering questions it is important to maintain the same style and demeanor you used in the presentation. A changc in demeanor can suggest that you arc not confident ahout your position. If you don't know the answer for a question you can say "I don't know, but I'll find out and get back to you later'. When a question is answcred involve the whole audience to your answer. It is best not to say that's a very good question. I am glad you asked it' etc. as it may suggest that you are unsure of the answer. It is not neccssary to preface answers in such a manner but go straight into the answer.

9.2 Speaking Well

a) Introduction

The PDHS is often called upon to address meetings; conferenccs, and ccrcmonies etc. When special occasions and functions likc laying foundations to construction - a health institution, declaring open a new health institution, starting a health project/campaign etc. thc PDHS is among the chief guests. At such situations gaining self confidence, courage, poise and the ahility to think calmly and quickly in a logical order are of crucial importance. Then alone it is possible to say clearly and convincingly before the audience. Dale Carnegie(1956) is of the view that puhlic speaking is like playing golf. Anyone can develop ones latent capacity if one has sufficient desire to do so. Many speakers feel that the presence of an audience is a stimulus; an inspiration, that drives their brains to function more clearly, and more keenly.

b) Principles

There are four essentials to become an effective speaker in puhlic:

a) Strong and persistent desire ;

b) Know thoroughly what you are going to talk about;

c) Act confident - look your audience straight in the eyes and talk confidently.

d) Practice is <u>sine qua non</u> - with practice the "buck fever"(state of intense nervous cxcitement) gets divorced.

c) How to prepare your talk - The following points are useful.

a) Determine the subject in advance.

b) Ask yourself all possible questions conceming it.

c) Jot down notes, fragments, of information and key sentences etc. Do some reading.

d) Study your audience - Think of their wants and desires.

e) Rehearse - If possible, dictate your talk to a dictaphone and listcn to it.

It is said that Lincoln prepared his famous speeches when he went ahout his usual work; as he ate his

meals, as he walked the street and even while he milked his cow. Real preparation consists in digging something out of yourself, in assembling and arranging your own thoughts in cherishing and nurturing your own convictions.

A good speech is well constructed, full of facts, stated clearly, vividly and interestingly. It is full of spirit. It has freshness and individuality.

There are some famous speeches such as that of Mark Antony's oration and that of LIncoln's Gettysburg address.

d) **Speech Plans**

There are three speech plans from which the PDHS can choose the most appropriate one that suits the occasion.

Plan 1

1. State your facts
2. Argue from them
3. Appeal for action

Plan 2

1. Show what is wrong
2. Show how to remedy it
3. Ask for cooperation

Plan 3

1. Secure interested attention
2. Show confidence
3. State facts, educate the audience about your proposition
4. Appeal for support and action

e) **Essential Elements in Successful Speaking**

1. The necessity of persistence
2. Keeping an everlasting interest
3. Know the certainty of reward
4. Effective opening - arousing curiosity, illustrations, quotations, questions, shocking facts etc.
5. Good delivery - the flavour with which the speech is delivered.

(a) Use conversational tone

(b) Don't imitate others

(c) Be natural and express emotional sincerity

(d) Stress important words, pitch your voice, vary thc rate, pause before and after important ideas.

The entire success rests on two things - your ability and the strength of your desires.

6. Make your platform, presence and personality accceptable and fresh

7. The close -

   a) Summarize your points
   b) Appeal for action/support
   c) Pay terse sincere complement
   d) Other - close with humour/quotation/climax.

8. Make your meaning clear - By using terms of the known, avoiding technical terms, using illustrations.

9. Attract - the interest of your audience - Be concrete and definite. Sprinkle your talks with phrases that create pictures with words. Sometimes it may be necessary to use glorified gossip and folk stories etc.

10. Improve your diction(style)

Mark Twain developed his delightful facility with words hy travelling long distances. He carried a dictionary wherever he went . He conversed with people around.

Your diction will be very largely a reflection of the company you keep. A dictionary will help in understanding the derivations of some words. When you speak be precise and exact in your meaning.

Summary

The six essentials for vocal proficiency are:

1. Clarity - clear diction, familiar language and simplicity - use direct speech.

2. Rate of speaking, pauses and duration - avoid monotony.

3. Rhythmic expressions, their phrasing and blending - sentence rhythm comes with experience.

4. Pitch tone and volume of voice

5. Emphasis, variety and animation

6. Style - Proper words in proper places (Jonathan Swift)

9.3 Writing Reports

PDHS has to submit several reports on the performance of his province, special programme areas, projects to his superiors.

Definition

A technical report is a written statement of the facts of a situation, project, process or test; how these facts were ascertained; their significance; the conclusions that have been drawn from them; the recommendations that are being made from them; (Recommendations may not be required in all cases)

Objectives

The principal reasons for writing a report are:

1. to provide information to the reader
2. to respond to a request by the superior.

Approach

Generally a systematic approach has to be followed. The production of a report divides logically into the following stages.

a. **Instructions** - Here the Terms of Reference that define the scope of the report is an important element. So is the thesis sentence(small summary of the report's object).

b. **Preparation** - Accuracy is essential. As such sources of information become extremely useful.

c. **Classification** - Either the numerical system or the consecutive number system can be followed.

d. **Planning and layout** - The recognized parts are - title page, foreword, abstract or summary, contents list, introduction, body of report(which may have several parts) conclusions, recommendations, appendices, bibliography, glossary, references, index, illustrations.

The body of the report gives the faets and findings, how they were arrived at and the inferenees that are drawn from them.

Bibliography is a list of words eonsulted by the author of the report.

Appendices inelude statistical tables, detailed results of experiments, series of graphs etc.

Glossary - Some technical words that need to be defined are included in the glossary.

Abstraet/Summary

The purpose of an abstract is to enable busy persons to get the gist of the report without having to read it all. Only the essentials are presented and it should usually be not more than two-thirds of a page in length and incorporates the following: the intention; what has been done; the findings; the conclusions; the recommendations.

Writing the Report

1. **The Build up** - The facts

   Teehnical writing needs the facts, the ordering of facts, the statement of facts in plain language and the supporting of the facts with adequate information and illustration.

2. **Expression**

   Writing is an art. Technical writing should be highly disciplined.

3. **Principles**

   When writing bear in mind:-

   a) The reader and his experience
   b) The choice of appropriate/familiar words, that convey the correct meaning.
   c) Avoid long roundabout expressions
   d) Use short sentenees of the modern journalistic style
   e) Prefer active to passive voice
   f) Write to inform not to impress and
   g) Observe the three "Y"s

      *Simplify
      *Justify
      *Quantify

4. **Order of Writing**

Abstract/Summary

Introduction

Body of report - (may have sections)

Conclusion

Recommendation

Ancillary parts - appendices, glossary, bibliography, references etc.

But generally the body of the report is written first as it is the main part. The introduction leads into it and the conclusions and recommendations arise out of the body. The abstract/summary is written last.

5. **Re-writing** - It may be necessary to re-write it to fine tune it.

9.4 Meetings, Conferences and Discussions

Introduction

There are several opportunities and occasions for the PDHS to organize, participate and chair staff or even public meetings and conferences. In some he will be the chairman and in a few a secretary. Generally he will be invited as a resource participant for an important conference, seminar or a workshop.

A Meeting

Organization

Many meetings fail through lack of preliminary organization. To begin with the purpose of the meeting, the nature of the expected audience(number and their interests etc.) and the space and time dimensions should be clearly considered. Generally the invitees, the agenda, the chairmanship and the secretarial work etc. are predetermined.

The choice of the hall or the auditorium is important. The cost, accessibility, space and facilities have to be taken into account. If a busy person is invited it is best to give him the choice of the date. For instance if DGHS is the key speaker obtain the convenient date and time for the meeting from him.

Chairman

The chair may be offered to the chairman of the organization, if not select a chairman who fully understands what will be required of him. Certain people possess the necessary qualities for chairmanship -

1. A calm and friendly disposition
2. The ability to think clearly and objectively

3. A sound knowledge of the procedure
4. A sense of humour and <u>absolute</u> control of temper.

The duties of the chairman are mainly administrative.

Chairman's opening remarks - There are six points.

1. To welcome the audience
2. To mention the purpose of the meeting
3. To stimulate interest in the subject and to read a motion(if any)
4. To introduce speaker/s
5. To refer questions to him
6. To call on the speaker.

