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NATIONAL HEALTH

STRATEGIC MASTER PLAN

2016 - 2025

Vol. IV

Health Administration & HRH

Ministry of Health - Sri Lanka

Message from Hon. Minister of Health, Nutrition and Indigenous Medicine

Good health is central to human happiness and well-being, and also makes an important contribution to economic progress of an individual, or a country as a whole. Sri Lanka can be proud of the success it has achieved so far in its Health Sector, through careful planning and efficient execution of programmes.

However, when I took office early last year I was dismayed to note that the then ongoing Health Sector Master Plan was to lapse in December 2015, with no new Plan in the pipe line, which made me to go ahead in developing an updated Health Policy and a Health Strategic Master Plan as a top priority. This was of prime importance to implement the developmental programmes of the government of Good Governance, which laid much emphasis on health sector development and welfare of the people.

A new Plan was necessary also due to the changing landscape of health care financing and delivery in the country due to life style changes and emerging environmental issues and accompanying health sector needs. I have no doubt that with proper planning and investment in both infrastructure and health personnel Sri Lanka has the potential to develop a health system comparable to the standards comparable to those in developed countries .

I am pleased to note that in spite of their heavy official commitments, the Director General of Health Services and the team of Ministry officials assigned for the task has come up with the Health Master Plan for the period 2016 - 2025 with in a relatively short period. I also wish to convey my sincere thanks to all the health professionals who contributed for this compilation .

Furthermore, the valuable comments/ observations / recommendations made by the professional Colleges and Associations, Provincial Ministries of Health and Health sector Trade Unions are much appreciated. I sincerely look forward to the full commitment and dedication of all the officials of the Ministry of Health as well as health officials in the Provincial Health Services to achieve the expected Health Outcomes in the Master Plan 2016-2025, with the view to improving Health care delivery to our people.

Dr Rajitha Senaratne
Minister of Health, Nutrition & Indigenous Medicine

Message from the Secretary of the Ministry of Health , Nutrition & Indigenous Medicine

Ministry of Health , Nutrition & Indigenous Medicine is responsible , to safeguard the status of Health of all citizens of Sri Lanka . Therefore a considerable amount from the national budget is allocated by the Government of Sri Lanka , to the Ministry of Health , Nutrition & Indigenous Medicine , to achieve the said objective . Thus it is our duty to utilize those public funds effectively , efficiently and economically to provide better standards of health care throughout the country

As such , it is essential to have a comprehensive Health plan with monitoring tools to make the best use of this massive budget ; and , I am much pleased to note that , the professional of the sector have made a collective and collaborative effort to produce a comprehensive Health Master Plan for ten years (2016 - 2025)

I hope the deficiencies of the previous health master plan will be corrected by the newly prepared Health Master Plan (2016 - 2025) As the proposals have been prepared by the relevant Programme Directors and the Consultants attached to those subjects , the ownership of the plan is correctly vested on the programmes itself . I feel that this is a crucial decision taken by the Ministry to establish sustainability and continuation of the Health Master Plan throughout the next ten year period .

As the indicators and the verifiable means have been identified for all proposals in the Health Master Plan 2016 - 2025 , it is essential to monitor the outcomes . A continued mechanism of Monitoring & Evaluation has to be linked to this Health Master Plan 2016 - 2025 , to achieve the expected health outcomes and justify the utilization of massive amount of public funds . Duplication to be avoided and allocative efficiency should be practiced at each step of translating strategies to activities

Finally I have to endorse that , it is the first and foremost duty of all officials in the Health sector to be adherent to this plan throughout the specified ten year period (2016 - 2025) and achieve the time targets specified in it , to offer best health services to the Sri Lankan nation

Anura Jayawickrama

Secretary

Ministry of Health , Nutrition & Indigenous Medicine

Message from the Director General of Health Services

Firstly I would like to place on record , my sincere thanks to my team of professionals , the members of National Steering Committee on Health Master Plan (all Deputy Director Generals), the Programme Directors and Consultants attached to relevant subjects , for their tireless work , (despite having to cope with tremendous work load in daily duties) which made the dream of a comprehensive ten year (2016 - 2025) Health Master Plan , a success and a reality .

As the Department of National Planning recommended , the team of professionals involved in the preparation of Health Master Plan , essentially comprised of local experts only , and the National Steering Committee on Health Master Plan , at the first meeting , decided to utilize only the Programme Directors and the Consultants attached at present to the Health Services as the experts responsible for the preparation of relevant proposals . This decision has given a great stimulus to the key officers in all Programms and I find that they have produced excellent proposals for the next ten year Health Master Plan (2016 - 2025).

I also acknowledge very specially the collaborative efforts and expert contribution made by all Professional Colleges and Associations , at my request , to make this plan to cover all specialties of Medical Sciences . Although the Preventive sector is well represented in the organogram of the Ministry of Health , the Curative and Rehabilitative sectors need developments . The proposals of Clinical Professions were able to cover the said gap in Health Master Plan , accordingly I have decided to have separate plans for each major task , (as separate plan documents for Preventive Health Services , Curative care and Rehabilitation)

This Health Master Plan (2016 - 2025) has been submitted for Public Opinion , Provincial Ministries of Health Services and Trade Unions as well . I am much thankful to all of them for sending valuable suggestions to improve services on various aspects .

At last , but not the least , the excellent coordinating of the activity and drafting of this ten year (2016 - 2025) Health Strategic Master Plan was undertaken by the focal point appointed by me for this activity . Dr D.A.B.Dangalla (Director - Policy Analysis & Development and , Acting Senior Assistant Secretary (Medical Services) functioned as the focal point , with his staff , devoted many months to accomplish the given task . I highly appreciate the degree of dedication of Dr Dangalla and his staff , towards the completion of this activity .

It is my advice to all of my officials (as we own the plan as we wrote the proposals) to adhere to the plan throughout the said ten year period and implement all strategies designed by you all , with a rigid mechanism of monitoring and evaluation of time bound targets . to make our health services comparable to Developed Countries .

Dr P. G. Mahipala

Director General of Health Services

Background

As the present Health Policy was prepared in 1996 and , now ; after 20 years it has to be replaced with an updated policy . There are many reasons justifying the preparation of a new health policy ; such as the following - Health issues which were not addressed with the present health policy , have to be tackled with new and different strategies . Newly emerged health issues have to be addressed with a new health policy . After the internal civil war , Sri Lanka can look forward to stability and increased investment in health . The country has the potential to develop a health system on par with the best in the world . But a change is needed ; to reduce inequity , to improve quality , to develop a health system which can respond to the needs and expectations of the new generation

The present health master plan was prepared in 2004 with JICA assistance and it is scheduled to be terminated at the end of 2015 Thus a new health master plan has to be prepared for the next decade starting from 2016 , and the need for a new health master plan is timely as explained below .

Some of the key subjects , which have become priority health issues in the present context , had not been included in previous JICA Health Master Plan (2005 - 2015) Eg . Renal Diseases , Estate Health , Nutrition , etc . Although the Preventive sector had been covered extensively by JICA HMP , the Curative service component had not been sufficiently addressed to the expectations of clinicians . With the demands of patients for better services , (Stroke centres , Cath Labs , Cataract Surgery , Waiting for Bypass Surgery) an extensive analysis of issues , is essential to design strategies . Certain indicators of Health have become stagnant and new approaches are required for further improvements in those sectors

Accordingly , a new health policy , a new strategic framework to develop health services ; and incorporating the new policy and strategic framework , a new Health Master Plan ; are needed for the country .

Simultaneously it is essential to design the goals and the expected Health Outcomes of this Health Master Plan .

Thus it was decided by the Ministry of Health , that the expected outcome would be a people centred health system which is sensitive to the needs and expectations of the patients / people .

The best tool to ascertain the patient factors , is the concept of universal coverage ; a conceptual model which can be summarized as (a) Equity of distribution of services to all patients living in all areas of the country (b)

Accessibility to health facilities by each and every patient (c) quality of service provided to each patient , and (d) Financial Protection of all patients

The processing of Health Master Plan was initiated with the establishment of National Steering Committee on Health Policy & Master Plan . The National Steering Committee on Health Policy & Master Plan comprised of DGHS (As Chairman) and the Deputy Director Generals of the Ministry of Health . Dr D.A.B.Dangalla (Director - Policy Analysis & Development and acting Senior Assistant Secretary - Medical Services) was appointed as the secretary to NSC and to function as the focal point for the preparation of Health Master Plan 2016 - 2025 .

At the first meeting of National Steering Committee (NSC - December 2014) it was decided to appoint all programme Directors and the Consultants to prepare the proposal for the relevant programme and respective deputy director generals to function as co-chair to the working groups . Terms of Reference (TOR) for the preparation of programme profiles , were approved by the NSC . Formats for preparation of strategic framework and programme profiles were also identified at said meeting of NSC

The format for the strategic framework was designed from the Reference document titled - Shri Lanka National Health Policy - 1992 (Prof Erl Fonseka , et.al) The said document has analyzed all sub sectors of health in a uniform matrix which contained a brief situational analysis of the sub sectors , followed by several policy measures . Therefore in the preparation of this Health Master plan , the situational analysis section was attached each of the programme profiles . But in the preparation of strategic framework (2016 - 2025) the health problems were listed with strategies designed to over come the issues (Instead of listing policy measures as in 1992 , the present Strategic framework (2016 - 2025) has extended beyond , to the level of designing strategies) A new feature has also been added to link the strategies to achieve the Sustainable Development Goals (where we should be in 2030)

The format for the preparation of programme profiles (attached) has been adopted from the JICA Health Master Plan (2005 - 2015) As it was a complex document , not referred as expected by many officials during later years . To avoid similar situation occurring once again , the format was deliberately simplified to contain the essentials but made more practical and user friendly manner ; and new sections are also added to justify the proposal eg . Situation and Problem Analysis in detail with the proposal for each programme .

A new tool has also been introduced (attached) for the Gap Analysis according to the concept of Universal Health Coverage - UHC . (to direct all proposals towards UHC) This new tool was approved by the NSC at the second meeting held in February 2015 .

At the third meeting of NSC (May 2015) it was decided to obtain external technical assistance , as there are no local experts for the following subjects (Disease Burden Studies , Elderly Care , Home based Care , Health Technology Assessment , Human Resources for Health - HRH , Health Economics and Regulating Private Health Sector) The suitable foreign experts shall have both academic qualifications (Post Graduate qualifications) and experience in employment of the relevant subject in other countries . This proposal has been approved by the Department of National Planning and forwarded to the Department of External Resources to seek foreign Technical expertise of aforementioned subjects .

At the fourth meeting of NSC (October 2015) the following areas were noted . Although the Preventive Health Services had been covered extensively by many proposals , the Curative Care sector proposals were inadequate . The said deficiency of not representing the curative care sector adequately at the Ministry level , has been a longstanding issue .(please refer to section on Reforms / Curative Division in pages 77 - 97 , in Vol IV of Health Master Plan / Health Administration & HRH) Therefore , as the Chairperson of the NSC , the Director General of Health Services invited all the Professional Colleges and Associations , to submit their proposals on Curative & Rehabilitative Services , according to the format designed to prepare programme profiles and to use the UHC gap analysis tool to identify the problems .

The responses from the Professional Associations & Colleges were encouraging ; Received the proposals form the following ;

College of Anesthesiologists of Sri Lanka

Sri Lanka College of Obstetricians & Gynecologists

Sri Lanka College of Microbiologists

Palliative Care Association of Sri Lanka

Neurosurgeons Association of Sri Lanka

College of Ophthalmologists of Sri Lanka

Sri Lanka Association of Oral & Maxillo-facial Surgeons

Sri Lanka Heart Association

College of Medical Administrators of Sri Lanka

Sri Lanka College of Pulmonologists

College of Community Physicians of Sri Lanka

Sri Lanka Association of Urological Surgeons

College of General Practitioners of Sri Lanka

Sri Lanka College of Haematologists

College of Otorhinolaryngologists and Head & Neck Surgeons of Sri Lanka

Sri Lanka College of Venereologists

Association of Plastic Surgeons of Sri Lanka

Sri Lanka College of Endocrinologists

As such the Director General of Health Services instructed the focal point to draft separate volumes of Health Master Plan for each major task area , (I) Preventive Health Services (II) Curative Care (III) Rehabilitative Care (IV) Health Administration & HRH .Many stakeholder meetings were held to prepare proposals , the manuscripts of proposals of each programme were prepared by the respective Programme Director and the Consultants attached to the relevant programme , under the guidance of the respective Deputy Director Generals . For the Preventive Sector , an additional group of Consultant Community Physicians were invited (including Professors in Community Medicine and Provincial Consultant Community Physicians) The final draft of all five documents of Health strategic Master Plan (1 / Strategic Framework for Health Development , 2 / Vol I - HSMP Preventive Health Services , 3 / Vol II - HSMP Curative Care , 4 / Vol - III Rehabilitation Care , 5 / Vol - IV Health Administration & HRH) was prepared by the Director - Policy Analysis & Development (the focal point for preparation of Health Master Plan) with the assistance of the staff of PA & D unit

As an additional procedure to cover the minor specialties , the staff of Policy Analysis & development unit , consulted the senior medical specialists of certain specialties to obtain proposals of those minor specialties . eg Medical Genetics , Stokes & Trauma care , Care of Abused Children , Plastic Surgery , Autism , etc

Several Field Studies have been conducted by the staff of the Policy Analysis & Development unit with regard to situational analysis of certain subject areas (a) Health Services of Plantation Estates , (b) CKDu affected communities in Districts of Anuradhapura and Polonnaruwa , Divisions of Thanamalwila , Sooriyawewa , Buttala , Angunakolapelessa , Sewanagala , Embilipitiya , and Thissamaharamaya (c) Primary Level Curative Services – Divisional Hospitals and Primary Medical Care units - the need for re-structuring (d) under utilization of Healthy Life style clinics - application of management concepts to improve screening (e) study to identify the issues related to management and availability of medicinal drugs at district level .

Further the data available at the Medical Statistics unit and also the data bases of the individual programmes had been analyzed prior to the formulation of proposals . However most of the analyzed data are presented in the Annual Health Bulletin (AHB) and also in the annual progress reports of each programme , As such data analysis is not presented in this document (to avoid duplication) In the previous Health Master Plan , maps & charts had been presented as a separate document ; but it is not required to attach a similar document to this new Health Master Plan because those items are already available with AHB and annual progress reports of individual programmes .

The previous Health Master Plan had a separate volume to describe the situational Analysis , but its linkage to programme profiles published in another document was not evident . To avoid this type of deficiencies , the new Health Master plan has incorporated the situational analysis in to the main text of programme profile (with indication of references to relevant research publications)

The final draft was submitted to the Department of National Planning , Ministry of National Policies & Economic Affairs , to Provincial Ministries of Health in all nine Provincial Councils (Northern , North Western , North Central , Eastern , Central , Uva . Western , Southern & Sabaragamuwa Provincial Councils) and also to the Trade Unions of the Health Services . Further the Health Strategic Master Plan (2016 - 2025) has been published in the website of the Ministry of Health and advertized in print media of all three languages inviting Public Opinion ; and the relevant comments , suggestions , and recommendations received through the said process have been incorporated to the plan .

The excellent leadership and the technical guidance given by Dr P.G.Mahipala - the Director General of Health Services , was the key factor in completion of this massive task . For the previous Health Master Plan , it is

said that JICA had to spent Rs 225 Million , and a foreign company by the name of Pacific International was assigned the preparation of previous Health Master Plan with the contribution of a group of local experts . But the new plan , the National Health Strategic Master Plan 2016 - 2025 was prepared with a cost less than Rupees one million (Funded by the Government of Sri Lanka) The main reason for the production of the new plan at a much lower cost is the dedication of Sri Lankan Experts . The number of Consultants involved in the preparation of this plan was well above hundred and they offered their services voluntarily and without any additional cost to the government . The Policy Analysis & Development unit would like to place its great appreciation to all of those consultants who offered assistance to prepare the HSMP 2016 - 2025 . It has been said that - Doctors are the voice of the poor , the sick and the dead . This statement has been once again proven by the said team of consultants ; by preparing a master plan for the next ten years to grant better health outcomes to the Sri Lanka nation .

= focal point

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Table of Contents

Health Strategic Master Plan - Ministry of Health - Sri Lanka 2016 - 2025

Volume 1V

Health Administration & HRH

Focal Point = Director / Policy Analysis & Development ; under direct supervision of Director General of Health Services

Preparation of HMP - funded by Ministry of Health (GoSL Funds)

Program Title	**Entrench a system to improve the patient rights and their access to systematically updated information on all public and private facilities**
Focal Point	Secretary of health Director General of Health Services
Back Ground/Situation Analysis	Universal Declaration of Human Rights recognizes "the inherent dignity" and the "equal and unalienable rights of all members of the human family". And it is on the basis of this concept of the person, and the fundamental dignity and equality of all human beings, that the notion of patient rights was developed. In other words, what is owed to the patient as a human being, by physicians and by the state, took shape in large part thanks to this understanding of the basic rights of the person and system to implement to impose the behalf of the grieved party
Target area &Beneficiaries	All citizens of Sri Lanka
Justification	Human Rights has been instrumental in enshrining the notion of human dignity in international law, providing a legal and moral grounding for improved standards of care on the basis of our basic responsibilities towards each other as members of the "human family", and giving important guidance on critical social, legal and ethical issues. But there remains a great deal of work to be done to clarify the relationship between human rights and right to health, including patient rights. Recognizing this method like Ombudsman draws setbacks ability of a grieved party toinitiate a complaints and obtaining justice. Systematic and reconciliation upgraded version of patient right friendly method. de
Important assumptions/risks/Conditions	Governments have a fundamental responsibility to ensure universal access to quality health care, education and other social services according to people's needs, not according to their ability to pay. The participation of people and people's organizations, trade unions and civil rights societies is essential to the formulation, implementation and evaluation of all health and social policies and programmes, Liaise and obtain upmost support in formulation of new policies.
Vision	Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world - a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity;.
Mission	Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalized people. Measurement is central to the concept of quality improvement; it provides a means to define what hospitals actually do, and to compare that with the original targets in order to identify opportunities for improvement.

Goal	Build broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and legislation. • Fight the exploitation of people's health needs for purposes of profit	
Objectives	Indications	Means of Verifications
Implement protracted version of Ombusdsmen system relevant to MOH&PMOH Relevant	• Patients' rights in relation to health • Notified case of patient rights violation	• Human rights organizations and charters
Out put	Indications	Means of Verifications
Patient charter in relation to patients' rights	Reinforce of patients charter	• patients charter accessibility
Patients' rights structural system establishment	• impose of regulations and legislations to prevent patients' rights violation	• method of reporting
Impose system to brief victims of patients' rights violations	• development of a system to bring	• enhance of the system
Monitoring & Evaluation	1. legislations-Ministry of health and its provincial ministries and other related disciplinary bodies 2. excellence- periodical surveys, and hoc surveys, and forms of reports 3. Activities-regulations, circulars, guidelines, disciplinary bodies, penalty of violation, training /rehabilitation ,compensations schemes for victims and other methods of grief.	