Generally the chairman follows the time table.

Hecklers -

Ordinarily the chairman will have little difficulty in keeping order as most audiences have a strong sense of fair play. But at meetings of highly controversial nature some heckling should be expected. Make use of good humour, to begin with. If that fails the chairman should appeal for a sense of fair play and use tact to secure order. If this too fails use the chairman's powers of authority to deal with the interrupters.

Conferences and Seminars

Introduction

Organizing and chairing a big conference requires considerable experience. But unlike a public meeting the conference is for members of a particular organization only and most of them are known to you. In a public meeting the public come to listen to you but in a conference the participants come to 'confer' so that the policy/subject under discussion can be strengthened by constructive criticism.

Begin making arrangements several weeks before the date fixed for the conference. Generally there would be a conference - committee that will coordinate all activities. Different tasks have to be allocated to members of this committee- some important ones are: catering, advertisements, invitations, hall arrangements, transport etc.

Generally invitations are sent to the invitees together with the agenda of the conference.

Chairman

The PDHS might be the chairman of a big conference or the chairman of one session of the conference. He should be thoroughly conversant with the subjects to be dealt with. He will have to open and

close the conference with the open sessions if there is one. He may chair other sessions. Chairing a conference should not be lightly undertaken by the inexperienced. It requires an exact mind, a wide knowledge of the work organization, and familiarity with the proceedings.

Agenda

The agenda must be carefully timed and overcrowding avoided. Adequate time should be allowed for discussions, otherwise the speakers would be over-tired. Sometimes the audience might fall asleep. The conference may last for a few days.

Generally the Open Session is held at the end of the conference when ideas and suggestions on matters not included in the agenda can be raised. Thus the delegates can air their views and voice complaints etc. The chairman could answer any question or any suggestions.

At the closing session the chairman should give a short summing up of the work of the conference and thank the delegates, committee and all who have helped to make it a success. Those responsible for catering, security, transport etc. should not be forgotten. The media personnel should be thanked in a careful and special way. After the chairman's speech a formal vote of thanks to the chairman and to those who presided at other sessions can be moved. Generally this is pre-arranged by the conference committee. Finally the chairman will reply and close the conference.

9.5 Group Discussions

Small group discussions or Focus Group discussions are useful for pooling experience and knowledge on specific topics of common interest.

A group leader commonly initiates the discussions. He introduces the subject. The group members, express their views. A rapporteur(recorder) makes notes.

The group members should express their views clearly and in brief. While one speaks others should be patient listners. The group as a team should agree on conclusions and recommendations. Finally the rapporteur presents the salient points, conclusions and recommendations at the main session/ seminar etc.

9.6 Panel and a Symposium

A few qualified professionals express their views on a given topic. The panel is managed by a moderator who introduces the topics and the speaker. There is no specific agenda.
A symposium is a series of speeches on a specific subject by different speakers. There is no discus-

sion. However, the audience may clarify some issues on the subject. The chairman finally makes a comprehensive summary.

9.7 Public Relations

Introduction

The PDHS has to establish a rapport with the people, convene, catalyze, facilitate and enquire, watch, listen and learn while performing his roles as a manager. In all these good public relations are important.

Definition

Public relations practice is the deliberate, planned and sustained effort to estahlish and maintain mutual understanding between an organization and the public(Institute of Public Relations, the United Kingdom).

The PDHS has several occasions to meet, converse and communicate with the puhlic. In conversing over the telephone, writing letters and addressing meetings the PDHS has to be extremely tactful, friendly, honest and flexible. Some important features of good public relations are:

* Addressing the public in a respectable manner;
* Avoiding unreasonable delays and omissions in attending to public matters;
* Being punctual;
* Using correct and clear instructions to the staff;
* Maintaining professional standards;
* Keeping the work place, staff and working procedures in order;
* Avoiding negative attitudes;
* Avoiding giving false promises.

Public officers are expected to be honest, sincere, courteous and duty bound at all times.

Dale Carnegie has suggested six ways to improve public relations.
These are:

1. Become genuinely interested in other people.
2. Smile - costs nothing but creates much. It enriches those who receive without improvising those who give.
3. Remember that a man's name is to him the sweetest and most important sound in any language.
4. Be a good listener.

5. Talk in terms of other person's interests.
6. Make the other person feel important - and do it sincerely.

Socrates was a great teacher. But he never criticized others. His method((Socratic method) was based upon getting a "yes Yes" response from the audience.

2. Public Support

The PDHS would need public support to carry out his official duties. There are NGOs and other organizations, community leaders and philanthropists who are willing to support the health sector. It would be beneficial to make a list of such persons, meet them, invite them to functions etc.

Trying honestly to see things from other person's point of view is essential if we want to change people and win them towards us. Placing one in another's position is difficult.

Ten ways to win public support are:-

1. Avoid arguments
2. Show respect for other's opinion
3. If you are wrong admit it
4. Begin in a friendly manner
5. Try to see things from the other person's point of view
6. Be sympathetic with public wishes and desires
7. Appeal to the nobler motives
8. Dramatize your ideas
9. Never tell another that he is wrong - use indirect language.
10. When all fails throw a challenge.

3. Media Personnel

The PDHS has to be extremely tactful in handling media personnel as they are public watchdogs. So as to prevent press reporters obtaining unqualified information the PDHS could :-

* Invite them for inspection visits if necessary, seminars, workshops etc.
* Attend media seminars convened by Provincial Health Authorities.
* Allocate a day and a time for the media personnel to interview him.
* Display the health statistics of the province in PDs office.
* Appreciate their comments.

4. **Writing letters to Public**

There are accepted ways of writing letters to the public. It should be simple, straightforward and up to the point and written in soft language. A format of an official letter will have:-

1. Senders No. address
2. Address of recipient
3. Salutation
4. Subject heading
5. Body of letter
   a) Information required
   b) Supporting details
   c) Conclusions/observations
   d) Complementary close
6. Signature, name and position of sender

Summary

P - Be patient. Be positive
U - Understand the other person
B - Believe in the other person
Begin in a friendly way
L - Learn from others.
I - Show interest in others
C - Everybody likes a compliment
R - Respect the other person's opinion
E - Use encouragement
L - Listen carefully - Be a good listener
A - Admit if you are wrong
Give bonest appreciation
Appeal to the nobler motives
T - Talk about your own mistakes before criticizing others
I - Call attention to mistakes indirectly
O - Let the otber man save his face
N - Don't nag - Never criticize in public
S - Praise sincerely every improvement and he sympathetic with the other persons ideas and desires

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CHAPTER 11

INTER-SECTORAL COORDINATION FOR HEALTH

1. Development and Health

1.1 The ultimate aim of development is the constant improvement of the well being of the entire population on the basis of its full participation in the process of development and a fair distribution of the benefits therefrom. Development is an integral process embodying both the economic and social objectives and must promote human dignity. It cannot be equated with economic growth alone. Economic growth has to be regarded as one of the means for attaining the broader goal of soico-economic development.

1.2 The recognition of the close relationship between health and development, and the realization that human energy is the key to development, led the Thirtieth World Health Assembly to decide in May 1977 that the main social target of govemment and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that permits them to lead a socially and economically productive life. To attain this target a complete re-appraisal of conventional health systems has taken place. These are now considered to reach far beyond the confines of medical care. It is recognized that improvements in health status of people can be reached only as a result of national and intemational political will, and the coordinated efforts of the health sector and relevant activities of other social and economic development sectors. Since health development both contributes to and results from, social and economic dcvelopment, health policies have to form a part of overall development policies, thus reflecting the social and economic goals of govemments and people. It is now clearly discemed that health programmes have to be devised to give effect to these policies and attain these goals, rather than bcing mere extensions of existing medical care services. Health Services, in tum, have to be reorganized in such a way as to deliver these programmes.

2. Sectors

In the case of inter-sectoral coordination for health, it would not be desirable to consider a purely health sector and non-health sector type of situation. It is far more complex.

2.1 The obvious demarcation would be into health and non-health sectors. eg. Health and Defence.

2.2 Health-related sectors are another type - eg. Health and Agriculture, Social Services, etc.

2.3 Within the health field itself, there could be different sectors.

2.3.1 Coordination between the public and private sectors.

2.3.2 Different disciplines of health care eg. Western, Ayurveda, Homeopathy, Acupuncture, etc.

2.3.3 Another way of looking at health would be as the government sector and non-government sector.

2.3.4 Although we talk of an integrated health care delivery system, there is still a wide dichotomy between the curative and preventive sectors.

2.3.5 There are a large number of international agencies with whom coordination is needed. eg. WHO, UNICEF, UNFPA, UNDP, World Bank, ADB, JICA, etc.

2.3.6 Within the state health care delivery system itself, there is division into Central (Line Ministry) and Provincial health services. Coordination is needed here.

2.3.7 The health services in certain local authorities(eg. Colombo M.C., Kandy M.C. etc.) still continue to function independently although they are supposed to be part of the Provincial health service.

3. Levels

Intersectoral coordination for health and development can be at different levels.

3.1 International Level

There can be cooperation between countries for the upliftment of the health status. Sometimes it could be through provision of human resource(eg. consultants, trained personnel, etc.). It could also be in the areas of equipment, training or even outright grants.

3.2 National Level

This could be broadly classified as inter-Ministerial and intra-Ministerial coordination.

3.2.1 Inter-Ministerial Level

3.2.1.1 The best example of this is the National Health Council. this is chaired by the Hon. Prime Minister and includes the Health Minister, Deputy Health Minister and Ministers of other health-related ministries.

Invitations are also extended to other Ministers, M.P.'s, Governors, etc. when the need arises. The relevant officials are also present to brief the NHC when necessary. Important health issues are discussed at the NHC and major decisions taken for implementation.

3.2.1.2 There are a number of committees in the Health Ministry where representation from other Ministries are seen.
eg. Food Advisory Committee, Pesticide Committee, etc.

3.2.1.3 The Health Ministry is also represented in committees and boards of other Ministries.
eg. National Environmental Council
National Water Supply & Drainage Board
Plantation Housing & Social Welfare Trust etc.

3.2.2 Intra-Ministerial Level

3.2.2.1 There is coordination between the Line Ministry and the Provincial Ministries. A good example of this is the National Health Development Committee chaired by the Secretary/Ministry of Health, and attended by the Provincial Health Secretaries and Directors.

3.2.2.2 Within the different branches of the Line Ministry itself(Medical, Public Health, Laboratory, Planning, Finance and Administration) there are coordinating meetings chaired by the Secretary Health and Director General.

3.2.2.3 Within each branch itself, there are coordinating meetings.
eg. Public Health Directors' meeting chaired by DGHS
Public Health Directors' meeting chaired by DDG(PHS)

3.2.3 Provincial Level

There may be differences in the strategies used on coordination of activities within different provinces. However, in each province there will be various committees and meetings chaired by the Chief Minister, Health Minister, Chief Secretary, Health Secretary and the Provincial Director of Health Services respectively, where officials from different fields(eg. Health, Agriculture, Social Services etc.) get involved in coordinating their activities towards a common goal.

Very often, there is political representation as well as non-government organizations' representation at these meetings.

3.2.4 District Level

As in the Provincial Level, there are a numher of committees at district level where there is representation from different disciplines.

A good example is the District Coordinating Committee(D.C.C.)

The District Secretary plays a major role in coordinating activitics, including that of health.
eg. District Nutrition Committee

The Deputy PDHS also plays a role in coordinating the activities of his own health staff(both field and institutional) as well as with other disciplines like education, social services, etc. and non governmental organizations.

3.2.5 Divisional Level

The Divisional Director of Health Services plays a key role in coordinating the health activities in his area, as well as being an important member of the Divisional Secretary's team. The DDHS has to mobilize resources from other sources in addition to his own, through coordinating with other officials and non-governmental organizations.
eg. Nutrition, Committees, Volunteer Programmes, etc.

4. Role of PDHS in inter-sectoral coordination

Under the 13th Amendment to the constitution, powers have been devolved to the Provincial Councils. In the case of Health Services, the PDHS plays a role within the province, similar to that of the Director-General of Health Services at National Level. He is responsible for the provision of comprehensive health care to the population within the province. As thc resources within the health serv-

ices are limited, he has to devise ways & means of mobilizing thc rcsources of other government organizations (eg. Agriculture, Education, Social Services, Fisheries etc.) and non-governmental organizations to cover up this gap. This entails a lot of coordination and cooperation with others, as it is a two-way mutually beneficial process. Coordination with the Central Health Ministry is also very important. As this coordination process should extend down to the Divisional Level, the PDHS has the important role of motivating the other health officials in the province with regard to inter-sectoral coordination towards achieving maximum results with available limited rcsources.

CHAPTER 12

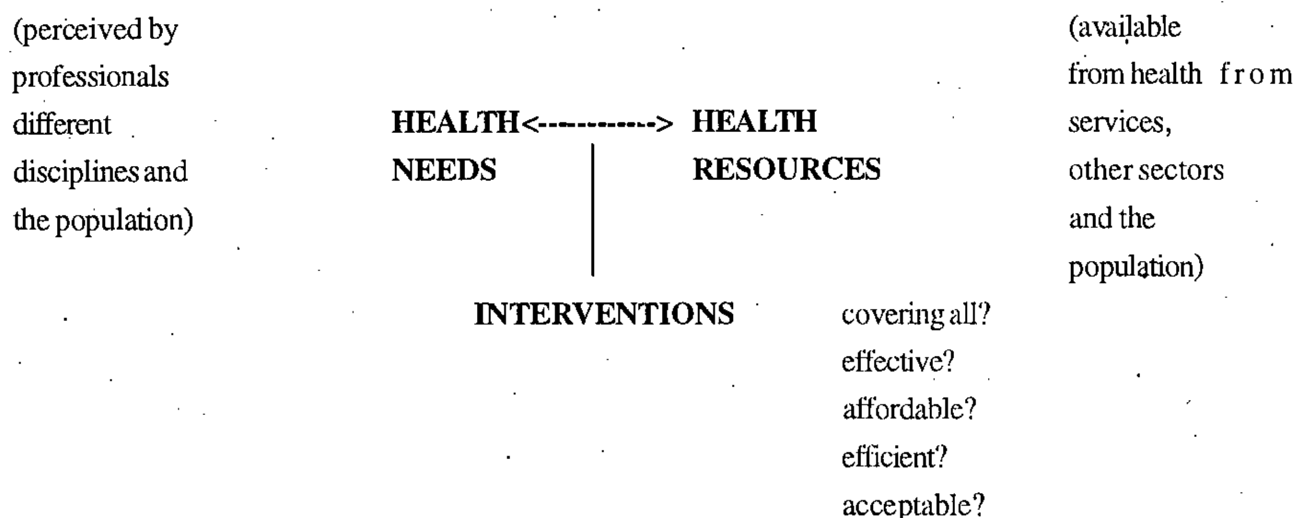
HEALTH SYSTEMS RESEARCH

The ultimate goal of any national health development process is to enable its people to reach a level of health that enables them to participate actively in the social and economic life of the community in which they live. To attain this objective meager resources available for health should be re-directed and allocated to achieve equitable distribution in terms of total coverage, increased accessibility to Primary Health Care (PHC) and effective referral to secondary and tertiary levels of care.

Such re-direction of health systems may require changes in health care planning not only at the national level but also at the provincial and divisional levels. To effect the necessary changes the health managers at all levels must decide on the best approaches to adopt. This requires detailed and accurate infomation on need, possibilities and consequences of recommended actions. Such information is often lacking, inadequate and unreliable. As a result, decisions are quite often based on assumptions leading to the discovery of consequences only after implementation. Research can provide the information needed for infonned decision-making.

Research is a systematic and scientific search for infonmation and new knowledge required to answer a certain question or solve a problem. Basic research is necessary to generate new knowledge and technologies to deal with unresolved health problems. On the other hand applied research is necessary to identify priority problems and to design and evaluate policies and programmes that will deliver the greatest health benefit, making optimal use of available resources. (Fig. 1)

Figure 1: Evaluating health interventions



Health Systems Research(HSR) is applied research ultimately concerned with improving the health of a community by enhancing the efficiency and the effectiveness of the health system which is composed of many components, as an integral part of the overall process of socio-economic development. HSR provides solutions to problems of a practical nature and is always action oriented.

This chapter will enable the reader to:-

(1) describe briefly the characteristics of Health Systems Research.