	Activities	Expected Results	Process Indicators
I.	Human rights issues advocated for surveillance	Identification of Groups of human rights issues	Galvanize policy making task force
II.	Formulation/upgrade of feasible system/standards to prevent patient right violations	Standard protocol of conduct to prevent patient right violation	Methodology to address respective disputes
III.	Upgrade/modify victims of patient rights violation	Justice for victims of patient right violators	Methodology to notify issues
IV.	Establish Ombudsman system within MOH to promote and protect patients' rights	Initiation of ombudsman system	Cabinet approval to secure funds
V.	Develop/upgrade patient charter in relation to health related human rights	Initiation of patient charter	Cabinet Approval for appoint task force

Programme Title	National Health Planning- Sri Lanka
Focal Point	Director Planning
Background/Situation Analysis	**Background:** Sri Lanka comprise of 21 million multi ethnic, multi religious people distributed among 9 provinces and 26 RDHS divisions, which are the basic health administrative units in the island. • **Sustainable Development Goals** Even though our country is considered a middle income country, we match the developed world by achievements in various health indicators such as Maternal mortality rate, infant mortality rate. Additionally, it is well known that we have either achieved or were on track of achieving many health related Millennium Development Goals (MDG). Although Sri Lanka had achieved a lot in the health sector as a country, regional and urban-rural disparities are well evident. Since we are at a stage of achieving the Sustainable Development Goals (SGD), much ahead of the MDGs, focus must be on all regions and in the quality of health service delivery as well as the quantity. • **Epidemiological transition** With rapid urbanization, unplanned development, globalization and open economy, a drastic change in the peoples' lifestyles and dietary behavior is visible. With these changes had risen the challenges related to demographic transition, economic transition and epidemiological transition. The epidemic of Non Communicable Diseases had affected all countries of the globe mainly affecting the economic growth of the developing countries including Sri Lanka. And many such countries face double burden in nutrition, further worsening the problem. Therefore, focus should be set in at all the stages of disease prevention; primordial, primary, secondary and tertiary preventive strategies. • **Universal Health coverage** In order to achieve complete physical and mental well-being of the people in the country as 'health' defines, universal health coverage is of utmost importance, where health care services will be provided equally and equitably in high quality with financial protection for them all. • **Low health expenditure**

	Sri Lanka had set an example for many developing countries to improve health service delivery with a low expenditure on health. Although the health service provision is free of cost to the people, out-of-pocket expenditure that has to be borne by the people is found to be high. Since the health care expenditure per person would grow continuously due to ever increasing health care demands, the system of free/ low cost government health care services would be further challenged and stressed due to low budgetary allocation for health. • **Medical Tourism** Despite Sri Lanka being a middle income country, foreigners view and visit Sri Lanka as a focal point for Medical tourism due to expertise in medical management and comparatively low cost. This is an opportunity for the country to cover state medical expenditure in order to provide quality universal health coverage for its people. With this background rises the importance of priority setting and planning for health in order to provide sustainable, undisturbed, quality universal health care coverage to all citizens in Sri Lanka and to promote medical tourism. **Situation Analysis:** **1. Strengths** • Support from the Minister of health and other hierarchical officials in the Ministry of Health for activities and improvement of the planning unit **2. Opportunities** • Support from the Minister of health and other hierarchical officials in the Ministry of Health for activities and improvement of the planning unit • Appointment of expertise on planning to the unit • Appointment of required additional staff to the unit • Training facilities of the staff on planning and monitoring **3. Weaknesses** • Lack of human resources in all staff categories eg: consultants, Medical officers, planning officers etc.

	• Lack of physical resources • Lack of infrastructure for the unit • Lack of management in subject areas • Lack of monitoring of the activities in each subject area • Several activities divided among various units, therefore, overlapping, gaps in activities and lack of accountability • Lack of proper job lists **4. Threats** • Several activities divided among various units, therefore, overlapping, gaps in activities and lack of accountability
Target areas and Beneficiaries	1. Development of a Human resource development (HRD) plan based on a comprehensive human resource information system (HRIS) and developed workforce plans 2. Development of a physical resource development plan based on a comprehensive physical resource information system and relevant institutional master plans and based on shared care cluster system concept. 3. Capacity building by In-service trainings: • Planning expertise in the central planning unit • Programme managers. • MO- planning of line- ministry managed institutions, provincial and regional planning units. • Staff of the central planning unit, provincial and regional planning units 4. Performance Monitoring (physical and monetary performances monitoring) of the action plans: • Planning expertise in the central planning unit • Programme managers • MO- planning of line- ministry managed institutions, provincial and regional planning units 5. Infrastructure development • Central planning unit • Provincial and regional planning units 6. Human resource development • Central planning unit 7. Physical resource development

	• Central planning unit	
Justification	Epidemiological transition, increasing health demands with Low budgetary allocation for health and high out of pocket expenditure further challenges the free health care delivery system in Sri Lanka. Therefore, priority setting and planning for health is of utmost importance in order to provide universal, continuous, quality health care service for the citizens in Sri Lanka. Thus, the central planning unit should be strengthened to accommodate, implement and monitor all national programme plans, institutional plans and regional plans. Since all the planned activities for the betterment of people will be implemented and monitored at the regional level, it is important that the regional and provincial planning units be strengthened as well.	
Vision (MDPU)	People of Sri Lanka enjoy optimum health status through well managed health care services	
Mission (MDPU)	To foster evidence based planning and management of health care delivery system at different levels, in order to achieve and sustain optimum health status of the people as envisaged in the national health policy	
Goal	To provide quality universal health care services to the citizens of Sri Lanka by effective planning and monitoring.	
Programme objectives	**Indicators**	**Means of verification**
1. Reorganization and revising of functions of the Planning Unit		
Planning Unit to be a separate unit under DDG-P, headed by • Director Planning • Deputy Director Planning And several sub-units to overlook the activities of the Director Planning with separate required staff for each sub-unit. Sub-units: • <u>1 Consultant</u> – Cadre revisions, update current in-position, cadre projections and publication based on HRIS • <u>1 Consultant</u> – Action Plans over see, coordination,	Additional Staff in place -Deputy Director -5 Consultants -5 Medical Officers (1 per each sub unit) -1 Engineer -15 PPO/PPA (3 per each sub unit)	Appointments of -Consultants -Medical Officers -Engineer -PPO/PPA

compilation and publication. - Compare the action plans with institutional master plans and shared care cluster systems - Oversee project proposals and liaise with the National planning. • 1 Consultant Monitoring- Monitor the Health Master Plan, Action Plans and project proposals -Conducts audits and need assessments -Monitor the expansions and developments based on the institutional master plan and shared care cluster system -development of physical resource development plan based on the shared care cluster system • 1 Consultant / Training – In-service training for expertise; central, programme managers, institutions and regional planning cells -In-service training for staff of planning cells; central, programmes, institutions and regional • 1 Medical Administrator Research and system development: To conduct system related research and publications • 1 Engineer- Dedicated to the Planning unit, based at the department of Building, Ministry of Health: To		

oversee the constructions, attend field visits etc.		
2. Human resource development plan development, implementation, monitoring	• Human resource development plan developed • Regular presentation of the progress: once in 3 months	-Periodic reports -staff meeting minutes
3. Physical resource development plan development, implementation and monitoring	• Physical resource development plan developed • Regular presentation of the progress: once in 6 months	-Periodic reports -staff meeting reports
4. Capacity building of the staff in central and regional planning cells • Consultants: twice/year • MO-P: Twice/year • Other staff: Once/year	• Development of a training schedule based on requirements • Development of a data base on training • No. of training programmes conducted • No. of officers trained	-Training agenda -Training data base
5. Performance monitoring	• Quarterly review meetings for programme managers, institutional and regional MO planning (MO-P) (review of physical, financial progress of action plans, need assessments and system development research) • Bi-annual publication of statistic Bulletin on physical and human resources by programme managers and MO-P • Quarterly review meetings at the central Planning Unit (review of physical, financial progress of action	-Review meeting minutes -bi-annual statics bulletins published by each district/ province and programme

	plans, need assessments and system development research) • Monthly conference at the central planning unit (to review overall functions of the planning unit)	
6. Infrastructure and physical resources development • Central planning unit • Provincial/regional planning units	• Need assessment of resources • No. of infrastructure developed • No. of physical resources provided	-Review meeting minutes -published statistics bulletins
Outputs		
1. Reorganized central planning unit and its functions revised	• 3 separate sub units for planning, separate sub-units for monitoring, training, Research and system development research with revised functions	Document on job functions
2. Implemented human resource development plan	• Cadre projection published • Gaps in human resources identified	Review meeting minutes
3. Implemented physical resource development plan	• Physical development based on shared cluster system and institutional master plans	Review meeting minutes
4. Trained staff in planning cells	• Planning priorities identified • No. of properly written action plans • No. of properly written project proposals	-Action Plans -Project proposals
5. Strengthened planning units • Central • Provincial/regional • institutional	No. of planning units with trained staff linked to the central planning unit	Review meeting minutes

6. Action Plans/ projects regularly monitored	• No. of action plans/ projects in line with their proposed Gantt chant	-Review meeting minutes
7. Functions of the sub-units in the central planning unit monitored	• No. of activities in each sub-unit failed to achieve the proposed Gantt chart	-review meetings minutes -monthly conference minutes
Monitoring and evaluation	1. Institutional/programmes/provincial and regional planning cells: - By quarterly review meetings - By published bi-annual statistics bulletins Done by: The central planning unit, PDHS,RDHS 2. Central planning unit: - Monthly conference Done by the Director-Planning - Quarterly review meetings Done by the Secretary health, DGHS,DDG-P,Director-P and PDHS	

Profile written by D S.R.U Wimalaratne Director / Planning and

Dr (Ms) Isanka Ayeshwarie Talagala MD (Comm. Med)

Program title	**Reorganizing and retooling primary curative health services**
Focal point	Director - Organization Development
Back ground/ situation Analysis *(Problem Analysis)	The needs for healthcare in Sri Lanka have changed drastically. As we go through an epidemiological, social, demographic ant changes. The health burden experienced today is largely that of non-communicable diseases, including chronic diseases such as hypertension, Diabetes, ischemic heart diseases, asthma, stroke, chronic kidney disease, canner, mental health. This is further fuelled by the lack of general and specialized care for elderly. We also face the challenge of acute care needs for injury. The healthcare needs of 20% youth population are almost neglected and a long term health promotion strategy is needed when addressing all these conditions and special needs of target groups. The health service structure has adopted a gradual incremental approach in service development. Whilst the emphasis given to expansion of specialized services in the past is commendable (the policy of development of one hospital in every district to the level of a general hospital), this has led to a shift from development of primary care services. Also the development and facelift given to larger specialized hospitals (TH, General, Base hospitals) have lead to attraction of patients to these hospitals, even when their needs are only for basic primary care. Due to the large workload in these hospitals, patients cannot be given comprehensive, personalized family centered care through specialized hospitals. Also the system is not being efficient if we use our specialized hospitals to be deliver basic primary care (other than to those in the immediate catchment areas) Sri Lanka can boast of a wide network of health institutions. The primary level of health has 970 hospitals (Divisional hospitals and primary medical care units) and 350 Medical Officers of health units (community health services), that are managed by non-specialist doctors. This network has not been changed in any significant way to address the current needs. Only random isolated interventions have been carried out without a significant impact. The government expenditure on health care is currently at a low level of only 1.7% of GDP. The Government has pledged to increase allocation for healthcare. This increased allocation must support reforms to health care delivery system in a way that it effectively and efficiently provides universal access to health care that addresses current needs. Expansion of primary health care is a recommended strategy endorsed by the WHO for Universal health coverage.

	Although a large number of institutions exist in the government sector a clear demarcation of the roles of specialized hospitals and non-specialist primary care institutions does not exist, especially for outpatient services. A large number of patients access primary care at specialized institutions, but are not necessarily cared for by a specialist. Unlike the community or preventive health services there are no access demarcations for registering with institutions. Eg. For antenatal care services at community level a mother will register with the local PHM and the local MOH office depending on their location within the MOH area. For curative services persons are given the liberty of accessing care from any institution and there is no registering requirement in the system. Whilst this may be considered convenient to patients, there are several drawbacks in such a system. As there is no gate keeping function and due to standard essential services not being available at primary care curative institutions there is considerable bypassing to reach specialist institutions. There is also no accountability for patient clinical outcomes within a defined population or area as there is free mobility or no registration of patients at an institution. Institutions also have not been made responsible to cater to a defined catchment population or area. In such a situation the specialist and non-specialist primary care institutions both largely function independently of each catering to undefined populations with overlapping primary care functions. Several interventions are proposed and some being implemented to strengthen primary care (these are revising the essential drug list for primary care level, NCD management guideline for primary care, health lifestyle clinics, provision of basic lab tests for NCD care are some of these). However there is lack of continuity in overall patient management and the following needed consideration a. continuous supply of essential medicines and a mechanism for basic essential laboratory tests b. a personal record and proper record system to ensure continuity of patient management c. proper lifestyle guidance appropriate to all patients and those at risk on an appointment basis – current scope of healthy lifestyle canters to be revisited to include planned lifestyle guidance sessions d. correct attitudes and practices of primary care practitioners to provide individual personalized and family care, requiring transformations in graduate training and basic training programs of health professionals e. Availability of basic emergency care f. Adherence to the NCD guideline and the adoption of referral and back referral with shared care between specialist and

	primary care practitioner. Whilst items a to e will give the community surrounding the primary care institution the confidence to access care at their closest institution, there is considerable system reorganizing to achieve item f. **The proposed model of reform** is a cluster model referred to as the " shared care cluster" **General definition of "shared care cluster"** A cluster is considered as a unit where a specialist care institute functioning as the apex hospital providing general specialties of care will be considered as a shared cluster together with its surrounding primary care curative institutions (divisional and primary medical care units). (*shared care : a. an individual's health care will be shares and form continuum between primary care and specialized services* *b. Resources with the cluster to be shares so that there is optimum availability and utilization)* **Justification for the proposal** Recent and ongoing improvements to healthcare have moved away from improving utilization of primary health care. We have been gradually moving patients to seek care at the specialist level hospitals bypassing the smaller primary level hospitals. Developed countries that exhibit efficient and effective health systems have invested adequately in their primary health services. 2015 was the deadline for achievement of the Millennium Development Goals. In the post Millennium development agenda WHO has called for all countries to move towards universal Health coverage (UHC). WHO recommends that health systems must expand and strengthen primary health care to provide most needed health care whilst including all vulnerable communities if Universal health coverage (UHC) is to be achieved An analysis of the existing health service structure and policies was carried out by the policy Analysis & Development unit in 2009. This lead to the understanding that major changes to the existing health delivery organization was needed to address the challenge for chroviding the system was not geared to providing continuity of care or to providing the necessary changes to prevent or manage lifestyle related diseases. The policy analysis unit suggested system changes and a decision was taken to conduct pilot studies.

	The proposed developments were shares at the National policy forum for strengthening primary level health care in 2010. The pilot studies were conducted in collaboration with the primary care unit of the Ministry of health to develop protocols, tools and monitoring plans that were needed to improve the system. These developments lead to development of a personal Health Record and clinic record for adults, emergency care guidelines for primary care, easy reference education material for health staff, finalization of an essential medicines list for NCDs at primary level, lifestyle guidance tools, checklists for institutional assessment for infrastructure and logistics and a social marketing tool. The organization development unit in 2013 having noted that primary care needs to be supported with optimim specialized care with a proper referral and back referral proposes that the health institutions be clustered. The basis for clustering is that a specialist hospital serves appropriate specialized services to a group of surrounding primary level hospitals. This was given the name of "shared care cluster system".
GAP ANALYSIS by using UHC tool	
Target areas & Beneficiaries	General population
Justification	
Important assumptions / Risks/ Conditions	Assumptions- primary care strengthening requires financial allocation that can be accommodated within the increase in budgetary provision to health sector. People's choice to access health care will not be directly regulated but through improving the supply more people would demand for primary level services. The increase demand can be met Private health sector regulations for price and quality control will simultaneously take place to shift people who can afford private care to access those facilities
Vision	A primary care Doctor to all providing personalized continuity of care
Mission	To reform primary level health care which can afford the greatest coverage in terms of accessibility to the people, in a way that provides personalized, family centered, continuity of care of good quality, where good health outcomes can be achieved with reduced out of pocket expenditure to the people.

Goal	Improved health status – special reference to chronic diseases (NCDs) Responsive health care Reduced out of pocket expenditure	
Programmer Objectives (Please prepare separate indicators for each objective)	Indicators Refer the results framework for shared care cluster	Means of Verification
Output (Please prepare separate indicators for each output)	Indicators	Means of Verification
Monitoring & Evaluation	Cluster performance is to be monitored at local level through the provincial health system Overall health performance to be monitored and evaluated at national level (reference : National Health Performance Framework)	
(*) Reference to Research		

Proposal Submitted by

Dr. Sussie Perera

Director - Organization Development

Program title	**Human Resource Development**
Focal point	DDG (Planning), Director - organization Development
Back ground/ situation Analysis *(Problem Analysis)	Health sector human resources are managed through the Line Ministry and the provincial Health Administration. The strategic guidance for overall Human Resource development lies with the Line Ministry. The overall staff is approximately 1,25,000 The central ministry plays the lead role in determining numbers, recruitment, training, deployment and ensuring optimum level of personnel management to ensure that the right numbers of human resources are available in the right place at the right time, who have the right attitudes and skills and perform to achieve organization objectives and goals. The Ministry of Health developed the strategic plan for HRH 2009 – 2018. After a detailed situation analysis The strategic plan clearly identifies three key areas of policy, management and training for HRD. the need to establish a central HRD unit within the Health Ministry organization that will improve Human resource planning and management systems was identified as a requisite in the implementation of the strategic plan. Gaps in the capacity to establish a central coordinating mechanism to address key HRH policy issues are noted. Existing post graduate training in related disciplines also need to focus on these areas. Related specialties may need to be developed further to take on these important functions.
GAP ANALYSIS by using UHC tool	Human resource is a critical need when providing universal Health coverage. Health cadres (numbers, skill mix, quality and distribution) need to be planned according to projected development vision. Staff performance needs to assess in terms of expected health outcomes.
Target areas & Beneficiaries	Overall benefit will be to general community
Justification	
Important assumptions / Risks/ Conditions	Requires a competent team with specialization in Human Resource Development. Requires competencies of the Team can be developed through different strategies (expert involvement and on the job training, formal training etc) Networking with all units involved in HRH functions is required
Vision	A skilled and motivated health workforce in right numbers to help achieve equitable access and good quality care, responsive to the needs of the population

Mission	Adopt a coordinated, evidence based approach to cater to the expected development in the health sector that will ensure the optimum workforce	
Goal		
Programmer Objectives (Please prepare separate indicators for each objective)	Indicators Establish HRD unit Develop a team for HRD Capacity building of team (on the job and formal) Develop workforce requirements and cadre projections Ensure equitable distribution of staff through harmonizing recruitment, training and deployment plans and retention strategies Ensure that job descriptions are available to all staff categories Measure staff performance Conduct research relevant to HRD	Means of Verification Milestone Team identified and appointed (Milestone) % of planned training % staff for which cadre projections are made % staff categories that have job descriptions % of planned reviews taking place using objective indicators Number of research projects implemented that have contributed to HRD Current research projects
Output (Please prepare separate indicators for each output)	Indicators	Means of Verification
Monitoring & Evaluation	HRH indicators to be used	

(*) Reference to Research	Human Resources for Health strategic plan 2009 – 2018 A detailed situation analysis was conducted in preparation of the strategic plan.

Proposal Submitted by

Dr. Sussie Perera

Director - Organization Development

Program title	**Strengthening central functions of Human Resource Management**
Focal point	DDG (Planning) , Director - Organization Development
Back ground/ situation Analysis *(Problem Analysis)	The Ministry of Health is a large organization with staff of approximately 1,25,000 The central ministry plays the lead role in determining numbers, recruitment, training, deployment and ensuring optimum level of personnel management to ensure that the right numbers of human resources are available in the right place at the right time, who have the right attitudes and skills and perform to achieve organization objectives and goals. The Ministry of Health carried out a situation analysis prior to the development of the Human Resources Strategic plan for the period 2009 – 2018 . An assessment of the organization for HRD was carried out using a tool used by the Management of Health Sciences in Boston. The tool has been widely used by other countries and rates the organization ability to perform HRD functions. The instrument is used for identifying the gaps in human resources management. Conclusions from this assessment are as follows a. HRD occurs in a fragmented manner within the health system. The functions of HRD are currently scattered in this large organization and often are not well coordinated b. There seems to be poor conception of the strategic issues related to HRD and a more operational approach has been considered in distributing the functions. c. Different components of HRD are at varying levels of development. d. Given the magnitude of the organization and large number of staff categories the distribution of HRD functions on the basis of staff categories seem to be relevant. e. Given that HRD functions are scattered within the organization, there does not seem to be any single unit within the Ministry of Health that is responsible in keeping track of HRD overall. The strategic plan clearly identifies the need to establish a central HRD unit within the Health Ministry organization that will improve Human resource planning and management systems.
GAP ANALYSIS by using UHC tool	Human resource is a critical need when providing Universal Health coverage. Health cadres need to be planned according to projected development vision.