(2) discuss the contribution HSR can make towards solving priority problems in the health systems within the local context.

(3) list the steps in the development of a HSR proposal.

(4) prepare an outline of a HSR proposal.

1. Components of the Health System

As a basis for understanding HSR it is necessary to study the various components that constitute the health system. In a broader context, the health system is not only the traditional governmental health services but comprises of all other health related and health influencing aspects of the country.

Accordingly a **HEALTH SYSTEM** may be described as:

- A set of cultural beliefs about health and illness that forms the basis for health seeking and health promoting behaviour;
- The institutional arrangements within which that behaviour occurs; and
- The socio-economic/political/physical context for those beliefs and institutions.

(1) The individual, family and community

The individual, family and the community assume a vital responsibility for health promotion, disease prevention and for the curative care of its members. What people do to remain healthy and cure disease depends on what people believe in and know about health and illness.

(2) **Health Care Services**

There are health care services in the public(govemment) sector, in the non-governmental sector and in the private sector. The number, type, distribution and quality of services provided by these services influence the people's health and well-being.

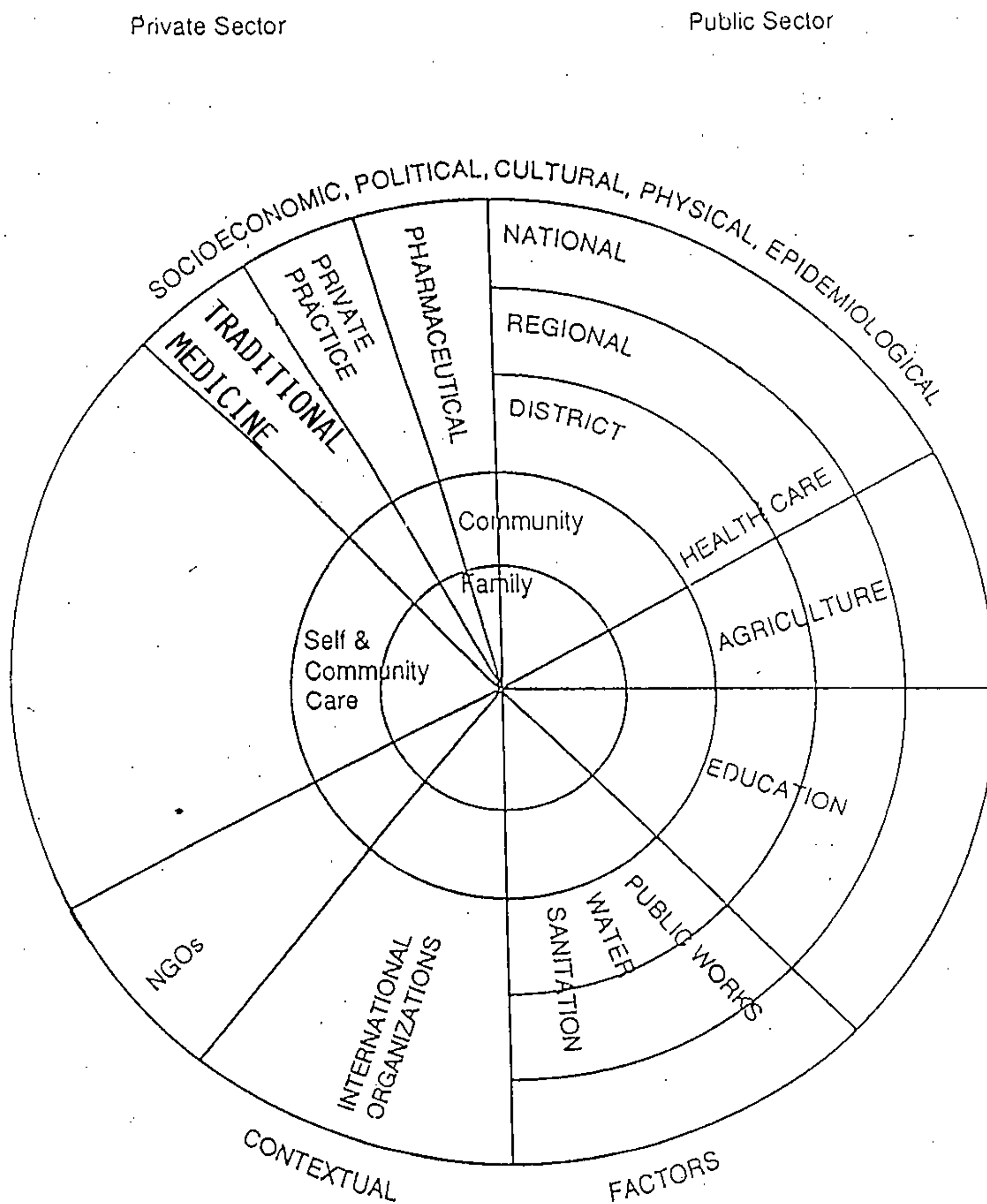
(3) **Health related sectors**

These include for example:
-Agriculture and food
-Education
-Water and Sanitation
-Transport and Communication
-Irrigation

All these sectors contribute to health, either directly or indirectly.

Fig. 2 illustrates the Health System.

Figure 2. **The Health System**



The realization of the complex nature of the Health System in contrast to the simplistic health services model ha. resulted in this area of research being described as Health Systems Research and not Health Services Research as was known earlier. the vast health system poses many practical problems, especially at the provincial and divisional levels, for which answers/solutions have to be found through research.

2. Steps in the development of a research proposal

Fig. 3 illustrates the questions one should ask, the steps one should take and the important elements of each step, in the development of a HSR proposal.

Fig. 3 **STEPS IN THE DEVELOPMENT OF AN HSR PROPOSAL**

Questions you must ask yourself	Steps you will take	Important elements of each step
What is the problem and why should it be studied?	Selection, analysis and statement of the research problem	-problem identification -prioritizing problem -analysis -justification
What information is already available?	Literature review	- literature & other - available information
Why we do want to carry out the research? What do we hope to achieve	Formulation of objective	- general and specific - hypotheses
What additional data do we need to meet our research objectives? How are we going to collect this information?	Research Methodology	- variables - types of study - data collection techniques - sampling - plan for data collection - plan for data processing and analysis - ethical consideration - pretest of pilot study
Who will do what, and when	Work Plan	- personnel - time table
How will the project be administered? How will utilization of results be ensured?	Plan for Project administration and utilization of results	- administration - monitoring - identification of potential users
What resources do we need to carry out the study? What resources do we have?	Budget	-material support and equipment - money
How will we present our proposal to relevant authorities and potential funding agencies?	Proposal summary	-N.B. development of a research proposal is often a process. The arrow indicate that the process is not always linear.

3. Guidelines for Health System Research

Bearing in mind that HSR is undertaken primarily to provide information to support decision making that can improve the function of the health system, one can summarize some essential guidelines for success:

1. HSR should focus on priority problems in health care.

2. It should be action oriented, i.e. aimed at developing solutions.

3. An integrated multi-disciplinary approach is required i.e. research approaches from many disciplines are needed because health is affected by the broader context of socio-economic development.

4. The research should be participatory in nature involving all parties concerned(from policy makers to community members) in all stages of the project.

5. Studies should be scheduled in such a way that results will be available when needed for key decisions. Otherwise, the research loses its purpose, i.e., research must be timely.

6. Emphasis should be placed on comparatively simple, short-term research designs that are likely to yield practical results relatively quickly. Simple but effective research designs are difficult to develop, but much more likely to yield useful results when needed.

7. The principle of cost-effectiveness is important in the selection of research projects. Programme management and operational research should focus, to a large extent, on low-cost studies that can be undertaken by management and service personnel in the course of daily activities.

8. Results should be presented in formats most useful for administrators, decision makers, and the community. Each report should include:

   -A clear presentation of results with a summary of the major findings adopted to the interest of the party being targeted by the report.

   -Honest discussion of practical or methodological problems that could have affected the findings.

   -Alternative courses of action that could follow from the results and the advantages and draw backs of each.

9 Evaluation of the research undertaken should not be a measure of the number of papers published but of its ability to influence policy, improve services, and ultimately lead to better health.

Thus, an HSR project should not stop at finding answers to the questions posed, but include an assessment of what decisions have been made based on the results of the study.