Target areas & Beneficiaries	Improves the overall stewardship functions of the Ministry of Health	
Justification		
Important assumptions / Risks/ Conditions	Requires a competent team with specialization in Human Resource Development. Networking with all units involved in HRH functions is required	
Vision	A skilled and motivated health workforce in right numbers to help achieve equitable access and good quality care, responsive to the needs of the population	
Mission	Establishment of a HRD unit with a competent team to coordinate HRH policy, strategic planning that will support health sector development.	
Goal		
Programmer Objectives (Please prepare separate indicators for each objective)	Indicators Develop workforce requirements and cadre projections Ensure equitable distribution of staff through harmonizing recruitment, training and deployment plans and retention strategies Ensure that job descriptions are available to all staff categories Conduct research relevant to HRD	Means of Verification % staff for which cadre projections are made Staff: population ratio by district % staff categories that have job descriptions Number of research projects implemented that have contributed to HRD Current research projects
Output (Please prepare separate indicators for each output)	Indicators	Means of Verification
Monitoring & Evaluation	HRH indicators to be used	
(*) Reference to Research	Human Resources for Health strategic plan 2009 – 2018 A detailed situation analysis was conducted in preparation of the strategic plan.	

Program title	**National Health Performance monitoring**
Focal point	DDG (Planning)
Back ground/ situation Analysis (Problem Analysis)	The Sri Lankan health system has often been cited as a model for efficiency in the delivery of good health outcomes despite the relatively low investment on health care. Currently the government contribution to health care is approximately 1.4% of GDP. The total allocation for Health accounted for 4% of the government budget. (2014 central bank report) Sri Lanka has achieved commendable progress in providing universal health care and the main health indicators are far ahead of the averages for countries at comparable levels of income. As the policy of the government is to provide health care free of charge at all points of delivery, the Ministry of Health must utilize the limited available resources optimally. Given limited resources it is important that the government can take timely decisions to further improve health status of Sri Lankans. Performance indicators that are currently used to describe health systems do not adequately capture the requirements of a changing health burden due to different transitions experienced in the country. Performance measurement offers policy – makers an opportunity to secure health system improvement and accountability and aims to improve the quality of decisions made at all levels in the health system. Performance measurement system should be monitored frequently to ensure alignment with other health system mechanisms and to identify areas for improvement. Seeks to monitor, evaluate and communicate the extent to which various aspects of the health system meet their key objectives. The diverse uses of health system performance measures necessitate a wide variety of measurement methods; indicators, analytical techniques and approaches to procurement methods, indicators, analytical techniques and approaches to presentation. It is also to ensure that all major areas of health system performance are covered by the measurement system, that priorities for new developments can be identified and that collection and analysis efforts are not misdirected or duplicated. Some critical situations in performance evaluation are that • Policy impact / outcomes of National programs/ Healthcare delivery practices are not routinely reviewed • Mostly we do this through external reviews conducted purposefully, but not on a regular basis or for international reporting • Limitations in performance indicators as these mainly reflect public health programs and the need to capture other health services and health determinants • The Ministry of Health needs to be accountable for government allocation in terms of health performance • Change/ continuation of strategic direction needs to be discussed objectively using indicators with time series and sub national analysis where relevant • All national program indicators are not required as policy impact monitoring indicators. (some program indicators have been traditionally used to monitor public health programs) • The direction of National policy must be captured in trend analysis of the indicators

	selected. • Explanation should be available for success/ failure through the wider range of program indicators that are available. • However any critical indicator that measures a particular strategy can be included if the National program has valid reason for it to be monitored. • Performance measurements should have relevance o Sustainable development goals and their indicators. The National health performance framework: The framework has been developed after a long process of consultation with all relevant professionals and requires a suitable mechanism for implementation. A guide to the National Health performance Framework is developed by the Organization Development Unit of the MDPU, MoH. It is an initial effort and improvements to the indicators areas of measurements should be done once in practice.	
GAP ANALYSIS by using UHC tool	Not applicable The profile for health performance monitoring will serve as a future mechanism to track determinants for UHC	
Target areas & Beneficiaries	Non specific Health systems strengthening will benefit all	
Justification		
Important assumptions / Risks/ Conditions	Performance monitoring will have sufficient independency in analysis, interpretations and providing feedback on the health system	
Vision	A Health system that is effective, efficient and provides equitable health care to achieve good health status of Sri Lankans	
Mission	To provide a mechanism that will produce performance information that will enable timely interventions for health improvement	
Goal		
Programmer Objectives	Indicators	Means of Verification

To establish a National Health performance system that will track health systems performance	Mechanism established through the establishment of a dedicated unit for National performance monitoring Information support systems established % of indicators used in the review Annual reviews take place Policy changes that took place.	
Output (Please prepare separate indicators for each output)	Indicators	Means of Verification
Monitoring & Evaluation	The guide to national Health performance framework has identified the indicators and position regarding data availability.	
(*) Reference to Research	Arah, O. (2006). A conceptual framework for the OECD Health Care Quality Indicators project. *International Journal for Quality in Health Care*, 18 (supplement 1), pp.5-13. HM Government, (2013). *Part 1A: A public health outcomes framework for England, 2013 – 2016.* Improving outcomes and supporting transparency. [online] London. available at: https: // www.gov.uk/government/publications/healthy - lives - healthy – people- Improving – outcomes – and – supporting – transparency [accessed 23 Jul. 2015] HM Government, (2013). *Part 2: Summary technical specifications of public health indicators*. Improving outcomes and supporting transparency.[online] London. available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/382115/PHOF_part_2_Technical_Specifications_Autumn_2014_refresh_02.12.2014_FINAL.pdf [Accessed 23 Jul.2015]. Nuh.nhs.uk, (n.d). *Clinical Indicators procedure. Version 2.*. [online] available At: https:// www.nuh.nhs.uk/handlers/downloads.ashx?id=17957[Accessed 23 Jul. 2015].	

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Worlf health Organization, (2011). *Monitoring maternal, newborn and child health: understanding key progress indicators*. [online] Geneva: World HealthOrganization. available at: http://www.who.int/healthmetrics/news/monitoring_maternal_newborn_child_health.pdf [Accessed 23 Jul. 2015].

Program title	**National Health Performance Matrix**
Focal point	DDG (Planning)
Back ground/ situation Analysis *(Problem Analysis)	The National Health development network comprising of sectoral level, inter-ministerial level and cabinet level meetings for operational and policy decisions was established with the country adopting the primary health care strategies and Alma Ata declaration for health for all. The mechanism intends to bring together at different levels all stakeholders to implementation. National strategies for health for all stakeholders to implementation. National strategies for health for all were formulated and adopted in 1980. The main features of the strategies were: a. Establishment of a National Health Development network to ensure intrasectoral and intersectoral coordination for health development activities. b. To place greater emphasis on decentralization of health administration c. Priority identification of primary Health Care (PHC) component and development of an implementation model The Health Development Committee meeting (HDC) is chaired by the DGHS and addresses policy implementation, strategic guidance, feedback from implementing stakeholders within the government health sector. Regular HDC meetings have been conducted The National Health Development Committee is to be chaired by the Secretary health and is attended by relevant secretaries and technical focal points in ministries according to the health development agenda identified. Provincial Health secretaries and provincial chief secretaries also attend the NHDC. From the Ministry of Health officials, DDGs and above would participate. NHDC meetings have not been regularly conducted. The ministry has however adopted a process of having several National Advisory committee meetings or National steering committee meetings sometimes chaired by the secretary Health / DGHS where other sectors are invited. This happens according to program area or subject wise. The National Health Council is chaired by the prime minister. It is to be attended by several Ministers, secretaries to these ministries, provincial Health Ministers, selected officials from the Ministry of health. The NHC gives opportunity to discuss implementation of health policy through its different stakeholders and to identify new policy directions to be taken. A National Health Council has not been held for a long time. Objective information should support these development meetings
GAP ANALYSIS by using UHC tool	Not applicable, however the network provides useful platform to discuss implementation along UHC to overcome critical bottlenecks beyond sector

	limits.	
Target areas & Beneficiaries	Non specific	
Justification		
Important assumptions / Risks/ Conditions	High level commitment is needed to drive the development process.	
Vision	A Health system that is effective, efficient and provides equitable health care to achieve good health status of Sri Lankans	
Mission	To provide a mechanism that will provide effective contribution from all relevant stakeholders for health developments	
Goal		
Programmer Objectives (Please prepare separate indicators for each objective) To establish a National Health performance system that will track health system performance	Indicators Number of HDCs conducted as planned Number of NHDCs conducted Number of NHCs conducted Policy changes that took place.	Means of Verification
Output (Please prepare separate indicators for each output)	Indicators	Means of Verification
Monitoring & Evaluation	The National Health performance Framework can serve as a guide to support monitoring and evaluation of health policy implementation. This can be supported with Indicators more specific to program areas as per the need	
(*) Reference to Research	Correspondence on decisions taken to establish the health development network is available at the DOD unit	

Program Title	**Improvements for the quality, timeliness and dissemination of hospital Information system**
Focal Point	Deputy Director(Medical Statistics)
Background	The public health sector of Sri Lanka provides healthcare services for approximately 5.6 million inward patients and 53 million OPD patients each year. There are ~~over~~ 1080 hospitals geared for this activity. The data generated in this process is a vital part of the health information in the country. This information is utilized in planning the management of healthcare services, monitoring of disease Burden, for disease prevention activities and evaluation of treatment outcomes. Medical Statistics unit (MSU) is the central unit for processing of collected data from Health institutions in Sri Lanka. In addition to that Indoor Morbidity and Mortality Data using the manual system and the E- version of the IMMR (eIMMR)whichhave been covered more than 50% of the hospital system. The accuracy and the timeliness have been gained a considerable improvement by the eIMMR system in comparing to the manual IMMR. The Annual Health Bulletin (AHB) is the main publication for data dissemination. AHB is also getting late to publish due to the time wastage for the data cleaning process. So the accuracy of the data should be enhanced to improve the timeliness of the publication. Though several actions have been already taken to improve the quality and timeliness of data, further implementation of the overall process is needed in order to provide high quality data. There are many reasons which are affected to quality of the data negatively, such as poor descriptive data collection on OPD and Clinics, incomplete diagnosis writings, and unavailability of well-trained medical recording staff for medical record rooms due to

	the transferable situation of the said staff categories, etc. Staff who is submitting data from the Hospital level to the MSU should be well trained in order to improve the quality of the data. Currently data preparation and submitting is done by different hospital staff categories such as Medical Officers, Registered Medical officers, Nurses, Midwives, Programming and Planning Officers, Development Officers, Development Assistants, Programming and Planning Assistants due to lack of Medical Recording Officers (MRO) or Medical Recording Assistants(MRA).Data collecting and submitting is done by clerical or minor staff in some hospitals in rural areas. Those officers may have been transferred to the stations unrelated to statistics and untrained staff from any other field could be appointed to the record rooms for statistical duties. Therefore trainings are needed to be done continuously to keep the quality of the data. Because of the above reasons the required benefits cannot be achieved. Manual data collection formats to be replaced with the new trends. When considering the data dissemination, health information should be easily accessible to general public. But currently Annual Health Bulletin (AHB) is published only in English language.
GAP ANALYSIS by using UHC tool	
Target areas and beneficiaries	**Target Area Beneficiaries** Hospital information system Health decision makers
Justification	Information system should be expanded to acquire the data from uncovered areas. The system should be efficient, accurate and sustainable. This need a well-trained Medical Recording Officer. The eIMMR system should be expanded to meet appropriate needs including the private sector and indigenous medicine (Currently data collection is limited to government sector only). Data collection formats should be revised. Special awareness programmes for medical officers needed to be implemented. Web based information sharing has to be implemented to easy access.

Important Assumptions/Risks/Conditions		
Vision		
Mission		
Programme Objectives **(Please prepare separate indicators for each objective)** 1. To develop a sustainable data flow for Health Information System 2. To improve a quality assured data collection system 3. To Improve the data dissemination system	**Indicators** • Percentage of coverage of E-Version of Data Collection System • Timeliness of reporting • Percentage of coverage of web based information system	**Mean of Verification** eIMMR
Output **(Please prepare separate indicators for each output)** ○ Re-established MRO post ○ Learning Management System (LMS) ○ e IMMR ○ Data collection system of uncovered areas such as private sector, indigenous medicine sector ○ Revised data collection format ○ web based MSU ○ Sinhala and Tamil versions of publications	**Indictors** • MRO to Inpatient ratio in hospital level • No of training Programme Conducted • Percentage of coverage of E-Version of Data Collection System	**Mean of Verification**
Strategies / Major Activities ○ Re-establishing MRO post with appropriate recruitment and promotion		

procedures ○ Establish a Learning Management System (LMS) for the needs of medical recording staff and other users ○ Introduce an e version for data collection in OPD and clinics ○ Develop eDental data collection system ○ Develop an institution frame to collect data from uncovered areas such as private sector, indigenous medicine sector ○ Developing new data collection processes for ○ Training of Health staff on e IMMR ○ Link with other information systems ○ Revision of Annual Health Bulletin to meet new trends and approaches ○ Establish a Web site page for MSU ○ Starting a quarterly publication for general public, especially school children with a distribution plan for school and other libraries. This should be in both Sinhala and Tamil language		
Monitoring & Evaluation		
(*)Reference to Research		

Programme Title	Directorate of Training & Education
Focal Point	Director, - Training
Background / Situational analysis	The Directorate of Training of the Education, Training and Research Unit of the Ministry of Health is responsible for capacity building of the health work force through pre-service and in-service training programmes. The Directorate of Training coordinates with Ceylon Medical College Council, University Grants Commission and other relevant academic and professional institutions and organizations in Sri Lanka in strengthening human resource capacity of the health sector. **1. Pre-service training** The Directorate is responsible for providing technical guidance and the coordination of pre-service training programmes for the health workforce except Medical Officers, Dental and Nursing Officers. The pre-service training for the above workforce is unique in its governance mechanism as they are trained entirely by the training schools under the purview of the central unit, the Directorate of Training. There are 17 training schools and seven regional training centers. The schools are mainly located at National Hospital of Sri Lanka, National Institute of Health Sciences, Medical Research Institute and few other teaching hospitals. These schools of training are technically supervised by the Directorate yet function under the administrative supervision of the respective health institutions. The intake for pre-service training is determined by the Administrative Sections of the Ministry of Health in consultation with ET&R Unit and the MDPU. The 'National Standards' for upgrading the training schools and the regional training centres have been identified which consists of components such as strengthening governance, trainer capacity development, revision of pre-service training curricula, strategies for trainee retention, infrastructure development, monitoring and evaluation. An oorientation programme of six months is also conducted for the four categories of graduates (PSM) passing out from the Universities in Sri Lanka before employing in the Ministry of Health. **2. In-service training** The Directorate provides the necessary technical and financial assistance for the in-service training programmers for the health workforce which are conducted based on the needs analysis submitted by the healthcare institutions. An ISTP (In-Service Training Programme) management system is in place for reviewing of the training proposal, approval for funding, and monitoring and evaluation of training programmes. A National Framework for continuous professional development (CPD) is being advocated among relevant stakeholders and policy makers.

	The Directorate also coordinates overseas training collaborations for different categories of health workforce to bring novel methods of teaching , learning and service delivery in to local practice.
Gap analysis	**1. Pre-service training** ▪ Gaps in governance o Lack of Terms of Reference (TOR) and Scheme Of Recruitment (SOR)for heads of the training institutions and trainers o Lack of a comprehensive information management system o Lack of updated, explicitly defined Standard Operating Procedure (SOP) and profiles for the training programmes o Unavailability of an efficient mechanism to recruit trainees regularly, based on service needs ▪ Gaps in curricula o Mismatch between the healthcare needs and the exit outcomes of the training programmes due to non-aligned training curricula ▪ Gaps in trainer capacity o Lack of orientation in adult training methods o Lack of capacity to use novel methods of teaching ▪ Gaps in infrastructure facilities of the training institutions o Construction and renovations needed in the physical learning environment to meet the 'National Standards'. o Learning and educational material (books, journals, e-learning material, m-learning etc.) needed to meet the 'National Standards'. ▪ Gaps in attraction and retention of trainees o Unavailability of information on training programme profiles o Inadequate accommodation facilities o Inadequate counseling, medical and recreational facilities ▪ Gaps in monitoring and evaluation o Lack of a system for periodical data collection, review meetings and feedback mechanisms **2. In-service training** ▪ National Framework for continuous professional development (CPD) not in place
Target areas &Beneficiaries	• Target area: Pre-service training, In-service training, Overseas training collaborations

	• Beneficiaries: Trainees of the basic schools, Trainers, Health workforce
Justification	Conducting pre-service training for health workforce (PSM, paramedical and several non-technical categories) is the main responsibility and the mandate of the Directorate of Training. The recruitments are carried out by the Ministry of Health based on the carder, vacancies, attrition and retirement for which the directorate is responsible for providing training. Annually over 3000 health personal are trained prior to recruitment; however is falls short of meeting the annual national requirement. Furthermore, the increasing Non-communicable diseases (NCDs), demographic transition with aging population and adverse environmental changes were witnessed over the recent past, creating significant negative health impact in our country. The Sri Lanka country profile published by the Global Burden of Diseases[1] strongly suggests that the NCD burden have emerged as leading causes of years of life lost (YLL) due to premature mortality. In addition, the public is demanding for more non-healthcare needs when seeking care such as autonomy, dignity, confidentiality, prompt attention, choice of healthcare provider, basic amenities and provision of social health needs[2]. Transformation and scaling up of education and training is a multi-dimensional process that involves not only increasing the number of health professionals, but also ensuring that they have the knowledge, skills and competencies relevant to the needs of the population[3,4]. The training programmes need to cater to the above circumstances and needs while incorporating the new technologies such as ICT, computer based simulations, m-Health and web-based learning. Therefore, evidence based strategies are needed to transform and scale up health professionals' education to attain the right 'mix of skills and competencies' of health workers who can respond to the changing needs of the population.
Important assumptions / Risks / conditions	• Governance mechanism will remain unchanged • Periodical and systematic recruitment of students to the pre-service training will occur • The attraction to the pre-service training programme will remain unchanged • The perceived interest of the health workforce on the benefits of in-service training programmes will rise • A professional development framework for each category is in place
Vision	Being the central agency for training of quality and qualified health personnel contributing to economic, social, mental and spiritual development of Sri Lanka

<table>
<tr><td>Mission</td><td colspan="2">To be the focal point of facilitation, central agency of monitoring and evaluation and principal provider of technical expertise in education and training in the Sri Lankan health sector for the development of competent, patient-centered, innovative and globally accepted health personnel.</td></tr>
<tr><td>Goal</td><td colspan="2">To produce the best healthcare workers in Asia</td></tr>
<tr><td rowspan="2">Programme objectives</td><td colspan="2">Objectives:
1. To strengthen the governance mechanism of the training institutions and training programmes.
2. To conduct capacity development programme on pedagogy for the trainers in collaboration with medical educationists
3. To revise and update the curricula to meet the healthcare needs
4. The ensure trainees the successful complete the training within the course duration
5. To ensure upgrading the infrastructure of the training institutions to meet the ‘National Standards’
6. To develop a web-based human resource management system for training programmes
7. To develop and implement a national framework for CPD
8. To facilitate in-service training programmes for the health workers</td></tr>
<tr><td>Indicators

1. The percentage of schools meeting the minimum standards of the National Standards for the training schools
2. Percentage of trainers undergoing the capacity development programme on pedagogy
3. Percentage of updated curricula among the selected
4. Percentage of trainees successfully completing the training within the course period
5. Percentage of programmes sending the monthly return
6. The availability of a national CPD framework
7. The number of health institutions conducting in-service training programmes</td><td>Means of verification

1. Annual survey (1)
2. Database of the Directorate (2,3, 6)
3. Web based information system (4, 5,7)</td></tr>
</table>

Output	Indicators	Means of verification
	1. Percentage of training institutions with approved TOR 2. Percentage of institutional heads and trainers with approved SOR 3. Percentage of training programmes with updated, explicitly defined SOPs and training Profiles 4. Percentage of trainers undergoing capacity development programme on pedagogy 5. Percentage of updated curricula among the selected 6. Percentage of trainees successfully completing the training within the course period 7. The percentage of schools meeting the minimum standards of the infrastructure facilities as per the 'National Standards' for the training schools 8. Availability of a comprehensive information management system 9. Availability of a national CPD framework 10. The number of in-service training programmes facilitated	• Annual survey (1) • Database of the directorate (2,3,6, 8, 9, 10) • Web based information system (4, 5,7)
Strategies / Major activities	1. Transforming and scaling up of pre-service education and training of health workforce to meet the healthcare needs 2. Implement a national CPD Framework for standardizing the in-service training of health workforce	
Monitoring & Evaluation	Monitoring and evaluation will be carried out in a systematic manner under the monitoring and evaluation framework. The data is collected in depicted periods to arrive at monitoring decisions and implement corrective actions in a timely manner. The data will be collected by following means. 1. Database of the Directorate 2. Annual surveys 3. Web-based information system to collect monthly data from the programme	

Reference to research	1. Institute for Health Metrics and Evaluation. Sri Lanka. *Global Burden of Disease* (2016). at <http://www.healthdata.org/sri-lanka> 2. Darby, C., Valentine, N., Murray, C. J. & De Silva, A. *World Health Organization (WHO): strategy on measuring responsiveness*. (World Health Organization, 2000). at <http://www.who.int/entity/healthinfo/paper23.pdf> 3. Wheeler, E., Fisher, J. & Li, S. W.-S. Transforming and Scaling Up Health Professional Education. *Res Medica* 22**,** 143 (2014). 4.. World Health Organization. *Transforming and scaling up health professionals' education and training: World Health Organization guidelines 2013.* (2013). at <http://www.ncbi.nlm.nih.gov/books/NBK298953/>

Program title	Strengthening Health care system and Capacity Development with the assistance of foreign funded agencies
Focal point	Director / International Health
Back ground / **Situation** Analysis *(**Problem Analysis**)	Under the supervision of DDG / Planning , the International Health unit coordinates three main functions , viz (a) All matters pertaining to preparation and submission of biennial proposals and monitoring of implementation of all activities under funds of WHO , UNICEF and UNFPA ; and provide feedback to relevant officials and agencies on the progress of foreign funded activities (b) Processing of all fellowships (for training programmes , Consultative meetings , International seminars , Workshops and Conferences) offered to the Ministry of Health . This includes the selection process of nominees at the fellowship committee and obtaining approval of Hon Minister , arrangement of payments for foreign travel and evaluating the activities planned after the fellowship (c) **International Health Governance** – The related activities are as follows Coordinating activities pertaining to WHA – World Health Assembly and SEAR regional meetings , SAARC technical committee meetings , SAARC & Commonwealth Health Ministers meetings Coordinating and processing requests for concurrence for long term and short term foreign consultants under regular budget and inter country programme Coordinating with Ministry of Foreign Affairs and Sri Lankan missions abroad Coordinating with International agencies involved in Health , such as Bay of Bengal movement for economic and technical corporation , Indian ocean rim association , International Red cross and red crescent Preparation and evaluating MoU
GAP ANALYSIS by using UHC tool	
Target areas & Beneficiaries	
Justification	International health unit functions as the agency for all international relations of the Ministry of Health
Important assumptions / Risks / Conditions	

Vision		
Mission	To serve as the focal point for planning , implementation and monitoring of international health activities	
Goal		
Programe Objectives 1. To improve international relations in health care through international health governance 2. To manage foreign funded programmes cost effectively 3. To utilize fellowships received optimally to train the most suitable officials	**Indicators**	**Means of Verification**
Output (Please prepare separate indicators for each output)	Indicators	Means of Verification
Strategies / Major Activities		
Monitoring & Evaluation		
(*) Reference to Research		

Name of official who documented the profile

Dr AllenLudowyck - Director / International Health

Programme Title	**Health System Research**
Focal Point	Deputy Director General - Education, Training & Research **Director / Research**
Background / Situational analysis	Health research is an imperative part in the ever changing, continuously modernizing and rapidlyevolving health system, as they provide updated and evidence-based knowledge for all health care decision makers, either in clinical or non-clinical fields. The Deputy Director General – Education, Training and Research Unit (DDG-ET&R) of Ministry of Health will be the main focal point for promoting, coordinating, facilitating and regulating health research.

Gap analysis	▪ Research priorities for specific health related fields are not readily identified and/or visible
	▪ Findings of already conducted research are not widely accessible for relevant decision makers and stakeholders
	▪ Translation of research outcomes into action has been lacking
	▪ Less accessibility to and/or lack of means of facilitation for potential researchers in the Ministry of Health with regard to:
	  ▪ funding for evidence based research
	  ▪ training on research methods
	  ▪ approval for research allowance
	▪ Inadequate awareness and knowledge on research methods and ethics in research among health care staff interested in conducting research

Target areas &Beneficiaries	▪ Health related research – potential researchers and eligible officers for research allowance specifically and, decision makers including policy makers, stakeholders, funding agencies, scientific community and the public, in general ▪ Ethics in research - potential researchers, research participants, general public
Justification	Institutionalizing a research culture among health care providers at all levels as well as translating research findings in to policy and practice has been a long felt need. The Directorate, having identified the gaps, will work towards achieving the desired objectives to ensure that evidence would be available for decision-making and management for provision of quality health care.
Important assumptions / Risks / conditions	Facilitation of ethical and quality research requires the services of experts in relevant fields within and outside the Ministry of Health for review of proposals, development of guidelines etc. These experts, already overburdened with multiple functions, may require extended time for the tasks assigned by ET&R Unit, which

	may lead to unintentional delays Approval and release of funds may get delayed due to the standard financial procedures to be followed
Vision	Ethically conducted quality research for a healthier nation
Mission	To promote, facilitate, coordinate and regulate health related research for development of knowledgeable, skilful, effective, and innovative health personnel and generation of evidence for better health care.
Goal	Promote evidence based practices through conduction of ethically sound, relevant and quality health related research in Sri Lanka. confirming to National and International guidelines, while safeguarding the interests of research participants
Programme objectives	▪ To promote and facilitate health related research through: ▪ provision of guidance to potential researchers, ▪ review and approval of proposals for new research submitted for eligibility for research allowance, ▪ review and approval of progress reports and publications submitted for continuation of research allowance ▪ To disseminate findings of health related research through worldwide web and publications of completed research annually ▪ To build capacity among prospective researchers in the Ministry of Health on research and statistical methods ▪ To build capacity among prospective members of Ethical Review Committees in the Ministry of Health on ethics in health related research ▪ To develop Standard Operational Procedures (SOPs), ToRs and guidelines for Ethics Review Committees in health care institutions ▪ To identify priorities in health related research ▪ To regulate health related research through the collaboration with National Health Research Council (NHRC)

Prepared by

Dr Risintha Premarathna

Director - Research

Education , Training & Research unit

Ministry of Health

Programme title	**Improve health service delivery through better health information management**
Focal Point	Director / Health Information
Background / Situation analysis* (problem analysis)	Information Management applied to health care settings has the potential to improve the quality of patient care. Acquiring, analyzing and protecting digital and traditional medical information are major components of health information management. Many forms used to collect data are outdated and does not cover the present scope of work. Also the traditional flow of information has caused delays in using information for decision making. Therefore it is important to study and simplify processes. Implementation of electronic health information systems can improve health care efficiency and safety(1) while increasing health and other social benefits in addition to long term cost benefits. Unique Health Identifier(2) is a prerequisite for any electronic health record. With the use of electronic health records incorporated with clinical decision support has the ability to improve patient safety through assisting drug dose calculation, allergy highlights, drug interaction highlights, etc.(3) An electronic health record that contains past diagnosis, laboratory investigations, radiology images, etc. has the potential to reduce the repeat of investigations due to lost investigations. It also allow public health surveillance activities(4) and administrative decision making through results of data mining in the large electronic databases created in health records. Networking of government healthcare institutions is important to harness the full potential of electronic health records. New health technologies needs proper assessment before introduction in to the health system. A technology assessment(5) and innovation laboratory will help filter-in most suitable technologies that would maximize the benefits.
GAP ANALYSIS by using UHC Tool	
Target areas and beneficiaries	(1) Patients seeking care at healthcare Institutions (2) Doctors through clinical decision support (3) Public health specialists with improved disease surveillance data (4) all public in the country using the preventive health services, (4) Health Administrators with data to make evidence based decisions
Justification	Improvements in Health Information Management leads to improved patient care, strengthen public health initiatives and health administration while preserving patient's privacy. Also continuity of care could be assured

Important assumptions / Risks /Conditions	(1) Better computer networking through Lanka Government Network V2 implemented by the Information and Communication Technology Agency. (2) Ability of the health workforce to adapt to technology rich work environment. (3) Adequate resources to implement and sustain information systems in healthcare institutions.	
Vision	To improve the Health Information Management to achieve improved patient care, strengthen public health initiatives and health administration	
Mission	To design or redesign health information systems to improve efficiency and effectiveness of service delivery through introduction if a personal health number, process simplification and implementation of e health initiatives.	
Goal	To implement e health initiatives throughout the country by 2030.	
Programme Objective	Indicators	Means of verification
Issue a Personal Health Number to all healthcare seekers in Sri Lanka.	Availability of a PHN to all citizens of Sri Lanka	census
To streamline human resource management through a HR management system	Implementation of a HR management system	Observation
To implement e health initiatives in the health sector Indicator	% of institutions implementing e health solutions	Observations
Use of data mining and other data tools on electronic health information		

systems to improve disease surveillance and public health data flows. Generate analysis for health administration through health information systems Setup a health simulation and innovation laboratory Put in place thorough legislation, policies and guidelines to preserve patient privacy in electronic health information	Availability of a simulation laboratory	
Out put	**Indicator**	**Means of verification**
All healthcare institutions is sung PHN	(1) Number of Hospitals issuing PHN (2) Number of hospitals issuing PHN at birth	Annual census of health information systems used in government health care institutions
All health personal included in the	% coverage of persons in the HR management system.	5 yearly senses of healthcare staff

HR management system.	No of administrative procedures carried out through the HR management system	Observations
E health solutions introduced to OPD and supportive services(laboratory, radiology, pharmacy) of all hospitals.	% of institutions implementing E health solutions	Survey
Electronic data management of epidemiological and maternal and child health data islandwide	% of MOH offices conducting electronic transfer of data for epidemiology % of MOH offices conducting electronic transfer of data for MCH services.	Survey Survey
Availability of a fully equipped health simulation and innovation laboratory	Availability of a fully equipped health simulation and innovation laboratory.	Observation
Conduction of quarterly steering committee meetings	No of steering committee meetings held	
Availability of a software registry	No of software registered in the software registry	
References	1. Hillestad R, Bigelow J, Bower A, Girosi F, Meili R, Scoville R, et al. Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs. Health Aff (Millwood). 2005 Sep 1;24(5):1103–17. 2. Unique Health Identifier for Individuals: A White Paper [Internet]. US Department of Health and Human Services; 1998 [cited 2015 Jun 15].	

	Available from: http://aspe.hhs.gov/ADMNSIMP/nprm/noiwp1.htm 3. Shulman LN, Miller RS, Ambinder EP, Yu PP, Cox JV. Principles of Safe Practice Using an Oncology EHR System for Chemotherapy Ordering, Preparation, and Administration, Part 2 of 2. J OncolPract. 2008 Sep;4(5):254–7. 4. Klompas M, McVetta J, Lazarus R, Eggleston E, Haney G, Kruskal BA, et al. Integrating Clinical Practice and Public Health Surveillance Using Electronic Medical Record Systems. Am J Prev Med. 2012 Jun 1;42(6):S154–62. 5. Sorenson C, Drummond M, Kanavos P. Ensuring value for money in health care: the role of health technology assessment in the European Union. {S.l.]: European Observatory on Health Systems and Policies; 2008. 156 p.

Name of officials who documented this profile

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6	Dr.Janaka Wickramarathne	Medical Officer (Health Informatics) Disaster Management Unit
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10	Dr.Arjuna Wijekoon	Medical Officer (Health Informatics) PDHS Office North-Western Province
11	Dr.Saminida Dharmaratne	Medical Officer (Health Informatics) Teaching Hospital Kandy

Gap analysis by using Universal Health Coverage tool

Activity Area	Equity of distribution	Accessibility to all	Quality of service	Financial protection for the patient
Health records	No continuous health record maintained outside the clinic setup	Health records are not accessible across healthcare institutions and across different clinics in the same healthcare institutions	Health records are poorly maintained and difficult to retrieve	The clinic books needs to be purchased by the patients them selves
Patient safety	The service is different at different levels of care	Drug formularies are not easily available, not updated and no training performed to improve patient safety regularly	Patient safety is presumed better at larger hospitals where consultants and PG trainees provide inputs	Adverse drug events cause increased morbidity and mortality
Innovation in the field of health information	More in larger tertiary care centres	Resources were centrally located	The number of innovations in improving the quality of services through information management not sufficient	Not sufficient work
Improved public health service information systems	Mainly in areas where there us connectivity	Information dissemination weak	Delays in information collection and dissemination , resulting in delays in actions taken	As the networking of institutions is not functioning well, people gave to spend money in obtaining laboratory services
Health promotion	Web sites and e learning platforms are not widely available	Not using SMS , social media to younger generations	The web site and e learning platforms not there	Lack of promotion through information abatement system reduce

				the financial protection
Patient protection in eHealth era	Only in areas with good reception	Not there	Still developing. So, not there.	Leaked health information abused by insurance industry , etc.

REFORMS

	Reforms **Improving the Utilization of HLC (Healthy Life Style Clinics)** **By Management Strategy termed as FORWARD EXTENSION**
Focal point	Director General of Health Services
Back ground / **Situation** Analysis *(**Problem Analysis**)	**A study on utilization pattern of Healthy Life-style Centres (HLC)** **Introduction** Majority of diseases , when acquired by patients , are felt immediately by the patient , because of their nature of symptoms But major NCD are not of that nature ; those diseases (Hypertension , Diabetes Mellitus , Heart Diseases) are asymptomatic at early stages, therefore patients themselves do not feel that they are suffering from NCD ; and therefore , they do not seek Medical advice or screening for NCD . Finally such patients are rushed to Emergency rooms , Preliminary care units and Intensive care units with states of Coma , Stroke or Arrest ; (with minimum chances of saving the life) This scenario is much common among economically active group (age 35 – 65 yrs.) In addition the Aging of population has contributed immensely to increase the NCD Burden of the country. Considering these two problems (increased No of deaths due to major NCD in economically active age group & the Burden of NCD associated with aging of population) the Ministry of Health has developed a model named as Healthy Lifestyle centers (HLC) in all Hospitals to screen the population at risk. **Present Situation** The government allocated over Rs Mn 600 to create HLC island - wide ; and it is linked to a disbursement linked indicator (DLI) of having at least two HLC per MOH division .Definition of a fully functioning HLC is given in Annexure One ..The guidelines for the establishment of healthy life style centres in health care institutions ; had been described in DGHS letter No NCD/41/2011 ; dated 31.07.2013 (Annexure Two) Further instructions and additional guidelines had been issued by general circular No 02 – 25 /2013 (Annexure Three) Accordingly the performances of HLC are tabulated by the District MO/NCD and submitted to the NCD Directorate of the Ministry of Health as a quarterly summary of NCD screening activities in the District . (Annexure four) In the directorate the statistics are maintained in the form of cumulative figures (Annexure five) However , due to various reasons (Eg:

Symptoms not felt by at risk individuals , daily employment permit no time to attend HLC during daytime , Not knowledgeble about NCD , Behavior Change Communication not reached the target population , etc.) the attendance of individuals for screening at HLC is said to be low and the intervention instituted is becoming less cost - effective.

Therefore the Director General of Health Services instructed (at the Health Development Committee meeting held on 27 November 2014) the Policy Analysis & Development unit of Ministry of Health to conduct a study to evaluate the utilization pattern of HLC and identify predisposing causes as well as mechanism/s to improve the situation .

Objectives

(a) To identify the utilization pattern of healthy life style centres in medical institutions

(b) To identify the causes influencing the utilization pattern

(c) To identify mechanism/s to improve utilization of healthy life style centres

Methodology

As this is a health system analysis it was decided to include several methods to ascertain the different aspects of the problems listed above .

(1) According to the guidelines listed in Annexure two ; the expected target of clients to the HLC , should be 240 per quarter . (estimated number to be screened for 3 months = 240) Therefore it is expected that the estimated attendance per month to a HLC should be 80 (80/month) Thus it was decided to consider this norm as the denominator , and the average monthly attendance of clients of any given HLC as the numerator ; and the percentage calculated is termed as the utilization percentage of HLC

$$\frac{\text{Average Monthly Attendance of HLC}}{\text{Estimated monthly attendance (80)}} \times 100 = \text{Utilization \%}$$

Therefore all PDHS , RDHS , and the District M.OO. / NCD were requested (DGHS letter No PA & D / 30 /2014 on 08 December 2014) to send data on attendance at HLC ; pertaining to first nine months of year 2014 (Annexure six) The sets of data received from districts are analyzed according to aforementioned indicator and presented in Annexure Seven

(2) As programme implementers the PDHS,RDHS and District M.OO /NCD have a wide practical experience on this issue , it was planned to collect their expressions in terms of the following

(a) Best practices created by district staff to sustain / improve the attendance of clients to HLC (considered as Strengths & Opportunities to achieve targets)

(b) District specific problems leading to lowering of attendance (considered as weaknesses & Threats to achieve targets)

(c) Innovative proposals from district staff to improve screening and follow up

(3) Opinion survey from National level Technical Experts
(4) Interviews with clients who attended HLC
(5) Facility survey using check list (according to annexure one)

Results and interpretation

Out of 26 Districts of the country **23** districts had send the requested data ; Data on attendance of clients of 663 HLCs during January – September 2014 were analyzed accordingly . The total number of HLC established in the country at present is 742 . Therefore this survey has covered 89.35 % of HLC of the country . Calculation of Utilization percentage of each HLC is given in annexure seven . A summary of utilization of HLC according to RDHS divisions is given in table one .