4. Problem areas for HSR

1. Health Care Delivery

-Health care needs
-Organization for delivery of care
-Management of Health care organization
-Cost factors
-Quality of care
-Role of consumers

2. Human Resources for Health

-Manpower mix and distribution
-Competencies of health care workers
-Training of human resources for health
-Team work
-Management of human resources

3. Organizational factors

-Health services organization
-Training institutions
-Professional bodies and trade unions
-Community development

4. Socio - cultural and demographic factors
-Lack of community involvement
-Community aspirations
-Behaviours and values related to health

-Resistance to change

-High levels of social problems affecting health

-Demographic features

5. Political

   -Unsuitable health policies, lack of political will.

6. Economic

   -Resources available for health care

   -Low budget for health

   -Increasing costs

   -Inequitable allocation of resources

   -Low cost-effectiveness

7. Technological

   -Difficulties in application

   -Inappropriate technology

8. Management

   -Lack of concern for good management

   -Unsatisfactory management processes

   -Utilization and quality of health care

   -Low coverage

   -Lack of integration of services

9. Coordination

   -Insufficient coordination between health and other sectors

10. Ethical

5. Identifying and Prioritizing problems for Research

As health managers we are often confronted with many problems which may require further study to determine answers/solutions. Some of the prohlems are obvious management problems which could be solved without research. For example in a construction project the failure or the delay of the project was due to non-availability of building material such as cement for a large part of the project, one should try to ensure that cement is available continuously rather than embark on research to explore the reasons for the delay in the project implementation.

Whether a problem situation requires research depends on three conditions.

1. There should be a perceived difference or discrepancy between what exists and the ideal or planned situation.

2. The reason/s for this difference should be unclear.

3. There should be more than one possible answer to the question or solution to the problem.

Once the problems are clear, we sbould attempt at prioritizing the problems as wc are unable to study all problems. A detailed analysis of the problems involving all concemed with thc problem situation should be conducted in order to prioritize the problems. There may be several ideas and options to cboose from and some guidelines or criteria can help in choosing the research topic.

6. Criteria for selecting a research topic

1. Relevance
2. No research done earlier
3. Feasibility
4. Political acceptability
5. Likely applicability of research findings
6. Urgency of data needed
7. Ethical acceptability

Finally the problem identified should be stated including the following information;

1. A brief description of the situation relevant to the problem.

2. A concise description of the problem - the discrepancy, its size, scverity, distribution, tbose affected, place time and the consequences to those affected and for the services.

3. An analysis of the major factors that may influence the problem and a justification for selecting the problem.

4. A brief description of any solutions that have been tried in the past - literature review.

7. Formulation of Research Objectives

Research objectives should be closely related to the statement of the problem. For example, if the problem is low utilization of certain type of curative care institutions, the general objective of the study should be to identify the reasons for this low utilization, to find solutions.

The general objective of a study states what is expected in general terms. It is possible(and advisable) to break down a general objective into smaller, logically connected parts. These are normally referred to as Specific Objectives. They should specify what you will do in your study, where and for what purpose.

8. Title of the Study

Every research study should have a clear and precise title. Now that you have formulated your objectives, you are in a position to decide on your title based on the problem.

9. Research Methodology

Now you must decide exactly how you are going to achieve your stated objectives. The question in Fig. 4 cover the major issues that must be examined as you develop your research design.

Figure - 4 Health Systems Research Methodology

	Questions you should ask	Components of research design
1.	What new information do we need?	Selection of variables
2.	How will we collect this information?	Selection of type of study
3.	What tools do we need to collect it?	Selection of data collection techniques
4.	Where should we collect it?	Sampling
5.	How do we collect the data?	Plan for data collection
6.	What will we do with the collected data?	Plan for data processing and analysing

7.	Are we likely to harm anyone as a result of the study?	Ethical considerations
8.	How can we determine whether our methods for data collection are correct before implementing the study?	Pretesting the methodology

Note: The steps are interrelated. The process is often cyclical in nature. After completing a step, it is useful to review previous steps to ensure consistency in your proposal.

9.1 Variables

Now we have come to a stage where we must ask ourselves the question - "What information are we going to collect in our study to meet our objectives?". It is essential that the prohlem itself, and the factors that influence the problem, are carefully defined. To do this we must select variables.

Variables which are expressed in numbers are called numerical variables(age, height, weight, distance) and variables which are expressed in categories are called categorical variables(colour, outcome of a disease).

9.1.1 Dependent and independent variahles

The variable that is used to describe or measure the problem under study is called the dependent variable. For example if the problem is non utilization of medical care institutions the dependent variables will be the OPD/clinic attendance, number of deliveries, bed occupancy etc.

The variables that are used to describe or measure the factors that are assumed to cause or at least to influence the problem are called independent variables. In the above problem the independent variables may be the waiting time, availability of drugs, attitude of staff etc.

9.2 Study types

Several classifications of study types are possible but broadly speaking they can be divided into non-intervention studies and intervention studies.

1. Non intervention studies in which the researcher just describes and analyses researchable objects or situations but does not intervene and;

2. Intervention studies in which the researcher manipulates objects or situations and measure the outcome of his manipulations(eg. implementing extensive health education and measuring the improvement in immunization rates).

Non intervention studies can be categorized into:-

1. Exploratory studies - small scale, short term studies carried out when little is known about a situation or problem.

2. Descriptive studies - information collected and presented to give a clear picture of a particular situation.

3. Analytical (comparative) studies - explain possible causes or risk factors for the problem by comparing two or more groups, some having the problem and others not, eg. cross sectional comparative studies, case control studies and cohort studies.

Intervention studies can be:

1. Experimental studies - Randomization into two groups one group subjected to an intervention (experiment) and the other group not. the outcomes are compared.

2. Quasi-experimental studies - Either randomization or control group is missing. Other characteristics of an experimental study remain.

9.3 Data Collection

Data collection techniques allow us to systematically collect information about our objects of study(people, objects and phenomena) and about the settings in which they occur.

Various data collection techniques can be used.
-Using available information
-Observing
-Interviewing(face to face)
-Administering written questionnaires
-Focus group discussions

Whatever the technique used, an appropriate data collection tool has to be applied, Table 1.

Table 1 - Data Collection techniques and tools

Data collection techniques	Data Collection Tools
Using available information	Checklist, data compilation forms.
Observing	Eyes & other senses, pen and paper, watch, scales, microscope etc.
Interviewing	Interview schedule, checklist, questionnaire, tape recorder
Administering written questionnaire	Questionnaire
Focus Group Discussion	A group discussion of 6-12 persons guided by a facilitator during which group members talk freely and spontaneously about a certain topic.

Interviews and self administered questionnaires are probably the most commonly used research techniques. Designing a good questionnaire therefore is of utmost importance. The steps in designing a questionnaire are:

1. Identifying content - information required
2. Formulating questions to obtain the required information
3. Sequence questions - Arranging questions in a logical sequence.
4. Formulating the questionnaire - instructions/guidelines for the interviewer/interviewee to assist in the administration of the questionnaire.
5. Translation into an appropriate language.

9.4 Sampling

Some studies involve only small numbers of people and, thus, all of them can be included. Often, however, research focuses on such a large population that, for practical reasons, it is only possible to include some of its members in the investigation. We then have to draw a Sample from the total population.

9.4.1 Representativeness

If researchers want to draw conclusions that are valid for the whole population, they should take care to draw a sample in such a way that it is representative of that population. A representative sample has all the important characteristics of the population from which it is drawn.

If a sampling frame(list of all units of the study population) is available, any of the following probability sampling methods can be used. They are:

-Simple random sampling
-Systematic sampling
-Stratified sampling
-Cluster sampling and
-Multi-stage sampling

9.4.2 Sample size

Determination of the sample size will depend on many factors. Sample size depends on the expected variation in the data, the accuracy required, feasibility etc., It is best that the services of a statistician be obtained in the determination of the sample size.

9.5 Plan for Data collection

In our research methodology we have now answered the following questions:

1. What information we want to collect to answer the research questions stated in our objectives - variables.

2. What approach we will follow to collect this information - study type

3. What techniques and tools we will use to collect it- data collection techniques

4. Where we want to collect the data(s) - study area.

5. How we will select our sample, and how many subjects we will include in our study - Sampling

Now we enter a new phase in the development of our research methodology that is planning our field work.