Table 1 - **Utilization of Healthy life style Centres according to RDHS division**

RDHS	N	Mean	Std. Deviation
Matara	24	15.5	14.8
Trincomallee	23	16.3	12.8
Putttalam	47	20.7	28.9
Polonnaruwa	26	20.8	18.7
Kalmunei	26	22	11.5
Kilinochchi	7	24.3	18.9
Ampara	23	26.5	31.8
Anuradhapura	42	28.9	29.1
Ratnapura	50	34	27.1
Galle	25	35.1	23.7
Batticoloa	14	35.2	25.1
Kagalle	39	36.1	34.9
Kurunegala	100	38.3	31.8
Hambantota	11	38.6	39.5
Kandy	28	39.8	33.4
Jaffna	41	41.7	45.3
Colombo	31	42.5	42
Vavuniya	12	42.7	40.5
Mannar	9	49.5	59.4
Kalutara	16	57.1	24.1
Monaragala	26	62	58.3
Gampaha	39	65.7	44.9
Mulativu	4	179.2	175.7
Total	663		

It appears that the utilization percentage ranges from 30 % to 50 % in most of the (12) districts and it is below 30 % in 6 districts ; indicating that the present system is not cost effective and also unable to complete screening of target population in near future .(

recordings of high figures in Colombo ,Kalutara and Gampaha might have been the result of high population density and socio-economic factors ; it was informed that the , High figures in Monaragala and Mullathivu districts were due to screening by mobile clines)

The analysis of Best practices instituted by districts to sustain / improve attendance to HLC are described in table two

Table 2

Summary of Comments given by RDHS and MO / NCD on **best practices** (Strengths & Opportunities to achieve targets)

RDHS Division	Comments by RDHS / MO – NCD
Kandy	• Availability of a separate MO for HLC • Availability of uninterrupted transport • Lesser the travelling distance from home to HLC , higher the Number attending
Kilinochchi	• Mobile clinics • Help from Gramaniladhari • Mothers groups to deliver messages
Anuradhapura	• Dedication of Medical officers and staff • Encourage OPD patients to attend HLC • Encourage Hospital Development Committee to refer public to the HLC • Training volunteer groups in each MOH division to refer clients to HLC
Puttalam	• Hospital public address system is used at visiting hours to inform the public about facilities available at HLC
Hambantota	• Good coordination between MOH and DMO/MOi/c • Give targets for PHMM
Kurunrgala	• Well trained staff • Providing a good service including health guidance and therefore the clients give the message to the others • Good support from other sectors

Polonnaruwa	• Workshops for community leaders on NCD and make use of them to mobilize clients to attend HLC
Mullathivu	• Take the help uf the client who benefited from HLC to mobilize the others • Formation of clubs of clients groups according to risk category
Kegalle	• Screening of clients are mostly covered by mobile clinics
Kalutara	• Regular monthly review meetings at RDHS level • Contact tracing (Family screening) tracking • Leadership , team work and coordination between hospital and MOH staff
Ampara	• Conducting mobile clinics

It is to be commended to those who have created aforementioned sub systems to improve functions of HLC , However the weaknesses & Threats prevail the Strengths & Opportunities , as described in table three and four

Table 3

District Specific Weaknesses and Threats which results in failures to achieve targets - as highlighted by RDHS and MO / NCD

District	District specific reason/s for low attendance
Kilinochchi	• Without mobile screening clinics difficult to achieve targets • Transport problems • Poor economical background • Deficiencies in laboratory services
Puttalam	• Preventive sector staff is overloaded with MCH & RE programmes and unable to support HLC ?
Batticaloa	• Inadequate M.OO and staff in peripheral stations • Lack of community

		awareness (Tamil language)
	Hambantota	• Low population density • Poor male participation as majority are farmers - paddy/chena
	Tricomalee	• Some HLCs are situated in isolated geographic places with limited population and also with limited access eg : Sampalthevu , China bay • Lack of community awareness (amil language)
	Anuradhapura	• Social stigma of early screening for NCD
	Jaffna	• In certain areas one doctor has to cover two hospitals • Increasing patient load with single doctor • Shortage of MLT (checking RBS as most of the clients will not come again , if they given another date for FBS) • Areas with low population density (eg DH / Anailaithivu , PMCU / Eluvaithivu) always indicate low performance data
	Mullathivu	• Message has to reach every GN division with the help of field officers (lack of field officers) • Lack of community awareness (Tamil language)
	Mannar	• Some HLCs are situated in isolated geographic places with limited population eg ; Talaimannar
	Ampara	• Poor attendance to HLC during the period of paddy cultivation

Vavniya	• One man stations with large number of acute patients • Language barrier between doctor and patient • Not attending for follow up • Poor participation of males as they have to give priority for their daily earnings

Table 4

Identified General Weaknesses and Threats to system which prevent the achievement of targets

No	Reasons
01	Non availability of a MO and staff for the HLC (compare with the HLC with a designated staff , as in DGH/BH with MO/Public Health),
02	Conducted only one day per week
03	Attitude and capacity of the MO who conducts the clinic / Doctor patient relationship
04	Level of motivation of staff (hospital & MOH staff) towards NCD /HLC programe
05	Attitudes (eg : clients more likely to attend to institutions which are having more health facilities) and Scio- economic back ground of the clients
06	Low awareness among the population regarding HLC (Electronic & print Media , Schools , Religious leaders)
07	No publicity (sign boards/ banners describing ill effects of NCD and services offered at HLC) at least in front of the institution with HLC
08	Non availability of facilities to test cholesterol / Lipid profile
09	Non availability of other consumable items eg Glucometer strips , Personal Health Records , health education material and stationary
10	Difficulties encountered by field staff MOH/PHI/PHM in collaborating with hospital HLC staff as field staff have attend many other field preventive programs with target achievements
11	Population density and geographic conditions / terrain / transport difficulties
12	80/20 phenomenon - When a local target population is covered more than 80 % it is extremely challenging to screen the remaining percentage Initially HLCs screened higher numbers , but now the number screened is

	becoming low
13	If referrals from field staff , are not increased , a further reduction of attendance of clients to HLCs will be noticed in future .
14	HLC with catchment area of low population density , invariably indicate low utilization percentages .
15	NCD management guidelines training at district level to be conducted by a consultant physician trained on the subject

With the practical experience of the district staff , several new strategies have been proposed by the said district staff and those are listed in table five

Table 5

New proposals

District	Proposal
Kurunegala	• It is important to analyze the number of eligible clients in relation to the (a) Type of health institution (b) Population of the catchment area (c) Cumulative number screened to date • Introduction of legislation to make HLC screening compulsory for salary increments • Provision of facilities to improve secondary preventive care of NCD and educate the family members and visitors of patients , by health talks and exhibiting posters etc, about HLC at secondary and tertiary care institutions by Public health units of those institutions (including OPD , Clinics,Wards, and waiting areas etc)
Kalmunai	• The definition of new eligible candidate is as follows : " A person aged between 40yrs-65yrs and who is not previously diagnosed as having any NCD " According to this definition and as there will be an already diagnosed population living in the

		catchment area, 100% screening of the catchment area is not a reality (In certain areas the already diagnosed population – the disease burden , would be high as 30 % • Indicators to evaluate the performance of HLC should be linked to target population • Identify new strategies to recruit clients for HLC • Introducing an awards system for the best performing HLC s .(when assessing HLCs , the percentage of target population should be considered rather than the No. of clients screened) • Re arrange the different formats using in HLC according to the need and error-free simplified methods .
	Matara	• NCD /HLC activities should be included in the duty lists of field staff • Strengthen and implement programes jointly by MO/NCD & HEO with monitoring impact • A separate MO should be appointed to each MOH division with a PHI for NCD activities .(coordinating with District MO / NCD & HEO to conduct workplace screening and school NCD activities) • A separate MO should be appointed to each HLC with a nursing officer for NCD activities (Awareness programs and Screening) • All above activities should be aimed at improving

		male participation for NCD screening and follow up .
	Polonnaruwa	• Awareness and training programmes for community leaders (village level community organizations) • Repeated remainders by MOH at Divisional coordinating committee meeting at Divisional Secretariat with local political leaders
	Kegalle	• As the age limit for females in Well-women clinics is 35 yrs ; it is suggested to lower the age limit of HLC from 40 yrs to 35 yrs . • At mobile clinics RBS is tested instead of FBS ; thus it is suggested to consider RBS > 200mg/dl as the guide line .
	Ampara	• Screen the target population based on GN divisions (need to conduct mobile clinics)
	Rathnapura	• Introduction of cholesterol checking strips to the HLC without the services of MLT • Make available glucometers and strips through RMSD /MSD without instructing the districts to parches those items locally/ at district level • Appoint an additional M.O and a nursing officer (Community health nurse ?) with supporting staff to each MOH office ; with additional vehicle & a driver ; and designate the said team for NCD screening and followup activities • According to the voters

	register of GN division the target population should be screened and documented ; repeat the process at least at two year intervals . • Conduct follow up clinics in MOH office once a week by the same staff • Saturday clinic for government/private workers • House to house survey in each GN division to assess the NCD burden
Galle	• Conducing a NCD screening programe at a community centre , on a fixed date of a month in each PHM area • Annual schedule to screen work place employees of each MOH division

The aforementioned new proposals sent by programe implementers in the districts should be considered at programe reforms .

Opinion survey from National level Technical Experts

Several National level experts expressed their concerns as summarized in table six

Table 6

Consultant	Opinion / Key proposals
DrL.C.Somathunga DDG (MS) I	1. According to the World Bank report, Screening target is 8% of the target population, but by 2014, SL has achieved about 17%. 2. Stepwise approach is necessary for the next 5yrs because a. People attend for HLCs are apparently health b. Time is necessary to take the messages to community 3. Next step should be to increase the number of days of HLCs to be opened. But this can be achieved if human resource can be provided only. 4. Healthy people must be encourage to attend HLCs yearly to ascertain that they are healthy. 5. **Appointments should be given to work places to screen their workers to catch**

		up males.
	Dr Sarath Amunugama DDG (PHS) I	**1. Need system reforms** **a. Appoint a DDG NCD prevention** **b. Establish a NCD Prevention Bureau** **c. Need to strengthen the monitoring & Evaluation mechanism** 2. Community empowerment should be a main strategy of NCD prevention. HLC is only a part of NCD prevention. Without a community approach, establishment of HLCs , resource allocation will not give the expected results 3. Health promotion village concept may be used to prevent NCDs 4. PHM can be used to empower the community. PHM should not overburden. Population allocation can be reduced 5. Underutilized clinics operated in hospitals may be combined if possible– HLC, Youth Clinic, WWC **6. Outreach screening programmes may be successful than HLC clinics. Therefore possibility should be reviewed** 7. Good healthy behavior culture should be popular among community
	Dr Sunil de Alwis DDG (ET & R)	1. No feasibility study was conducted prior to establishment of HLC (Feasibility should have been obtained from people But no pilot study conducted) 2. Numerous rooms in the OPD (HLC , TB sputum collection room ,Youth Friendly Health service unit , etc) 3. Cost analysis on capital investment should be conducted 4. Rhythm of life of people should be analyzed . Accessibility and timing inconvenient for the clients . 5. **Extend to household level (Village level) Examples of similar programs which go to the village level are Ante natal clinics , School Dental Mobile Service & Private Dispensary**

		of Govt M.OO . 6. **People like active case detection , therefore village level mobile clinic are more suitable. Lists of names can be obtained from GN divisions** 7. Investigative facilities through mobile laboratories or out source to private laboratories . 8. To clear the backlog , conduct a National NCD day or National NCD week and all staff to be deployed to screening of 35 - 65 age group
	Dr Ananda Gunasekara DDG (MS) II 12 January 2015	1. **Need a separate responsible team for NCD care to conduct mobile clinics in villages** (in addition to HLC) because the allocation given by the Ministry of Health for HLC s is comparatively high. 2. Staff should be dedicated for activities of HLCs. Presently the HLCs are not a priority activity of most of the MOOs 3. Need to prepare a separate duty list and a follow up plan 4. Need to establish a high level unit like FHB 5. Need special monitoring of the activities 6. Establish a separate unit at the apex hospital to follow up of this patient to assure that the patient is on track. This unit need holistic approach on these identified persons – Nutrition, Endocrinology etc 7. Need costing of HLCs with the recommendations at the end of this survey.
	DrV.T.S.K.Siriwardana **Director / NCD** 16 March 2015	1. Screening should be compulsory 2. Screening can be link with other benefit packages (eg – OPD priority, Separate counter for patients with HLC registration). These benefits can be given for a limited period till adequate coverage is achieved. 3. Can ask HLC registration card when go for other government offices 4. Insurance agents all over the country can be used to promote HLCs. Can give a target of 100 clients per month

		5. Social groups (eg. Three wheeler associations) can be used for improve public awareness 6. GPs can be used to promote HLCs 7. Quality of data is doubtful 8. **Mobile screening system should be established**
	Dr Sussir Perera D/Organization Development	**1. Structure need to change to suit the need** **2. The present system focuses mainly on screening. HLC should be used for lifestyle modification of patients already attending Medical clinics ; (Because MCs are overcrowded and no time to give lifestyle guidance to patients and their families.) Then the messages are disseminated to others of community.** 3. We see the iceberg of the NCD problem only. Programme should be focus on risk factor manage. 4. Mostly the same patients attend different screening programmes. Personal Health Record should be linked to HLCs. Then repeated screening can be discouraged. **5.** The Ministry of Health has spent large amount of money on HLCs. Therefore **a Separate Health Promotion officer should be trained and recruited.** **6. HLCs should be opened daily basis incorporated different activities – Screening, Health education Life style modification of MC patients etc** 7. Need to introduce a target to PHMs to refer to a HLC (4 persons per month). 8. **Need to introduce a NCD notification system** and NCD register. Need strengthening of the NCD monitoring
	Dr Kumari Fernando D/ Primary Care Services	1. Support from Consultant Physicians should be improved ; priority to be given to patients referred from the HLCs to the MC 2. Attitude of MOOs should be changed 3. MOOs should be trained 4. May need training of other new staff category to overcome the staff shortage.

	Dr Samitha Sirithunga CCP NCD unit / MoH 03 March 2015	1. Must give more time to establish HLCs because still only 3 yrs. (Immunization programme took more than 20 yrs to achieve 100% coverage) 2. Need attractive NCD package 3. Need work station screening to capture more males 4. Can in cooperate with other clinic patients 5. Need to highlight 40yrs age group otherwise dilute 6. Need more supervision role of MO NCD at district level 7. Avoid the risk of getting false returns from HLCs 8. People do not like to come to HLCs only for FBS. Need to add other investigations if possible. 9. Need to continue HLCs for follow up of patients identified with risk factors. 10. PHI and PHM work profiles have to re-define to suit NCD requirements.
	Dr.V.Mallawarachci CCP / NCD unit	1. Public health staff support is not satisfactory in referring patients to HLCs. 2. Separate staff cannot be utilized to refer patients from the community to HLCs 3. Need to give adequate time to establish HLCs 4. MOOs attitude need to be changed 5. Educational reforms need to be introduced in curricula of medical faculties 6. HLCs are one of the strategies in the NCD policy. This is not a new concept. Accepted world wide 7. Need special strategies to improve male participation 8. Piece meal approach may not successful. Need systematic approach 9. RDHA level supervision is not adequate

It is evident that most of the technical experts are in favor of program reforms ; and it invites to the subject of management reforms rather than technical reforms (modifications) to the existing programe

Interviews with clients who attended HLC

Personnel who attended to HLC of Hospitals (according to District HLC timetable received from MO/NCD) ; presented their experiences as described in table seven .

Table 7

Date	Place	Who attended the client and what advice was given to the client
23 December 2014 8.15 am	DH - DIGANA	Examined by DMO / Prescriptions for drugs to be obtained from OPD and also to purchase from a pharmacy outside / Health advice given
17 December 2014 9.30 am	DH - KIRINDA	DMO informed that the HLC is not functioning
17 December 2014 9.45 am	DH - THALALLA	Though the District time table indicate that the HLC is functioning today , the hospital staff has informed the client to come on next day (day after)
17 December 2014 9.23 am	DH - KAMBURUGAMUWA	The client was informed that HLC is not functioning
17 December 2014 9.30 am	BH - AKURESSA	The client had met the RMO who was in the OPD but the RMO was not aware of HLC and the RMO had questioned a labourer about it . The labourer had answered by saying ' NO " , then the RMO had instructed the client to meet the Nursing Sister in Charge ; She had told the client that the HLC is closed as no reagents for testing,
23 December 2014 8.45 am	DH - MANIKHINNA	No of clients attended for the whole day = 03 ; Registration by NO , Weight and Height checked by PHM , (Height checking was not accurate) BMI calculated by NO , RBS checked by

			NO , RBS was re checked as the value was high , No health guidance given , Client examined by MO , MO advised the client to get admitted to the ward as the RBS was high . The client refused Then the MO advised tore-check RBS from an outside lab (Cost = Rs 100 / +) and advised to get admitted to the ward on the next day

Though the District time table indicate the HLC clinic dates on regular basis ; at certain places the HLC are closed due to technical reasons but not informed the RDHS/MO- NCD. The Quality of services offered at HLC should be assessed by a detailed study

Facility Survey

A facility survey was conducted (according to annexure one) in few hospitals and the report is annexed

Date of facility survey	Hospital
17 December 2014	BH - AKURESSA
17 December 2014	DH - KIRINDA
26 December 2014	DH - MANIKHINNA
23 December 2014	DH - TELDENIYA

GAP ANALYSIS by using UHC tool	Vide supra – Study Report	
Target areas & Beneficiaries	Vide supra – Study Report	
Justification	Vide supra – Study Report	
Important assumptions / Risks / Conditions	Vide Supra – Study Report	
Vision	Vide Supra – Study Report	
Mission	Vide Infra - Strategies	
Goal	Prevention of Deaths due to NCD , below the age of 65 years	
Programe Objectives (Please prepare separate indicators for each objective)	**Indicators**	**Means of Verification**

Output (Please prepare separate indicators for each output)	Indicators	Means of Verification
Strategies / Major Activities	**Recommendations** As described in detail above ; this Project HLC is failing to capture its target population (due to non compliance of at risk group) ; It is vital to Re Design the project using MANAGEMENT CONCEPTS Thus the selected , alternative management concept is FORWARD EXTENSION That is not to wait at HLC , but as a forward mission to visit the community / mobile screening at village level **Proposal One – Village Mobile HLC** A Medical Officer (Designated as MO/ NCD Prevention) will be appointed to all Primary care hospitals (906) in Sri Lanka Divisional Hospital type A = 41 Divisional Hospital type B = 132 Divisional Hospital type C = 272 Primary Medical Care Units = 461 The functions of the MO / NCD Prevention will be as follows • Based at the HLC of the Divisional Hospital/ PMCU after Training at NIHS for One month • Visits villages assigned (catchment area defined according to GN divisions) and village mobile NCD screening wiil be conducted • As Bed Occupancy Rates of all Divisional Hospitals are less in number , the nursing officers working in wards can be diverted (after offering a training in NCD , counseling , etc) to attend as a team to work in village mobile NCD screening clinics • Development assistants (DA) to assist in Data base & Family Folder system and also to visit village level community organizations as an extension officer for prior arrangement with CBO to prepare the calendar for each village level screening clinics • A vehicle (to visit villages on a monthly time table) with a driver will be assigned to Mo/NCD of hospital to conduct village mobile HLC • Targets to be achieved by the MO/ NCD prevention and performance appraisal of village mobile HLC will be reviewed quarterly • Deaths due to NCD below 65 yrs of age will be reviewed by MO/NCD prevention • MO/NCD prevention of Divisional Hospital should liaise with the Medical Officer of Health of the catchment area • At the monthly conference of MOH the MO/ NCD prevention has to describe the monthly advance program of village mobile HLC ; so that the relevant PHI &PHM of range could be released on that	

	particular day of village mobile HLC to refer community under care of them for the NCD screening at local level **Proposal Two – NCD Bureau** The MOH system is evaluated by FHB and Epidemiology Unit; as such the MCH activities throughout the country are at satisfactory levels .Similarly the activities of MO/NCD prevention should be monitored by a system parallel to MOH/FHB & Epid ,unit . Thus it is proposed to create a separate Bureau for PCS &NCD under a separate DDG (DDG 111) and the Director/ NCD and Director/PCS will be assigned to said DDG 111 to form the national level organization (Provincial and District/Regional levels are already attended by MO/ NCD of Province & District ,The Divisional level will be represented by newly appointed MO/NCD prevention in Primary care Hospitals **The above proposal was submitted by Dr Athula Dangalla (Director / Policy Analysis & Development / Ministry of Health - SL in 2014 Please refer to the Decision taken in 2015 by the Cabinet of Ministers of Democratic Socialist Republic of Sri Lanka to establish NCD Bureau**
Monitoring & Evaluation	
(*)Reference to Research	

Names of officials who documented the profile =

Dr Athula Dangalla , et.al

Director / Policy Analysis & Development

Ministry of Health - SL

Program title	**Reforms** **Establishment of NCD Bureau**
Focal point	Ministry of Health Director General of Health Services Deputy Director General (Non Communicable Diseases)
Back ground / **Situation** Analysis *(**Problem Analysis**)	**CABINET MEMORANDUM** **Establishment of a Non Communicable Diseases Bureau and approval of a cadre for Deputy Director General (Non Communicable Diseases) and support staff** **Background:** Sri Lanka has prioritized access to health services since the 1930s, and substantial and sustained investment in public sector services has ensured that almost all the populations have good access to curative and preventive care services. This with the universal free education has contributed to a high life expectancy and good health indicators. Substantial declines in fertility since 1970s, has led to a process of rapid demographic ageing. Today, Sri Lanka has fastest aging population in the world. Due to improvement of the health care services as well as the socio economic conditions of the country there is a reduction in the communicable diseases while the non-communicable diseases are on the rise. The country has a strategy to address non-communicable diseases, based on prevention and control which includes the promotion of healthy lifestyles as well as the Sri Lankan population is the fastest aging population in the world and as the Non Communicable Diseases are common among the elderly, provision of a quality Non Communicable Disease control programmer has become a national priority. **Justification:** NCD Unit of Ministry of Health was set up in 1999 with the expressed view of combating the emerging problem of NCDs in Sri Lanka. The NCD Unit, which is responsible for diseases which cause more than 50% of deaths in Sri Lanka

	currently has only the Director, Deputy Director, two consultant community physicians, and two Medical officers which is far less of strength in comparison to the disease burden. Also the activities related to control of cancers and mental health which are also part of NCD are tackled by a separate directorates. Therefore considering the disease burden and the scope of work it is proposed to have a separate Non Communicable Diseases Bureau under a Deputy Director General of Health Services (Non Communicable Diseases). The directorate of NCD, Mental Health and Cancer prevention and control will be managed under the DDG (NCD). The proposed NCD Bureau will carry out health promotion, disease prevention, community screening, disease control, disease surveillance and reporting, development and introduction of policies and guidelines, training and capacity building, research, piloting of innovative approaches for the following illnesses: • Cardiovascular disease (ischeamic heart diseases, stroke, hypertension) • Diabetes Mellitus • Chronic respiratory diseases • Chronic renal disease • Eye diseases • Accident and injuries including child injuries The Terms of Reference for the NCD Bureau are: 1. Plan and implement a comprehensive programmer to control the selected NCDs. 2. Coordination of activities related to NCD risk factors. 3. Establishment of an effective monitoring and evaluation framework for NCD 4. Conduct surveillance on NCD morbidity, NCD mortality, NCD risk factors and health system response. 5. Take action to improve reporting from Health Lifestyle centers and other NCD screening centers and form a National NCD data base. 6. Implementing a four yearly National Health Survey 7. Identify and facilitate research in priority areas for NCD 8. Facilitate implementation of innovative approaches to prevent, control and manage NCD 9. Coordinate and develop clinical Guidelines and Management protocols. 10. Ro conduct/ coordinate capacity development programmers for NCD management.