9.6 Stages in the Data collection process

Three main stages

Stage 1 : Permission to proceed

Stage 2 : Data collection

Stage 3 : Data handling

Once permission is obtained from the relevant authorities and individuals you should consider the logistics involved in the data collection. These will include questions such as who will collect what data? How long will it take to collect the data? In what sequence should data be collected? When should the data be collected.

9.7 Ensuring quality of data

Pretesting the research instrument, training the interviewers/research assistants, supervision of research assistants and cross checking samples of data collected will ensure quality of data.

9.8 Data Processing and Analysis

When making a plan for data processing and analysis, the

following issues should be considered.

-sorting data

-performing quality control checks

-data processing and

-data analysis

An appropriate system for sorting of data is important for facilitating subsequent processing and analysis. As the case may be, for purposes of comparison data may have to be grouped eg. socio economic groups, educational levels, or analysed separately. In addition to the checks carried out in the field during collection, data have to be checked again before processing for completeness and consistency.

As you begin data processing, you must make a decision whether to process and analyse the data manually using data master sheets or by computer.

Data processing involves:

-categorizing the data

-coding, and

-summarizing the data on master sheet.

In the analysis of data, frequency distribution tables for the variables have to be planned from data master sheets. Instead of giving the frequencies in ahsolute numbers percentages can be used. In addition to making cross tabulations at a time, it may be useful to combine information on two or more variables to describe the problem or to arrive at a possible explanation to it. For this purpose, cross tabulations have to be designed. Initially it is necessary to prepare Dummy cross tabulation.

10. **Budget**

In undertaking a research project, one of the most important resources required is money. Unless tbe availability of funds is ensured it may not be possible to implement your research. Financial assistance for research is provided by many national and intemational agencies. International agencies sucb as the International Development Research Centre, the World Health Organization, the United Nations Development Programme and national organizations such as NARESA provide financial assistance to HSR studies. The source of funding for the research has to be identified at the very beginning itself.

Preparation of the Budget Proposal will sometimes depend on the guidelines provided by the funding agencies. Basically, each of the activities planned in your work plan sbould be budgeted. Determine for each resource needed, the unit cost and the total cost.

The broad categories for budgeting are:

Personnel
Computer analysis
Supplies
Transport

Funding agencies prefer to fund research projects which are of short duration and with reasonably small budgets.

11. **Finalizing the research proposal**

Your final research proposal will be written according to the following outline

1. Introduction
    i) background infomation
    ii) Statement of the problem
    iii) Literature review

2. Objectives

3. Methodology
    i) Study type, variables, data collection techniques
    ii) Sample
    iii) Plan for data collection
    iv) Plan for data processing and analysis
    v) Ethical considerations
    vi) Pretest

4. Project Management
    i) Staffing and work plan
    ii) Administration and monitoring
    iii) Plan for utilization and dissemination of results

5. Budget
    i) Budget
    ii) Budget justification

Annexes
    i) References
    ii) List of abbreviations(if applicable)
    iii) Questionnaire(and/or other data collection tools)

Your proposal has to be submitted to relevant authorities for approval. Sometimes it may be necessary to prepare a summary of the main points along with the research proposal. You should implement the research only after you obtain approval.

12. Role of the Provincial Director in HSR

-Be familiar with the concepts of HSR
-Identify problems for research
-Promote/encourage HSR among staff

-Support/assist those conducting HSR

-Identify sources of funding

-Disseminate research findings

-Implement recommendations for overcoming problems in the health system.

13. Conclusions

This chapter will enable a prospective researcher to understand the characteristics and the concept of Health Systems research. In the understanding of research one would realize that there are vast numbers of practical day to day problems in the health system, which need answers or solutions. Such problems are faced not only by the care providers but also by health managers/administrators. Simple research into these problems should find relevant answers to such problems. The results of such research studies should help the decision makers to arrive at relevant and appropriate decisions in the management of health services.

In addition, this chapter will provide the basic knowledge for the designing of an outline HSR proposal. However, additional inputs may have to be obtained from relevant sources, including experts, in the preparation of a good HSR proposal and in the implementation of the proposal.

CHAPTER 13

MANAGEMENT AUDIT PRINCIPLES AND METHODS

Chapter Overview

This chapter defines the basic concept and purpose of auditing. A comparison is made between financial audit, medical audit and management audit. To place management audit in it's perspective, a brief overview of management is presented, highlighting efficiency, effectiveness, equity, quality of care, and sustainability as the key concerns. The main steps of conducting management audit are listed. Two illustrative checklists of management audit, one on 'Human Rclations' and the other on the district hospital, are presented.

1. FINANCIAL AUDIT

We are all familiar with the term "audit". Audit is an examination of accounts by an authorised person or persons. Two other meanings of the term audit as a noun are: a calling to account generally i.e. ascertaining accountability; and a check or examination. As a verb, to audit is to examine and verify by reference to vouchers.[1]

The first meaning of the term audit as mentioned above relates generally to financial transactions. Audit is intended to check whcther any lapse or irregularity has occurred in financial transactions, fix up responsibilities for omissions and commissions and to suggest ways and means for rectifications. The purpose of auditing is to ensure that financial transactions take place in accordance with the predetermined rules and procedures.

2. Medical Audit

The basic principles of auditing need not be confincd to financial transactions only. However, it is only recently that the principles of auditing have been applied systematically in other areas outside financial and business transactions. Medical audit is an example. Medical audit is a systematic rcview of various steps of the process of paticnt care to assess thc quality of care as against the certain standards and professional judgement. The purpose of medical audit is to guide care providers for improving the quality of care in a given situation.

3. Management Audit

Management audit means an examination of management.It is a method of reviewing managerial practices. What is done by a manager for the purpose of management is a managerial practice. More specifically, management audit is a self-evaluation of management, asking the question: how efficient is the management?. It is like looking at oneself in a mirror to see how he/she acts as a manager.[2]

The concept of management has different aspects and different dimensions, depending on the specifics of a given situation. There is, however, certain basic functions generally common to most situations. These include: planning, organizing, staffing, coordinating and evaluating. Each and every function requires control. A control process consists essentially of three steps: setting performance standards; measuring actual performance and comparing it with the standard; and taking actions to correct deviations, if any, between actual and planned or expected performance[3]. Management audit is essentially a summary of all operational control processes.[4]

4. Comparison of three types of audit

As mentioned earlier, the basic principles of auditing are same whether it is in financial transaction, medical care or health services management. The differences between them relate to the operational procedure and the parameters that are checked. A brief comparison of audits in the above mentioned three areas is presented below.

Table 1. Audits in finance, medical care and management compared

Comparison Parameter	Financial Audit	Medical Audit	Management Audit
. Premise	. Budget/ Allocation	. Patient care	Program/Institution/Organization
. Basis	. Financial rules and	. Norms and standards procedures	. Management principles and procedures
. Check	. Financial/material transactions	. Patient care process	. Managerial practices
. Information base	. Accounts ledgers	. Case records/Registers vouchers, etc	. Performance reports, supervision
. Objective	. Detect deviations/ lapses	. Detect lapses/ shortcomings	. Identify management deficiency.
. Focus	. Enforcement of rules	. Professional accountability	. Self-appraisal
. Purpose	. Ensure compliance	. Provide guidance for improving quality	. Improve management efficiency
. Responsibility for auditing	. Auditor (mostly external)	. Professionals/ Peers	. Manager/supervisor

5. **Purpose of Management Audit**

A frontline manager(health workers with management functions, eg. PHI,MOH) can use management audit as a tool to examine his achievements and shortfalls. A middle-level manager (eg. DDHS) can use it to assess the management efficiency of an organization(e.g. Maternity Home). As Provincial Director of Health Services, you can do medical audit to assess your own competence as a manager in such functional areas as planning, organizing, human resource management, public/human relations, etc. The main purpose of management audit is to review managerial strengths and weaknesses for assessing management efficiency in order to bring improvements in managerial practices.

6. **Management at a glance**

Now, to have a clear conceptual understanding of management audit and its purpose, we need to have a look at the basics of health service management. Management is getting the work done through harmonious working of people and efficient use of resources to achieve certain objectives[5]. The key concerns of health services management are: efficiency, effectiveness, equity, quality of care, and sustainability. These concepts are briefly defined below.

1) **Efficiency**

Efficiency expresses the relationship between the results obtained and the efforts made. Results may be equivalent to:

- Output e.g. The number of patients treated in an institution during a given period of time,the number of staff trained in a course.

- Outcome eg. The number of patients cured from among those treated, the number of trainees who have acquired the target skills.

- Impact e.g.The level of health status improved. improvement in performance of the trainees due to their training.

Results may relate to certain other products of an activity or a programme.

Efforts' relate to use of resources. A health programme is more efficient when it produces the desired result by using less resources. Efficiency involves a number of elements.Of them, allocative and technical efficiency are the most common.

a) **Allocative Efficiency**

Allocative efficiency requires such allocation of resources among the various health care programmes/ activities as will ensure the maximum outcome. It calls for setting programme priorities in keeping with the prospects of getting the highest health impacts of such programmes e.g. primary vs. tertiary care; curative care vs. preventive care; graduate vs. sub-graduate manpower production. Some of the indicators of allocative efficiency are:[6]

- Percentage of expenditure on all hospitals;
- Percentage of expenditure on tertiary hospitals;
- Percentage of expenditure on public health;
- Shares of staff time on identified high and low priority activities.

b) **Technical Efficiency**

Technical efficiency relates to whether the service is provided at the lowest possible cost.[7] It requires that the selected activities are carried out, maintaining the norms and without wastage of resources. Indicators of technical efficiency include:[8]

- Number of drugs prescribed per outpatient(OP) visit;
- Percentage of OP cases receiving antibiotics;
- Percentage of OP cases receiving injections;
- Percentage of children under five receiving ORS relative to anti-diarrhoeals;
- Cost per case for drugs per OP visit.

2) **Effectiveness**

Effectiveness is the extent to which objectives are achieved. There could be a number of indicators of effectiveness, depending on the type of objectives: service output(e.g. number of women given three doses of tetanus toxoid injections), service outcome(e.g. number of women who have actually developed immunity), and impact(e.g the number of deaths due to neonatal tetanus averted).

Cost- effectiveness means that maximum possible results are achieved with the given set of resources. Cost- efficiency means the use of the least possible resources to achieve the given results. Cost and effectiveness are combined in cost-effectiveness analysis to derive a measure of efficiency[9]. It involves assessing the gains(effectiveness) and costs of alternative ways of achieving a specified objective. The

results are expressed in terms of cost per unit of results for each alternative. The alternative with the lowest cost per unit of results is the most cost-effective.

Cost

Costs are often considered equivalent to prices paid for resources used. This is financial cost. Costs can be looked at from a different perspective[10]. Many health programmes have resource inputs for which no money is paid. Some examples are: community health volunteers working without payments; mass media projecting health messages without charge; health centres donated; equipment received as grant free of import taxes, etc. Their financial costs are zero in so far as the programme budget is concerned. But they have cost implications because somebody has paid for them. The volunteer's time could be utilized in other productive work, the land and building of a health centre could be used for other purposes. The returns that could be obtained from the alternative uses are foregone. These are opportunity or economic costs. The consideration of this type of cost is critical to future sustainability of the programme.

3) **Equity**

Equity means fairness. Equity has a number of dimensions. These are:[11]

- Equity in availability of services: location of hospitals, area-wise deployment of health personnel.
- Equity in access to services: geographical access - distance, terrain; Economic access - income, transport, service charge; Social access- education, tradition, etc.
- Equity in utilization of services: different groups of population may use services to different extents.
- Equity in finance: benefits vs. burden (charges), who bears the cost, who gets the services ?

4) **Quality of care**

Economists often look upon quality as one dimension of efficiency on the ground that efficient allocation and efficient use of resources will result in high-quality service. However, the question of quality of care or intervention in the context of health services is of prime importance to be considered as an independent criterion. There are many measures of quality of care, pertaining to structural, process and outcome variables. Users' perceptions of the quality of care are also very important.

5) **Sustainability**

Sustainability means the capacity of the health system to continue necessary interventions over time without much external support. This can be grouped in two broad categories: financial and institutional. Financial sustainability relates to sufficient levels of funding for continued operation. Institutional sustainability relates to the capacity of institutions and organizations to manage programmes.

It should be noted that efficiency, quality of care and people's perceptions influence the issue of sustainability. It is obvious that the managerial competence is crucial to sustainability and the factors that affect it.

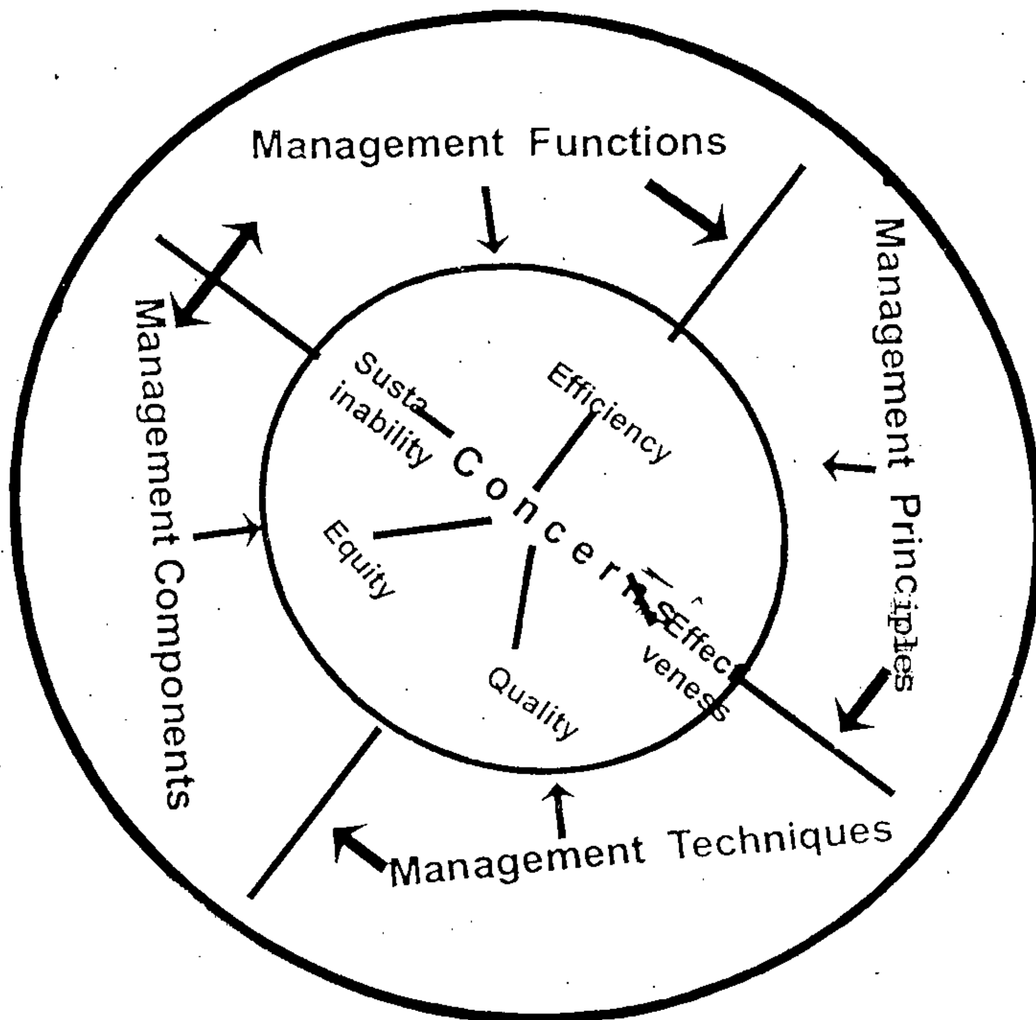
6. **Inter-linkages of various management aspects**

To achieve the above-mentioned objectives: efficiency, effectiveness, equity, quality and sustainability, a manager has to carry out certain functions, observe some principles, adopt certain techniques and deal with certain management components. These are as follows:

- Management functions: Planning, organizing, communicating, controlling.
- Management principles: Management by objectives, division of labour, convergence of work, substitution of resources, etc.
- Management techniques:
  Systems analysis, work study, cost analysis, operations research, etc.
- Management components: Human resources, Finance, Logistics, Drugs, Laboratory Services, Patient Care, Community Health care, self-management, office management, etc.