11. To prepare and disseminate an yearly bulletin related to NCD

For proper functioning of the NCD Bureau a sufficient cadre needs to be approved. Detailed Cadre requirement of the NCD Bureau is attached as Annex 1 and the Organizational structure of which is attached as Annex 2.

Recommendations:

I seek approval from the cabinet of Ministers:-

1. To establish a Non Communicable Diseases Bureau with the Organizational structure in annex 2.
2. For the creation of new cadre positions including Deputy Director General (Non-Communicable Diseases) as indicated in Annex 1 for the Non Communicable Diseases bureau.

Hon Dr. Rajitha Senarathne
Ministry of Health and Indigenous Medicine

Annex 1
Detailed cadre requirement of the Non Communicable Diseases Bureau

Category	Number
Deputy Director General – Non Communicable Diseases – (Deputy Director General Grade)	1
Director – Non Communicable Diseases – (Senior Medical Administrative Grade)	1
Deputy Director – Non Communicable Diseases – (Deputy Medical Administrative Grade)	1
Administrative Officer	1
Accountant	1
Consultant Community physician	9
Medical officer	10
Medical officer – Health Informatics	1
Development officer	10

	Research officer	1
	Computer programmer	1
	Public Management Assistant	7
	Information and Communication Technology Assistant	2
	Drivers	7
	Health Assistants	7

Certificate of Authorization

The aforementioned Cabinet memorandum No 15/0698/610/030 dated 11the May 2015 had been approved by the Cabinet of Ministers of Democratic Socialist Republic of Sri Lanka on 27th May 2015

Program title	**Reforms to the Curative Division of Ministry of Health - Sri Lanka**
Focal point	Ministry of Health Director General of Health Services
Back ground / **Situation** Analysis *(**Problem Analysis**)	**1.0 Introduction** Sri Lanka enjoys a long standing and historical tradition of prioritizing health care over other societal matters , by the initiation of the first ancient hospitals in Sri Lanka , named the ' Sivikasotthi-Sala' (Ayurvedic Hospitals) , spreaded throughout the country , during the days of King Pandhukabhaya (437 BC - 367 BC) as documented in the Mahawamsa (1) Correspondingly , the world renowned writer , Professor Heinz E Muller-Dietz , in his book ' - 1975 ' , describes the ancient hospital found in Mihinthale , to be one of the first in the world (2) denoting the global pioneering health position Sri Lanka had in the past . Thereafter , since the gaining of Independence , the policy of ' free health care for all ' was adopted and Sri Lanka continuous to be one of the few countries who have been able to sustain it while having an impressive health services record and being very much progressed in Universal Health Care . In 2012 the World Health Organization (WHO) adapted this new resolution on ' Universal Health Coverage ' which comprises of the four pillars of Equity , Accessibility , Quality and Financial Protection . (3) Both the WHO and the World Bank have devised a framework for analyzing the UHC progress , which comprises of three indicators of Health service coverage , Financial risk protection and Equity of distribution of health services to entire population Curative health sector is the largest service provider in Sri Lanka .Annually it serves 53 million out patients and 5 million in patients together which comes to three times the total population of the country , No other service organization whether it is in public sector or private sector has such a large customer base The closest competitor is the Ministry of Education which serves about 4 million students annually . Although Sri Lanka has this free health system , the out of pocket expenditure for health care services for the public was estimated at a massive 46 % by the year 2009 while government spends 54 % only (4) The Government Budgetary allocations for health was a mere 1.43 % of

	the GDP in 2013 while the highest it reached was 1.9 % in 2004 (5) But the present government has pledged to increase the health allocation to 3 % of GDP , historically doubling the previous allocations , as mentioned by His Excellency the President Maithreepala Sirisena himself at the International Family Health Day celebrations on 05th May 2015 . Therefore it is imperative the new impetus gained by this increase in financial allocations , be distributed in a justifiable manner to all the districts , while prioritizing on scientifically based criteria which encompasses the UHC perspectives , as well as national and district perspectives Is there a mechanism to undertake this challenge of the needs & demands for better health services . **The best answer to the aforementioned question had been given by the Hon Minister of Health, Nutrition and Indigenous Medicine Dr Rajitha Senarathna , at an international forum . The Afghanistan and Maldives island delegations had discussions with the Hon Minister of Health Sri Lanka at the SAARC Health Ministers Meeting in New Delhi India (February 2015) Both countries have stated that they are impressed by the health status and health service provision indicators of Sri Lanka and they wanted to know the mechanism by which we attain such high indicators , The reply of the Hon Minister of Health Sri Lanka had been two fold (1) Due to high literacy rate in our country all mothers are health conscious (2) excellent health service delivery designed and managed by Medical Administrators . This is the first and only and best ever recognition given to Sri Lankan Medical Administrators at International Forums , Whilst thanking the Hon Minister for giving the Medical Administrators of Sri Lanka a long awaited appreciation internationally , it is the duty of all Medical Administrators to preserve it by making innovative efforts and reforms to deliver the best health service in the SEAR countries** Both statements , of the H E the President and the Hon Minister of Health are of high importance at this particular period of time , as it is the time , the preparatory activities have begun to create the next health policy and next health master plan for our country .The excising health policy was introduced in 1996 and by now 19 years have elapsed and a new health policy has to be designed according to the issues at present and also considering the needs and demands of health futures . (as the present health master plan ends in 2017) Simultaneously the strategic framework to implement the new policy (= new health master plan) has to be developed . Thus Medical Administrators of today have a great task to perform for tomorrow's patients .More specifically , (according to WHO) the Medical Administrators are the voice of the poor , the sick and the dead .

2.0 The present situation in the Curative Services Division of the Department of Health Services / Ministry of Health - Sri Lanka

Although certain ordinances pertaining to public health were enacted (Example - Ordinance of Quarantine and prevention of diseases was enacted 100 years ago) by the British Colonial Rulers , the Health Services Act was enacted after the independence (as Act No 12 of 1952) According to section 3 a , b , c , and d ; the Director of Health Services , Deputy Directors Medical Services , Public Health Services and Laboratory Services were appointed respectively . (6) Later the designations were improved as Director General of Health Services , Deputy Director Generals of Health (Medical Services) , (Public Health Services) , and (Laboratory Services)

The first Health Policy of Shri Lanka was introduced 40 years later , in 1992 by Prof Earl Fonseka et.al (7) The team of officials who participated in the Presidential Task Force in the preparation of Health Policy in 1992 have paid a fair attention to situation analysis in their documentation before suggesting policy options , In deed they have analyzed the following sub sectors in curative services at length in 1992 .

- Cardio Vascular diseases p 28
- Accidents and poisoning p 36
- Blind and visually impaired p 50
- Deafness and hearing impairment including dumbness p 51
- Geriatrics p 53
- Occupational health p 55
- Snake bites p 56
- Population groups living in areas of development projects of other sectors p 57
- Estate population p 59
- Primacy level curative services p 61
- Health services at secondary and tertiary levels p 63
- The centres of excellence p 67
- Laboratory and diagnostics services p 69
- Blood transfusion , tissue grafting and organ transplantations p 71
- Human resource for health p 128
- Drugs and vaccines p 141
- Equipment supplies p 149
- Private health sector p 152

Unfortunately a National Framework to establish Divisional Health System (which emphasized more on preventive sector) was fixed on top of this extensive analysis , and the result was neglecting the reforms in the curative sector

Few years later , in 1996 , another Health Policy was prepared (and it is still in existence) But no evidence was available about situation analysis

	and problem analysis The emphasis was on two major areas (1) Subjects which were not available as directorates in the Ministry before , were established (Examples D/YED . D/E & UH, D/Mental Health , D/ PHSD) The other area to which the clinical professors who were involved in the preparation of this health policy of 1996 , paid major attention was (2) to incorporate the growing number of young clinical consultants in to a rapidly nominated Base Hospitals scattered all over the country . For this purpose , some of the larger District Hospitals were identified to appoint consultants , As those hospitals were belonging to Provincial Councils , the allocations within the Provincial councils were not sufficient to establish operating theatres , Diagnostic facilities etc . Because of the Provincial Council Act the Line Ministry was unable to fund the Provincially owned Base Hospitals , and it took nearly 20 years to over come the problem of funds and make those BHH suitable for Consultants units Though out the Curative Services Division of the Line Ministry of Health (DDG MS I and II , DDG LS) were not involved much in planning these new facilities in the Provinces . In 2006 the JICA health Master plan was prepared (the first health master plan of the country) Unfortunately most of the planners had their origin from Community Medicine stream and little emphasis was paid for the development of Curative services Division of the Ministry of Health . Though it had spend several millions of Rupees/Yen , there are serious defects in this JICA master plan Document . They have failed to prepare plans for some of the major subject areas . Examples are Kidney disease , Thalassemia , Estate (Plantation) Health , Occupational Health , HRH , etc (Now we are at the end of time period of JICA master plan 2006 - 2016 ; and now the CKDu and Thalassemia have become major problems of the country , whielst the Tamils of Indian origin have made complains to the LLRC - Commission on Learned Lessons & Reconciliation , about defects in the Estate (Plantation) Health services .Thus JICA Master Plan has failed to address key health problems in our country even after spending millions of money for the preparation of plan document On the other hand JICA master plan writers elaborated more and more on officials engaged in preventive health services and a large number of ramification of preventive subjects and offices and posts were created to incorporate all post graduates in Community Medicine . (as directors , deputy directors and as national programme managers , up to the extent of NPM/ Suicide prevention , NPM/Gender based violence , NPM/Birth defects etc !) Because of this numerous ramifications in preventive sector , the present post graduate students in Community Medicine will be benefited as a post will be available for them when the time they qualify / Board certified !! Will the people of Sri Lanka get the benefit of these ramifications in Preventive subjects (the cost of Administrative overheads in retaining officers in Colombo than sending them to Districts , and the outcomes / Impacts) are to be assessed !!! The opportunity cost of all aforementioned preventive health

	developments was mal development of curative service component of the Ministry of Health . Thus the Organization of the curative division was unchanged for 50 years ; but the needs and demands have been increased many folds . With the increased literacy of people over the past years , the expectations for standard clinical care have become increased . The professional colleges of clinicians demand more from the curative division of the Ministry of Health to provide more care (with their knowledge and skills) to the patients , But the age old structure is not capable in delivering the expected to the clinicians as well as patients The patient's Grievances or the commonest complains made by the patient's and their next of kin include the following (a) delay in attending the patient (b) rudeness or unkind attitude of staff (c) Medical negligence (d) negligence by other categories of staff (d) non availability of drugs , investigative facilities and ambulances (e) problems in critical care units including transfer of critically ill due to non-availability of ICU beds , problems in Labour rooms and operating theaters , The present directorates (D/MS , D/TCS & D/PCS) are unable to attend all these problematic zones island wide as they are at present mostly engaged in transfers of all categories of Medical officers On the other hand , the clinical professions too have ramified over the past decades creating various sub specialties and each of these sub specialty has it's own national plan to develop and cater a quality service throughout the island . But at present there is no directorate to liaise with the clinical professions and materialize their plans to improve the sub specialties to deliver an equitable and quality service through out the country . Though we claim that we offer Universal Health Coverage in Sri Lanka , it is only with regard to the preventive services , The curative services have to achieve many development strategies to attain the status of (1) Equitable coverage of Curative Services (2) Accessibility for all patients who need any specialty of Curative Care (3) Quality service by making available the relevant clinical professionals and trained staff , Bio Medical equipment and drugs etc (4) Financial protection of all patients who seek curative care At present the Curative Services division is mainly divided in to two sub departments , the Medical Services and the Laboratory Services The Medical Services Sub department is further divided under two Deputy Director Generals - Medical Services I and II The Directors of Tertiary Care Services , Health Care quality & Patient Safety with D/NCD and D / Cancer control are functioning under DDG (MS) I . The Directors of Medical Services ,Primary care services , Private Health Sector Development and D/NBTS are assigned to DDG (MS) II . The DDG (Laboratory Services) has two directors namely D/Medical Supplies and D/ Laboratory Services . It will be evident from the aforementioned description that the present organization is overloaded and have no capacity to undertake the new demand for services and challenges of health futures

Therefore it is essential and timely to introduce reforms to the curative services division of the Ministry of Health as follows

- Reforms to the PRIMARY CARE SERVICES unit (D/PCS)
- Reforms to the Medical Services unit (D/MS) be re-named as SECONDARY CARE SERVICES
- Reforms to the TERTIARY CARE SERVICES unit (D/TCS)
- Reforms to the LABORATORY SERVICES unit (D/LS)
- Creating a separate Division of the Ministry of Health known as CURATIVE SERVICES DIVISION with DDG MS I ,II, II DDG LS and DDG Medical supplies with a structure of directorates relevant to functions (and responsive to needs of clinical professions and patients)

3.0 Reforms in the Primary Care Services (PCS)

At present the D/Primary Care Services operates as a branch of DDG (Medical Services) II , and since its inception no developmental changes have been implemented to uplift its services . But from the table below it will be evident the crucial importance of it (D/PCS) as the Technical authority of all Divisional Hospitals and Primary Medical Care units distributed through out the country .

Type of Hospital	Number of Institutions in the Country
(a) Divisional Hospitals - A	42
(b) Divisional Hospitals - B	129
(c) Divisional Hospitals - C	322
Primary Medical Care Units	474
Therefore total Number of Institutions under technical supervision of D/PCS (all D HH and all PMCUU)	**967**

However , with the establishment of Provincial System , the importance of D /PCS had been lost Each and every Province (and each and every District) had been adopted their own methodologies in development and management of these Primary level Curative institutions , creating wide disparity among institutions and services as no inputs were obtained from national technical focal point , the D/PCS . These variations of service provision invariably affected the recipient population , the patients living in those catchment areas . It should be noted that a large percentage of patients attend to out patient units of these Primary curative care institutions (please refer to the table below) As such the services offered to those large populations has to be technically monitored by the D/PCS

Diagnosis	Tertiary Level	Secondary level	**Primary level**
Injuries	11.9	18.5	**19.7**
Asthma	1.8	3.0	**7.7**
Other Ischemic Heart Diseases	1.7	1.9	**1.5**
Malignant Neoplasm	2.5	1.8	**0.1**
Hypertensive Heart	1.0	1.5	**3.5**

Disease			
Diabetes Mellitus	1.1	1.4	**1.2**
COPD/Bronchiectasis	0.4	0.6	**0.9**
Cerebrovascular diseases	o.6	0.6	**0.5**
Myocardial Infarction	o.2	0.5	**0.3**
All other causes	81.2	72.1	**64.7**
Total	100.0	100.0	**100.0**

An analysis of the list of duties assigned to the D/PCS will clearly indicate that the present structure is not adequate to deliver the expected services

Duty assigned at present	Comment
Attend the health care delivery related problems of district hospitals , peripheral units , rural hospitals , central dispensaries , and maternity homes , categorized under divisional hospitals and refer to DDG (MS) II when advice required	At present D HH and PMCUU are managed by Provincial and District health authorities and involvement of D/PCS is minimal or nil (No technical advice is sort from D/PCS)
Support and assist regional authorities in preparation and implementation of development plans / projects	The assistance of D/PCS is never obtained at present by Provincial /Regional authorities thus uniformity of plans / projects have been lost
Support and assist National Quality and Productivity improvement programme according to the guidelines provided by the Quality secretariat of the Ministry of Health	At present the involvement of D/PCS in this activity , in D HH and PMCUU , is minimum or nil as D / PCS has not been invited into Provincial or District programmes
Organize , support & monitor National Health Sector Excellence awards Programme according to guidelines provided by DDG (MS) II	Non functioning
Take part in progress review meetings conducted by regional authorities that are related to D/PCS area of responsibility	Provincial and District health authorities usually do not incorporate D/PCs in their progress reviews and function independently Thus national norms are not implemented / not monitored at provincial /district levels
Visit health institutions (D HH and PMCUU) if requested and take part in appraisal of divisional hospitals under National Health Sector Excellence awards Programme	No invitations to visit No appraisals of Hospitals Thus no maintenance of norms and quality
Prepare comparisons of appraisals of institutions according to standard format provided by DDG (MS) II	Non functioning

Thus it will be evident that a large majority of hospitals in this country are not

been managed by the technical focal point due to the fact that those hospitals are owned by provincial authorities , making in accessible to the D/PCS alone , and creating wider disparities - inter and intra districts /provinces , resulting poor quality and non safe services to thousands of patients in those catchment areas .

Therefore it is strong evidence to strengthen the Primary care services , to make it penetrate in to provinces and districts , embark on supervision and appraisal of Divisional Hospitals and Primary Medical Care units , promote norms and standards and reduce disparities to offer a **quality** and **accessible** service with **financial protection** of the patients through out the country in an **equitable** manner (= Universal Health Coverage)

Thus the proposal is to establish a new structure for management of Primary care services under a separate and new Deputy Director General (PCS)

For the effective function of this new DDG (PCS) several new directorates have to established , taken in to account the age old non development in Curative Services Division of the Ministry of Health

(a) Director / Primary care services

D/PCS will function as it is and with the same duty list but with more authority as the DDG (PCS) will have the same duties .So that both can penetrate in to Provincial and District health authorities and implement technical standards monitor quality & safety to uplift the D HH and PMCUU through out the country .

Depending on the work load a Deputy Director may be appointed (example = to attend the technical needs of large D HH = type A)

(b) Director / Palliative care (Transitional and Integrated Care) services

Growing number of patients in need of Palliative care has demanded a creation of this new discipline in the Ministry of Health . The Profile of the Directorate has already been prepared by the Consultants in Palliative Care . The preparation of National Policy and strategic plan for Palliative care is in progress , In addition the subjects of Home based care and community nursing will be attended by D/Palliative Care (Transitional and integrated care involves transition of patients from acute care (Tertiary) to rehabilitation and palliation at next level , which capture more wider and appropriate intervention

(c) **Director / Geriatric care services**

With the increase of patients with NCD complications and Aging of population , the Ministry of Health has to face a greater challenge in developing Geriatric care services in an equitable basis and accessible manner to all such patients living anywhere in the country . As such a new directorate of Geriatric care services should be established

(d) **Director / Tele-health**

As centres of excellence are located far away from DHH and PMCU , the linkages to and from such centres of excellence is of utmost importance to the poor patients attending DHH and PMCUU (as out of pocket expenditure for such

patients to attend centres of excellence would be unbearable) Thus tele health net work has to be established to cover all DHH and PMCU through out the country . M.OO with medical informatics qualifications will work under D / Tele health to maintain the services 24 hrly .

(e) **Director / Operational Development (PCS)**

All the planning issues under the DDG (PCS) involving the development of all DHH and PMCUU in the country will be attended by D/ operational development (A hospital planning Specialist) It includes Infrastructure , equipment , Quality & safety , HRH and health system research and design in Primary level curative institutions

4.0Reforms to the Secondary Care Services

At present Director / Medical services is attached to the Deputy Director General (Medical Services) II . It is hereby proposed to re – name the post as Director / Secondary Care Services and make responsible for activities pertaining to all Secondary level Curative institutions (Base Hospitals A & B) in the country

The present job description of the Director / Medical Services is analyzed below

Assigned Duty	Comment
1. Prepare vacancy list for post intern medical officers based on priority vacancy list , sent to Ministry by relevant Heads of Institutions	Inability to adhere to the priority vacancy list
2. Calling of applications and selection of Post Interns according to UGC merit list and posting to respective stations ; monitor progress of reporting of post interns	Inability to adhere to the priority vacancy list
3. Direct the Planning unit of MoH to obtain cadre approval from Dept of Management Services , to recruit M.OO	Provincial and District cadres of M.OO are not attended by D / MS at present
4. Annual transfers of grade medical officers Prepare the list of names noted for transfer annually Call of applications from M.OO eligible for annual transfer Prepare interim list of annual transfer	 This function has been almost handed over to the online application system and the transfer board

		orders by 31st August Call for appeal and prepare annual final transfer order list and publish before 01st November	-do- -do-
		5. Special Appeal Board Conduct special board of grade medical officers twice a year (March and June) Chair the special appeal board and peruse through appeals and prepare special appeals transfer orders list ; monitor and regulate special appeal transfer movements of grade M.OO	This function has been almost handed over to the online application system and the transfer board
		6. Special post appointments Advertize vacancies received by MoH to fill special posts falling vacant in Teaching and Provincial General Hospitals annually . Peruse through applications select eligible M.OO. and prepare special post transfer order list ; Monitor and regulate special post appointments in Line Ministry and Provincial Councils	This function has been almost handed over to the online application system and the transfer board
		7. Seconded post appointments Advertise from time to time vacancies for M.OO in forces (Army Navy and Police) and SJGH . Applications shall be perused and selection list to be submitted to the PSC for approval . Once approval of PSC is granted the list should be published for attachments to selected institutions	This function has been almost handed over to the online application system and the transfer board
		8. Special lists Advertise special vacancies in health institutions for urgent filling to maintain uninterrupted services .	This function has been almost handed over to the online application system and the transfer board
		9. Medical Boards	

	Medical examination of employees of MoH and other Ministries by Medical boards on request of relevant authorities (except M.OO) Appoint medical boards and deliver decisions of the medical boards t the respective departments	
	10. Public Complains Attend to public complains received from public or otherwise Call for reports inquiries and investigate matters or refer complains to investigation branch of MoH for necessary action	Mostly referred to DDG Investigations
	11. Special Correspondence from office of His Excellency the President of Sri Lanka Promptly attend all quarries , inquiries and other communications received and provide a feedback to His Excellency the President	
	12. Upgrade Health institutions Attend to request of respective authorities to upgrade institutions Study the request Act to upgrade if compatible with re categorization circular	No time to inspect and ascertain the validity of request Sometime this act is duplicated at D / Planning
	13. Disciplinary functions Attend promptly any disciplinary matter of any health institution or any employee of MoH when directed by S / H or DGHS	Handed over to DDG Investigation
	14. Paying ward facilities Arrange to issue authorization letters to who are entitled for paying ward facilities on request	No time to develop the sector

15. Facilitation of Health Service Delivery Work in corporation with Provincial council authorities to deliver quality health care services ; under the guidance and supervision of DDG (MS) II , DGHS and S / H	In sufficient time / due to appeals of M.OO requesting transfers
16. Attend management committee meetings of allocated hospitals as liaison officer of MoH	In sufficient time / due to appeals of M.OO requesting transfers

Out of the functions of the D /MS about 50% (8 out of 16) are involvements with the transfers of Grade M.OO. Therefore , in practice , D / MS is unable to attend the rest of duties due unavailability of time . Duties such as , Up grading of Institutions , Facilitation to Provincial Health system and attending management committee meetings are the important issues but the attention paid at present is less due to around the clock engagement with transfers and appeals of M;OO

Therefore the following new structure / system is proposed

(a) the aforementioned functions 1,2,3,4,5,6,7 and 8 should be separated and given to a separate Director of Senior Medical Administrative Grade who has Qualifications in Medical administration and name the post as **Director / HR management of Medical Service**

(b) A separate new Director post to be created , assigning the aforementioned functions 9,10,11,12,13, 15 and 16 ; thus named as **Director / Secondary care Services** . The Director / Secondary care services will be the technical focal point for all secondary care hospitals in the country (all Base Hospitals A & B) S/He shall be the liaison officer of MoH at all management committee meetings of those hospitals and at meetings of professional colleges of clinicians with regard to Base Hospital issues

(c) Director / Private Health sector development shall be re named as **Director / Private HealthSector Regulation** (as at present there are no norms and charges vary ; amounting to very high out of pocket expenditure by patients)

(d) As pre hospital care is becoming a subject often discussed and , as the government is planning to establish an ambulance service for the same purpose it is essential to have a separate unit for per hospital care planning developing (including training of health personnel and civilians in emergency care) management and evaluation Thus the post of **Director / PreHospital Care** is proposed

(e) A hospital planning specialist should be appointed as **Director / Operational Development** (**Secondary Level**) to streamline and develop all Base Hospitals according to the norms in liaison with professional colleges of clinicians In addition the aforementioned duty No 14 will be assigned here to develop the paying ward system in all hospitals with consultants S/He may also involve in PPP

- Public Private Mix Projects to up lift the services of the Base Hospitals

(f) **Director / Migration Health & Medical Tourism** - has to deal with all health issues pertaining to foreigners who come and stay in Sri Lanka , Recovering their medical fees etc and the Health & wellbeing of the Sri Lankans who have left the country for jobs in foreign countries and the families felt behind in Sr Lanka , In addition S/He has to promote Medical tourism in our centres of excellence by obtaining the help of our Embassies / High commissions in SAARC countries (a foreign exchange generating project with a fee for service for our technical staff)

5.0Reforms to the Tertiary Care Services

At present Director / tertiary Care services functions under supervision of Deputy Director General (Medical Services) I . However it is observed that the Ministry has not given a job description to the post of Director / Tertiary Care Services . Furthermore it is evident that the transfers and placements of clinical consultants have become the main and only function of Director / tertiary Care Services ; making no time and attention to the planning , development , implementation and evaluation of Tertiary Care Services . To make the situation more complex , the personnel files of clinical consultants are kept in the TCS unit in the alphabetical order , If the personnel files of clinical consultants are kept according to the specialty and , within specialty according to seniority , it would have been much easier to find (a) who has gone abroad for foreign training and when S/He will be back to service in Sri Lanka (b) Who is next to arrive after completion of foreign training in a given specialty (c) the vacancy list of all specialties and the priorities . At present it takes over one week to grant a work place for a consultant who comes after completion of foreign training

The following reforms are proposed

(a) It is suggested to issue a job description to Director / TCS and re name the post as **Director / Tertiary Care - management** and give all other functions pertaining to development of Tertiary Care to a set of new Directors as indicated below

(b) A post titled **Director / surgical Services** will be established and S/He shall be responsible for planning , Development , Implementation and evaluation of all Surgical Services throughout the country . For to perform this very special s/he shall collaborate with Professional colleges of General Surgeons , Ophthalmologists , Otolaryngologists , Oral and maxillofacial surgeons , Cardio Thoracic surgeons , Billiary and Gastroenterologists , Urologists , Orthopedic surgeons , Neuro surgeons , Transplant & vascular surgeons (Special surgical hospitals such as National Eye Hospital falls with in the perview of this directorate) The national , Provincial and District plans to provide the services according to Universal Health Coverage concept will be prepared and

	implemented (c) **Director / Critical Care & Emergency Services** will collaborate with professional college of Anesthesiologists & Critical care consultants . S/He shall be responsible for planning , developing (including training of staff) implementation and evaluation of all critical care and emergency services of the country National Intensive Care Surveillance system and implementation of National Accident & Emergency care policy , are other key functions of said directorate (d) **Director / Pediatric Services** will be responsible for planning , development (including special training of relevant staff local and abroad) implementation and evaluation of all Pediatric Services in the country . To perform this task S/He has to collaborate with professional colleges of Pediatricians & Neonatologists .The special Hospitals for Children and the Children who need special care (Autism , Thalasemia) are among the other key responsibilities of said directorate (e) **Director / Obstetrics & Gynecological Services** will be another new directorate , All the special hospitals for women shall come under the preview of this directorate , S/He shall collaborate with Sri Lanka College of Obstetricians & Gynecologists to prepare National Provincial and distinct plans in accordance with UHC concept to develop Obs&Gyn services throughout the country . Further S/He shall work with Gynecological Oncology specialists to improve those services . (f) **Director / Internal Medical Services** will be responsible for development and management of all internal medical services in tertiary care institutions To perform this task S/He has to collaborate with the professional colleges of clinical consultants namely Ceylon college of Physicians , Neurologists , Cardiologists , Pulmonologists , Endocrinologists , Nephrologists ,Rheumatologists , Dermatologists , Oncologists & hematologists . (Example - apart from the surgical section all other units of Nephrology - CKDu Hospitals comes under preview of this directorate) S/He may also collaborate with Palliative care experts to deliver a home based service package for the chronically ill . (g) **Director / Hospital Planning** - Tertiary level will be another new post to address the needs of expansion of services according to universal health coverage concept . To ascertain the uniformity in planning and implementation S/He shall collaborate with all professional colleges of clinicians . Norms to maintain allocative efficiency to be prepared Project management expertise is needed for this directorate (h **) Director / Health Innovations & Translation Medicine** - one of the functions of this directorate would be translation of research in to Policy and Practice (this subject is also known as Getting Research in to policy and practice = GRIPP) S/He shall also be responsible for coordinate all types of innovations in health

sector and be responsible / focal point for arranging annually the health sector excellence awards system

(I) **Director / Health Technology** will be responsible for health technology assessment (HTA) and preparation of norms of bio medical equipment for National Provincial and District levels . Take part in preparation of specifications and Technical evaluation of bids both at national level and provincial bio medical equipment tenders as Ministry liaison officer . Arrange end user training as hands on training at national , provincial and district levels , prepare user guides in Sinhala & Tamil . Monitor the maintenance services of bio medical equipment at all levels of health institutions . Maintain data bases and also collect the utilization data to ascertain the need for re location or extra equipment

6.0Reforms to the Laboratory Services

At present there is only one director for all laboratory services and attached to Deputy Director General (Laboratory Services) The main functions of Director Laboratory Services are given below .

Planning annual laboratory requirements and assist Director / Medical Supplies Division in ensuring supply
Planning all laboratory equipment and Technology updates annually and assist DDG (Laboratory Services) in resource allocation
Evaluation of laboratory performance regularly and review with a view to improve the section
Maintenance of necessary data bases with regard to laboratory sector
Coordinates with all relevant directorates with regard to issues of laboratory sector
Conducting monthly review meeting with the national committee on laboratory policy
Implementation of all activities as per laboratory policy with a view to improve quality , accessibility , and affordability by laboratory sector
Handling of all complains and non conformities with regard to laboratory sector
Assist DDG (LS) in all activities in directorate

The aforementioned duty list had been prepared about ten years ago and as of now , the subject has acquired complex dimensions , necessitating a reform to the whole of laboratory sector , to undertake the challenges and demands for service (Especially the out of pocket expenditure of all patients has been an alarming issue and the major contributory factor for the increase of OOPE is the inadequacy of laboratory and diagnostic facilities in government hospital

Therefore the following reforms are proposed

(a) Director / Laboratory services will be re named as **Director / Laboratory Services – Logistics** to take care of all supplies (specially the reagents) Explore the possibility of manufacturing all reagents locally for automated analyzers

(b) **Director / Laboratory Services - Planning** will be responsible for planning laboratory services equipment and machinery . To perform this function S/He shall collaborate with professional colleges of Pathologists , Microbiologists , Hematologists , chemical Pathologists , Histo pathologists , Virologists , Parasitologists , Implementation of approved plans monitoring and evaluation with databases on utilization are some of the other key functions

(c) **Director / Diagnostic & Imaging Services** shall collaborate with the professional colleges of Radiologists and Interventional Radiologists to prepare plans for development of services according to UHC concept , Implementation and monitoring of Diagnostic and imaging facilities with data bases to assess utilization and cost effectiveness

(d) Director / Medical Research Institute - post already functioning but it has to be detached from DDG (ET & R) and re locate under DDG (LS)

(e) Director / National Blood Transfusion Service - post already functioning but it has to be detached from DDG (MS) II and re locate under DDG (LS)

(g) Director / Transplants and Medical Genetics - As the legal issues pertaining to transplants are on the increasing trend , Policies and legal framework have to be prepared , and approvals for all transplants should be channeled through this directorate . Medical Genetics has become a subject developing with the passing out of M.Sc qualified M.OO in Genetics , this directorate should take necessary steps to develop the services accordingly

7.0DDG - Clinical Governance & HRH

The Deputy Director General (Clinical Governance and HRH) will be a new post and under this DDG the following directorates should be located

(a) **Director / (Quality Assurance - Curative Services**) Health Quality & Patient Safety - post already functioning , but to be detached from DDG (MS) I , and re locate under DDG (Clinical Governance & HRH) This involves setting standards and indicators , monitoring and reviewing performance related quality care in curative sector . Need to collaborate with professional colleges and prepare / revise clinical guidelines .

(b) **Director / Quality Assurance (Preventive Sector)**This involves setting standards and indicators , monitoring and reviewing performance related quality care in Preventive sector . Need to collaborate with other Preventive sector programmes and prepare / revise guidelines

(c) **Director / Patient safety** This is another important area deals with adverse events reporting and analyzing it , identify the root causes , conducting clinical

	audits , death audits and does risk mitigation (d) **Director / Infection Control** Infection control at present carried out in a very vague manner .With the increase of resistance to antibiotics and poor control of infection has a huge task .It involves in proper waste management in hospitals , CSSD , & CLSD procedures , monitoring of infection control and hand washing techniques etc (e) **Director / Medical Audit & Investigations** - as the name implies the key functions would be the assessment of negligence (for this activity S/He has to collaborate with relevant professional colleges) and to protect from litigation (f) **Director / HRH** - shall be in charge of Human resource cell of the MoH , and be responsible for all HRH activities As such an officer who is a specialist in HRH should be appointed to this post (PG qualifications in HRH) (g) **Director / Heath Care accreditation -** This should be **an** independent body - all over the world it is independent . Since Sri Lanka Accreditation council for health is already established , this can be an independent body and not under department of health ; may be directly under the Ministry of Health . Establishment of Key performance indicators and standards , acts as an external body for performance reviews through those established health care key performance indicators and awarding of accreditation status (h) **Director / Medical Practice and Professional Development** deals with all issues pertaining to Medical ethics public relations and complains regarding private practice (including General Practioners) , and also arranges the CPD – Continuous Professional Development programs throughout the country . All in service training in curative sector , Credentialing of Health Professionals should also be included In addition , It has been observed that a new DDG post has been approved by the Cabinet of Ministers , as **DDG Medical Supplies** , under which the following director posts have also been approved to improve the Curative Division of the Ministry of Health (a) **Director - Pharmaceuticals** (b) **Director - Surgical Consumables & Devices** (c) Although the **Director - National Drugs Quality Control** has been listed under new DDG - Medical Supplies , it should be correctly placed under the DDG - Laboratory Services
GAP ANALYSIS by using UHC tool	Vide supra
Target areas & Beneficiaries	Vide supra

<table>
<tr><td></td><td colspan="2"></td></tr>
<tr><td>Justification</td><td colspan="2">Vide supra</td></tr>
<tr><td>Important assumptions / Risks / Conditions</td><td colspan="2">Vide Supra</td></tr>
<tr><td>Vision</td><td colspan="2">Vide supra</td></tr>
<tr><td>Mission</td><td colspan="2">Vide supra</td></tr>
<tr><td>Goal</td><td colspan="2">Vide supra</td></tr>
<tr><td>Programe Objectives

(Please prepare separate indicators for each objective)</td><td>Indicators

Vide supra</td><td>Means of Verification</td></tr>
<tr><td>Output

(Please prepare separate indicators for each output)</td><td>Indicators

Vide supra</td><td>Means of Verification</td></tr>
<tr><td>Strategies / Major Activities</td><td colspan="2">SUMMARY OF REFORMS TO CURATIVE DIVISION
<table>
<tr><th>DDG (MS) I</th><th>DDG (MS) II</th><th>DDG (PCS)</th><th>DDG (LS)</th><th>DDG (Clinical Governance & HRH)</th><th>DDG (Medical Supplies)</th></tr>
<tr><td>D/Tertiary Care HR Management</td><td>D/Medical Services HR Management</td><td>D/Primary Care Services</td><td>D/ Laboratory Services (Logistics)</td><td>D/Quality Assurance - Clinical Services</td><td>D/Pharmaceuticals</td></tr>
<tr><td>D/Surgical services Development</td><td>D/Secondary Care Services</td><td>D/ Transitional Medicine & Palliative</td><td>D/Laboratory Services (Planning)</td><td>D/Quality Assurance - Preventive</td><td>D/Surgical consumables & Devices</td></tr>
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			Care		Services	
	D/Critical Care & Emergency Services Development	D/Private Health Sector Regulation	D/Geriatric Care Services	D/ Diagnostic & Imaging Services	D/HRH	D/Cosmetics
	D/Pediatric Services Development	D/Pre-Hospital Care	D/Operational Development (Primary Care Services)	D/MRI	D/Health Care Accreditation	D/NDQAL
	D/Obstetric & Gynecological Services Development	D/ Operational Development (Secondary Care)		D/NBTS	D/Patient Safety	
	D/Internal Medical Services Development	D/Migration Health & Medical tourism		D/Transplant & Medical Genetics	D/Infection Control	
	D/Hospital Planning				D/Medical Audit & Investigation	
	D/Health Innovation & Translation Medicine				D/Medical Practice & Professional Development	
	D/Health Technology					

Reforms To Curative Division of Ministry of Health (Summary)

For more details , justifications and job descriptions of each new directorate please refer to the document titled " Reforms to the Curative Division of Ministry of Health '

Monitoring & Evaluation	Vide supra

(*) Reference to Research	**References** 1. Contributors W. Sinhalese People : Wikipedia , The Free Encyclopedia : [updated 12 August 2015 03:51 UTC 22 August 2015 14.04 UTC] Available from https://en.wikipedia.org/w/index.php?title=Sinhalese_people&oldid=675700207 2. Muller-Dietz H.E. HistoriaHospitallum 1975 3. WHO. Universal Health Coverage: World Health Organization : 2015 [Cited 22/08/2015] Available from http://www.who.int/universalhealthcoverage /unresolution/en/ 4. Dayaratne G.D. : Taking Economics : Institute of Policy Studies 2009 [IPS] Available from http://www.ips.lk/talkingeconomics/2012/09/06/oops-struggling-for-equity-in-sri-lankas-health-sector-admist-rising-out-of-pocket-expendeture 5. Sri Lanka - Health Expenditure [Internet] 2014 [Cited 22/08/2015] Available from http://www.indexmundi.com/facts/sri-lanka/health-expedeture 6. The Health Services Act of Ceylon (Act No 12 of 1952) 7. National Health Policy of Shri Lanka - 1992

Names of officials who documented the profile =

Dr Athula Dangalla , et . al

Director / Policy Analysis & Development

Ministry of Health - SL

Program title	**Reforms** **Re - Structuring Primary Level Curative Services**
Focal point	Director General of Health Services

Back ground / **Situation** Analysis *(**Problem Analysis**)

1.0 Introduction

Primary level curative service units are the frontline facilities available to any sick patient throughout the country . Therefore 906 primary care hospitals are established island wide to serve the above purpose , of which the categorization is given below .