All the above areas are interlinked and interactive in the process of achieving the key objectives of management (Vide Figure 1).

Figure 1. Interlinkages of various management aspects



7. What is to be audited in management

All managerial practices are subject to management audit. The quality of management practices depends on managerial competences. Managerial competence relates to several functional areas. Those include: maintaining and improving services; developing the team approach; organizing and assessing the work; enhancing effective working relationships; obtaining, evaluating and using information for action; and solving problems and making decisions.[12]

Each of these areas calls for many management activities. What are expected of managers in terms of his knowledge, skill, attitude, and practice concerning those activities are subjects of management audit. Other special areas such as 'self-management,' could be audited to assess the manager's competence and attitude.

Self-management

Effective self-management calls for continuous self education; periodic self-assessment, efficient time management; acquiring leadership qualities; effective presentation of self; and developing and maintaining good human relations. Self management as a whole or any of its components could be audited.

Creating and maintaining good relations with your staff, colleagues, superiors and others is essential to facilitate your work as a manager and operations of your organization. There are many principles to follow for promoting human relations. As a manager, you need to be careful and perceptive in your organizational and personal behaviour with others. Salient points conducive to developing and maintaining good human relations could be audited to assess the manager's competence in this regard.

8. The process of management audit

The process of introducing and conducting management audit consists of three stages: planning, auditing and follow up. The main steps in each stage are listed below:

8.1 Planning Management Audit

1) Decide the scope of management audit. To start with, it should be simple and hence selective, covering a few points. Select a management area or function that you consider a priority for auditing.

2) Select the points which are of prime importance to the attainment of your programme/objectives concerning the selected management area or function.

3) Prepare a checklist to be used to examine the points.

4) Identify the sources of information for each point of the checklist: records, reports, supervisory visits, observation, etc.

5) Decide how frequently you are going to check the points in the checklist.

6) Write down the management audit plan precisely, incorporating all the above points.

8.2 **How to Audit**

1. Examine the points as objectively as possible and make entries in the checklist.

2. Analyse the entries in the checklist, and other findings from your observations; identify shortfalls and achievements.

3. Identify the reasons of shortfalls. You can do it in the light of your experience, discussion with the staff and others concerned.

4. Take corrective measures to address the problems and improve the managerial practices. This may be simple, straightforward in many cases. In some cases you may require support from superiors and you have to mobilize it.

5. Prepare a precise report on the management audit conducted.

8.3 **How to Follow up**

1. List the points from the audit that have contributed to your self-learning.

2. Share the audit results and learning with others.

3. Repeat the management audit periodically as decided earlier or as found necessary in the light of the previous audit.

4. Try to improve the subsequent management audit in terms of its scope, content, information, analysis, documentation and dissemination.

5. Use the management audit as an instrument of your learning and improving managerial practices.

8.4 How to take planning decisions for management audit

You may take the necessary decisions, based on your own experience and or consultation with others. An analytical approach to your management responsibilities may he useful for this purpose. Have a closer look at your job. This manual itself shows several areas of your responsihility. (vide the contents of the Manual) All management functions(planning, organizing etc.) are required, to various extents, for each area. The most comprehensive scope would he to select all areas of responsibilities and look at all management functions. But it would be extremely difficult to conduct an audit with such an enormous scope. However, in some cases, it is worth conducting. This would provide an overview of the overall management and identify relatively weak areas which could be suhjected subsequently to further probing.

Suppose you want to limit the proposed audit to the management of patient care services. Then the next question is: which sub-areas or functions of curative services should he selected for auditing. Your roles and responsibilities in the management of patient care services have heen spelled out in Chapter two of this Manual. Thirty five items are listed there. You may select some of them or you may like to select some management functions concerning patient care services.

While you are responsible for management of patient care services, there are other levels under your jurisdiction where patient care services are managed and provided. These range from central dispensaries to outpatient and inpatient wards of the different types of hospitals. Suppose, you have chosen to conduct management audit for a district hospital. Then select the points which you want to check.(see the checklists as an example). The findings of this audit would show how well the district hospital is managing patient care services. No precise information on the content and quality of care would be availahle from this audit. These could be collected from medical audit as a part of quality assurance programme. Note that management of patient care services by district hospitals under your jurisdiction is one of many indicators of your management efficiency because you are their supervisors.

Suppose another special area that you have decided to audit is your 'self-management'. The next question is: which aspects of self-management? There are many aspects that include among others: self-education: self-assessment, time management, presentation of self, human relations. Each of them has many components, of which the main ones should he assessed for the purpose of management audit. A checklist in respect of 'Human Relations' is presented as an illustrative example.

Checklist for Management Audit for a District Hospital

Under the date, write Y(yes) or N(no) opposite each statement. If necessary, you may use separate sheet to describe the status of any statement.

A. Organization A.	1st Audit Date	1st Audit Action	2nd Audit Date	2nd Audit Action
1. The district hospital has its defined objectives				
2. These objectives are known to the hospital staff				
3. Clinical meetings are held regularly				
4. The minutes of the meeting are available				
5. The meetings are used as a means of staff education				
6. Staff duties are listed on a roster				
7. Patient referral procedures are in place.				
8. Patient referral registers are properly maintained.				
9. Hospital management module is available and used				
10. Sitting arrangements for waiting patients are in place.				
11. Name plates of clinical staff and service units are clearly written and in place to guide the patients.				
12. Health educational posters/materials are displayed.				
13. The list of essential drugs is available and displayed.				
14. Some technical efficiency measures(see the indicators on page 160) are in place				
15. Care providers are aware of their behavioral role in promoting equity in utilization of services				
16. Consumers' complaint/suggestion box is in place				
17. The complaints/suggestions received are analysed and acted upon				
18. The health needs of the public are discussed periodically in the clinical staff meeting.				

B. **Personnel**				
1. Each staff member of the hospital has a written job description				
2. Each staff member knows to whom to report and from whom to receive instructions.				
3. The team approach to clinical work is adopted.				
4. On-the-job training is organized periodically				
5. The leader appreciates good work				
6. Most of the staff are satisfied with their posting in the hospital				
7. Supervision is done for educating and helping the staff rather than criticizing them				
8. Staff are using the skills for which they were trained				
9. Staff show concern for the patients' health				
C. **Resources**				
1. The patient registers are properly maintained				
2. Basic diagnostic equipment are available				
3. Essential drugs are available				
4. The utility provisions (water, electricity and sanitation)are in place				
5. The stores are properly maintained				
6. Physical balance and book balance tally with each other				
7. The petty-cash balance sheet is correct				
8. There are adequate and clearly marked maps of the district.				
9. The transport system (log book /running charts etc.) is well maintained				
D. **Control System**				
1. There are monthly statistical reports on patients attendance				
2. The disease profiles are prepared month-wise and on display				
3. There are annual disease profiles on display for the last five years				
4. Statistical information on the community demography are available/displayed				

5. Statistical information on community health facilities and programmes are available/displayed				
6. Thc data on technical efficiency measures are analyzed and the results discussed				
7. The results of the analysis of public complaints/suggestions are documented and available.				
8. The hospital utilization statistics are periodically reviewed for bringing in improvements				

An Audit Checklist on Your Human Relations

		1st Audit Date*	2nd Audit Date
1.	Do I have self-control in any situation?		
2.	Do I try to understand an issuc from other's point of view?		
3.	Do I make myself always clear?		
4.	Do I admit when I am at fault?		
5.	Do I refrain from criticizing my staff in front of others?		
6.	Do I recognize good work done by others?		
7.	Do I encourage my staff to do hetter?		
8.	Do I lead and not drive my staff?		
9.	Do I avoid snub judgement about othcrs?		
10.	Do I take care of little things of my staff/ colleagucs?		
11.	Do I kccp my concerned staff informcd when I go out?		

12. Do I offer helpful <u>suggestions</u> to my staff/others?	
13. Am I generally free from <u>negative attitude?</u>	
14. Do I make small <u>sacrifices</u> now and then for my staff/friends/ relatives?	
15. Any <u>event</u> that has <u>positively influenced</u> my relationships with others?	
16. Any <u>event</u> that has <u>impaired</u> my relationship with others?	

* Note 1) under date, write Y(yes) or N(no) as per your own assessment; if you are not sure,it is better to use the three point rating scale as : +(little), ++(Fair), and +++ (good)

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