Type of primary level curative institute	Bed capacity	Total No. of institutions
Divisional Hospital type A (DH – A)	More than 100	42
Divisional Hospital type B (DH –B)	Between 50 -100	129
Divisional Hospital type C (DH –C)	Less than 50	322
Primary Medical Care Units (PMCU)	Central dispensaries & Maternity Homes	474

Analysis of patient movement statistics , viz; percentage of patients obtaining treatment from out patient units of different types of government hospitals indicate that 69.7% of patients obtain treatment from OPD of primary care hospitals (1)

Although the OPD of primary care hospitals are utilized by patients extensively (as indicated by a higher percentage of 69.7%) the in patient facilities are utilized comparatively less as indicated at the comparison of bed availability (49.1%) with admissions (37.7%) ie; whilst observing an under utilization of in patient facilities at primary care hospitals , a simultaneous over crowding is evident at secondary & tertiary care hospitals

Level of care	OPD	Admissions	Beds
Primary	69.7%	37.7%	49.1%
secondary	14.9%	23.0%	17.3%
Tertiary	15-4%	39.3%	33.6%

The reasons for above disparities have to be analyzed ; and a re-structuring methodology has to be developed to strengthen the primary level curative institutions to offer maximum and

	personalized care to the people living in the catchment area 2.0 Background The Department of Health Services had been established under the legal provisions of Health Services Act (Act No. 12 of 1952) According to section 5 of Health Services Act , the first National Health Policy was published in 1992 and later it was replaced by the National Health Policy of 1996 . None of the Health policies have failed at least to analyze the largest curative (primary) care network in the country- the Primary Care Hospital System . Later on , to implement the Health Policy of 1996 ,a Health Master Plan had been prepared in 2006 But the same mistake has occurred once again by not considering this vital segment of Sri lankan Health system . The National Health Development Plan (2013 – 2017) too , has not identified the issues in this important sector of service delivery for the simple fact that the planners were based in Colombo- the capital city and had no experience in rural and estate settings In addition to said problem of non-recognition of PHC curative services as equal importance to other segments of Health system ; New Base hospitals (Secondary level) were established throughout the country (at major townships) as a directive from National Health Policy of 1996 But those hospitals were established under the 13 th amendment of the constitution of the country , where provincial hospitals have to be financed by the provincial councils . As provincial councils had no sufficient finances to create several new BHH in their provinces , almost all the allocations were pumped to build and equip the new BHH ; at the cost of neglecting essential improvements of PHC hospitals (a Negative externality effect of creating new set of BHH) It is true that the inward facilities of primary care hospitals are underutilized because of the fact that facilities are not available to the standards .But said underutilization has created a negative effect on allocation of funds for improvements ; a reduction in allocations to primary level hospitals with low bed occupancy rates (? allocative efficiency) making the situation further deteriorated 3.0 current Situation The primary care hospitals comprise of three basic units (a) OPD (b) Clinics (c) Wards . To offer services at these three service outlets the Department of Health Services is utilizing five resources (1) Workforce HR (2) Medical supplies (3) Biomedical equipment (4) infrastructure & Transport (5) Procedures (Clinical & administrative)It is essential to note the response of patient community to each of aforementioned eight items as the final outcome depends on the interaction of all above

The issues at present in the sector is described in the paragraphs to follow ;

3.1. **The burden of NCD and PHC hospital**

PHC hospitals had been designed during the era of epidemics of communicable diseases But after several decades at present with epidemiological transition the country has moved to an era with high incidence of non-communicable diseases The problem has been further aggravated by the demographic transition ; The aging of population But the PHC hospital system is not geared to provided curative care services for the NCD in an organized and coherent manner . The following statistics indicate the need to strengthen NCD care at PHC hospitals

Percentages of patient discharges accounted by selected NCD at different levels of health care institutions (1)

Diagnosis	Tertiary level	Secondary level	**Primary level**
Injuries	11.9	18.5	**19.7**
Asthma	1.8	3.0	**7.7**
Other Ischemic Heart Diseases	1.7	1.9	**1.5**
Malignent Neoplasms	2.5	1.8	**0.1**
Hypertensive heart disease	1.0	1.5	**3,5**
Diabetes Mellitus	1.1	1.4	**1.2**
COPD/Bronchiectasis	0.4	0,6	**0,9**
CerebroVasculer Disease	0.6	0.6	**0.5**
Myocardial Infarction	0.2	0.5	**0.3**
All other causes	81.2	72.1	64.7
Total	100,0	100,0	100,0

In response to growing patient demands the healthy lifestyle centers have been established in PHC hospitals , but several issues are identified as follows ;

3.1.1 Inadequate referrals to HLC – Life style guidance is obviously lacking to a readily accessed target population attending medical clinics where further guidance should be extended to the families of the affected

3.1.2 low coverage of at risk population (specially males)

In the rural areas majority of females are housewives and they have spare time to attend the HLC But males are engaged at their employment and find it difficult to attend HLC

3.1.3 Capacities for managing risk to be emphasized (in par with screening) ; Inadequate guidance for healthier life styles (In addition to screening functional scope has to be broaden such as with life style guidance in an effective way)

The above subject is further analyzed and proposals of **Mobile HLC at Village level**& a monitoring unit at central level termed as **NCD Bureau** ; have been submitted to the Ministry of

	Health . 3.2 **Non availability of Referral and Back Referral system at PHC hospitals** The above problem is an age old issue in the Srilankan Health system and it is further affected by the following contributory factors 3.2.1 No demarcated catchment area and no designated population for the PHC hospitals 3.2.2 Choice of access to care ; Currently people have the choice of accessing care where they wish to Although patients accessing care at primary level hospitals ; are , at times referred to specialist hospitals and these would be mainly in acute situations or in difficult to manage situations . Referrals done to prevent an adverse outcome that need to be planned on a regular basis is not a standard practice As stated in the NCD policy it is important that premature morbidity and mortality are prevented . Proper referral and Back referral policies are important to make shared care possible between primary and specialist care and also to make the health care delivery more effective and efficient 3.2.3 No Sharing of Resources Optimum use of PHC curative care facilities and also the specialist facilities of apex hospitals are not evident at present Inefficient utilization of resources at both levels with no intension of sharing is an important issue to be solved The above issues are further analyzed and the proposal of **Shared care cluster system** is now being piloted in four districts by the Ministry of Health . 3.3 **Under Utilization of In patient facilities** As evident from statistics given above the wards of PHC hospitals are under utilized(bed occupancy rate below 37%)the valuable working hours of staff deployed have become not cost-effective . There are several contributory factors to this scenario ;it is rather best name those as aggravating factors 3.3.1 Inadequate Emergency care (Emergency rooms are not available in certain PHC hospitals) 3.3.2 Inadequate sanitary and other supportive services to the patients . 3.3.3 Inadequate Laboratory facilities 3.3.4 Shortage of medical supplies The shortages are mostly experienced with the group of drugs given for Cardio vascular Diseases and Diabetes Mellitus at medical clinics of PHC hospitals .When medications and tests are not available in PHC hospitals patients are often asked to , self purchase the medications from private pharmacies , (and tests from private laboratories) or may not be given any advice at all . Thus many patients find that the cost of self purchasing medications is so expensive that they chose to go without regular medications. Consequently for many patients

	NCD are not properly managed and subsequent progression to disease complications . 16 drugs were identified as essential for management of chronic NCD at Primary level care ,Although official circulars conveyed the decision , the ground availability for patient use has not been monitored . Due to mal-distribution of drugs within the RDHS/RMSD region a quasi –demand is created at certain locations and if a proper attention is given at local level regularly these issues could have been settled with re – distribution . Prescribing drugs for limited period also pose difficulty in patient complacence and access at primary care level . A detailed analysis of distribution and availability of cardiovascular drugs at PHC level hospitals was undertaken as a research by a MD trainee attached PA & D unit in 2014 (2) This study has recommended to use a new indicator termed " Adequacy of a drug for a given period " This methodology can be used by any District to analyze the movement of drugs from RMSD to PHC hospitals . 3.3.5 Gaps in knowledge , attitudes and practices of staff to manage Chronic Disease There has been inadequate attention to the practice of standard care in management of chronic NCDs . Even through the national guidelines for management of chronic NCD (Cardiovascular Diseases) were made available there is no consistent effort to build capacities , monitor and evaluate the implementation . Under graduate medical education too focuses mainly on episodic management rather than chronic diseases which need personalized and family centered care . Teaching is mainly focused on diagnosis and management in a specialist setting rather than managing in primary care settings with early clinical preventions The discipline of Family Medicine too , is not taught in all medical faculties and the practical exposure in primary care given to undergraduates is also limited . Although the Primary Care Services unit (PCS) of MoH has been involved in orientation of post intern M.OO. who are deployed at primary care hospitals , there is no overall understanding of the required competencies for primary care M. OO. (Even the trained personnel would go back to a system that has adopted its own style of working in an episodic functional mode , priority being managing the 'condition' rather than the person's total health needs 3.4 **Non availability of personalized care to the patients** 3.4.1 Non availability of patient friendly services at PHC hospitals ;- At the moment patients are seen at the OPD as ' cases ' of illnesses and no extra care is taken as in the general practice model . If a general practice model is applied in primary care settings Out Patient Doctors can be assigned to demarcated areas . (similar to principals applied in preventive health services

	) but the areas would be much smaller , corresponding to a few Grama Niladhari divisions .Currently the availability of M.OO. at primary level is low , when compared to numbers deployed at base hospitals and above .This would also work out a rational method for employing more doctors through primary care strengthening .However a clear job description and functional scope needs to be developed to include the provision of personalized family centered care 3.4.2 In general OPD clinics the systems available to have access to Medical records for follow up (of NCD)are not efficient and at time retrieval of records fails making the patient desperate and neglected 3.4.3 Patients in rural areas , have to travel along distance , and spend a considerable time to access the clinic , and spend a significant amount of money to purchase test reports and drugs , which facilities are not available at PHC hospital .(Out Of Pocket expenditure) are the frequent complains and causes for dis-satisfaction among the public sector patients (3) 3.4.4 Inadequate facilities for patients to obtain further information about their illnesses As doctors and nurses are always busy in therapeutics , patients find it difficult to approach them to have a discussion about the illness that the patient suffers at the moment Further the family members or next of kin experience the same in seeking advice 3.5 **Non availability of Policy decisions** 3.5.1 At present the Primary Level Curative Sector has no defined and comprehensive Policy 3.5.2 Morbidity information on out patients is not available as there is no such island wide system to collect those data ; Disease categories ,treatment provided , etc. are essential data for the decision makers. Although out patient information systems were established in few hospitals this has not been assessed for purpose of information used in decision making Medical informatics need to attend as this would benefit relevant information generation in primary care settings 3.5.3 Inadequate technical cadres to provide crucial services (M . OO. ,N.OO. ,MLT T ,Dispensers) 3.5.4 Capacity for Multi task is not developed ;- currently different units are being established similar to specialized hospital setting which may not be that efficient from a health system point of view . Whilst task specialization is rational at higher level s of care , the primary care level needs to be more effective through capacities for multi-tasking 3,5,5 Performance evaluation ;- Estimation for work carried through the curative system / measurement of health performance ; is lacking . Unlike the preventive health sector where MOH areas are demarcated with assigned population (giving a denominator on which statistics can be computed) there is no designated catchment area/population for PHC hospitals

	3.5.6 The primary care facility for the people living in the surrounding area of Secondary care and Tertiary care hospitals are the OPD of said Secondary care and Tertiary care hospital But the standard of OPD in these hospitals are quite different and superior to OPD of PHC hospitals 3.5.7 A decade ago health planners stated that every citizen of Sri Lanka is able to find a health facility within 3.5 km from his/her residence , but this scenario is no more in existence due to development of new settlements in remote rural regions The government , under rural development schemes , has provided a good road net work ; electricity and schools to these new settlements and now it is the time to design health facilities for them ; considering the **Universal Health Coverage** concept (Equity , Accessibility , Quality and Financial protection) (4)	
GAP ANALYSIS by using UHC tool	Please refer to Situation Analysis	
Target areas & Beneficiaries	Please refer to Situation Analysis	
Justification	Please refer to Situation Analysis	
Important assumptions / Risks / Conditions	Please refer to Situation Analysis	
Vision	Please refer to Situation Analysis	
Mission	Please refer to Strategies	
Goal	Please refer to Strategies	
Programe Objectives (Please prepare separate indicators for each objective) 4.0 Objectives 4.1 To re-structure primary level hospitals for the management of burden of NCD effectively and efficiently 4.2 To establish a referral and back referral system for patients ; with sharing of resources 4.3 To improve inpatient (wards) facilities in primary level hospitals through enhancement of procedures and	**Indicators**	**Means of Verification**

<table>
<tr><td>infrastructure
4.4 To establish a system of personalized care for the patients
4.5 To develop capacity for multi-task at PHC hospitals and adopt performance evaluation system</td><td></td><td></td></tr>
<tr><td>Output

(Please prepare separate indicators for each output)</td><td>Indicators</td><td>Means of Verification</td></tr>
<tr><td>Strategies / Major Activities</td><td colspan="2">5.1 Strategy One
Re-structuring primary level hospitals to manage the Burden of NCD

Activities<table><tr><td>5.1.1</td><td>To appoint a Medical Officer to each Primary level hospital , titled as MO / NCD prevention ; and the catchment area is defined { No of GN divisions } for the PHC hospital for screening and healthy life style guidance</td></tr><tr><td>5.1.2</td><td>Responsiveness to current health needs to be incorporated in to this new model (in addition to standard NCD care & prevention) ie;- Elderly care / Mental health services (eg ;- counseling) Screening for preventable cancers and provision palliative care</td></tr><tr><td>5.1.3</td><td>Create a central bureau at Ministry level = NCD Bureau (similar to MOH system and Family Health Bureau) incorporating the subjects</td></tr></table></td></tr>
</table>

	related to primary care services (NCD , Mental Health , YED and Cancer Control Programmes) to regulate and monitor the activities at PHC level
5.1.4	Advocacy and awareness programs about the new system ; to be conducted in addition to training of staff
5.1.5	Periodic evaluations to improve the system

5.2 Strategy Two

Establishment of referral and back referral system ; with sharing of resources

Activities

5.2.1	Define the catchment area of each PHC hospital (similar to activity 5.1.1 above)
5.2.2	Introduction of (a) personal medical record book for the patient and (b) the clinic record book
5.2.3	Training of staff of primary level hospitals , by the consultants of apex hospital of the cluster , regarding (a) treatment protocols (b) referral and back referral system and (c) sharing of resources Eg ;- managing chronic patients at underutilized wards of primary care hospitals and obtaining laboratory and other investigative services from apex (secondary level) hospital
5.2.4	Improvement of Emergency care and laboratory services in the primary level hospital and the apex hospital of the cluster (Link to Emergency rooms of Accident & Emergency care Policy and Laboratory Policy with satellite laboratory service }
5.2.5	Advocacy and awareness programs about the system and continuous monitoring of the quality

5.3 Strategy Three

Improvement of in patient care of primary level hospitals through enhancement of procedures and infra structure

Activities

5.3.1	Development of standard Emergency Rooms in all PHC hospitals according to accident and emergency care policy
5.3.2	Each primary care hospital to be granted Rs 0.5-1.0 Mn each year to improve the sanitary and other supportive services (from National Budget /Official name of PHC hospital to be sited in National Budget to avoid diversion of allocation at provincial level) Eg In addition to repairs and improvements to existing buildings ; maintenance of patients beds , trolleys , bedside cupboards ,mattresses and bed linen , Drinking water , seating facilities at waiting areas , dispensing envelopes , electrical generators and fans dining areas and food handling utensils etc,
5.3.3	Establish satellite laboratory service at each PHC hospital with sharing of resources of apex hospital in accordance with laboratory policy
5.3.4	Monitor the Distribution and availability of essential drugs in all PHC hospitals by using the Indicator = Adequacy of Drug (2) and Train relevant staff on Good Pharmacy Practices , Lead time , Reorder level ABC system , FIFO , Proper estimation of drugs etc,
5.3.5	Training programs for staff of PHC hospitals by consultants of apex hospital { to be conducted at apex hospital as hands on training – Training Modules and clinical protocols to be developed by the colleges)

5.4 Strategy four

Provision of personalized care for the patient

Activities

5.4.1	The Medical officer in PHC hospital should be trained in Family Medicine (General Practice) model , and thereafter performance to be monitored
5.4.2	Medical Record Retrieval system should be established in all PHC hospitals The Medical Informatics Unit will be able to help the PCS unit to develop software ; Link to Health Information Policy
5.4.3	A study should be undertaken (preferably by non health research officers to eliminate bias } to assess the problems faced by patients (travelling a long distance, increased waiting times , inability to be standing for long hours in queues , out of pocket expenditure etc) and identify methodologies to grant a patient friendly service
5.4.4	**As Prof Senaka Bibile stated in his original article (5) ; Patient information booklets on major NCD should be made available to patients**
5.4.5	Trained nurses at information desks should be make available during visiting hours to provide further information to patients and their relatives

5.5 Strategy Five

Development o f National Policy on strengthening Primary level hospital services

Activities

5.5.1	Develop the national policy on PHC hospitals in terms of accepted stages of formation, formulization , and formalization

		of a policy (with incorporation of this document)
	5.5.2	Develop a methodology to identify OPD data (eg ;- at the lower edge of OPD ticket , a separate area is given to write the tentative diagnosis/ the episodes are calculated to take decisions by policy makers) MIS /IT link to Health Information Policy
	5.5.3	Cadre expansion according to the needs of PHC hospitals , and obtain the approval of Department of management services of Ministry of Finance (Initiate Training of this subject according to Cadre projections ;- Link to Human Resources Policy HRH)
	5.5.4	Currently different designations (such as MO/Public Health , /Infection control nurse / Health education nurse , etc) are being created in PHC hospitals and they perform their duties independently and it is not efficient in the point of view of health systems . On the other hand the HLC is equipped and furnished but without regular staff to provide services .Considering both situations it is proposed to develop capacity of multi-task at HLC , converting it as the **PUBLIC HEALTH (PROMOTIVE& PREVENTIVE) UNIT ofPHC curative services** . All the said officers are housed under one unit to provide a comprehensive package of services to the patients and their relatives who will be called in to this unit according to a timetable and guide for a healthier lifestyle (Inward patients with NCD will be discharged from ward ; only after counseling at the PUBLIC HEALTH UNIT of the PHC hospital

	5.5.5	Development of a mechanism to evaluate the performance of PHC hospitals ;- Link to policy on health safety and quality , and the manuals prepared by HQ secretariat (Each section of PHC hospital eg ;- wards ,labor room, dispensary , etc to be evaluated by using check lists
	5.5.6	Improve facilities of OPD of PHC hospital according to standards of OPD of Apex hospitals eg;- seating facilities , ventilation ,drinking water etc.
	5.5.7	**Non availability of health facilities at distant places can be addressed through the concept of PURA = providing urban facilities to rural areas ; ie ;- a PMCU can be established for each 10,000 population Eg;- World bank funded PMCU at WERAGAMA in Rathnapura District**

Monitoring & Evaluation

Implementation and monitoring

Strategic Area	Implementation of activity	Monitoring
Restructuring of PHC hospitals to manage the Burden of NCD	Pilot study in Divisional hospitals at three different settings ;- Urban/Rural/Estate	A separate Bureau is to be established to monitor the activities of subjects mentioned in this document
Referral system of PHC hospitals	Shared care cluster system - pilot study is conducted by PCS & OD units at four RDHS divisions Vauniya, Rathnapura, Puttalam , Anuradhapura	
Improving In patient facilities	(a) A study on Distribution and	

		availability of Cardiovascular drugs was conducted at RDHS division Kalutara& NIHS region (b) Action to be initiated by PCS , PDDHS , and RDDHS	
	Personalized care to the Patients	MoH , PDDHS , RDDHS	
	Policy issues	MoH , DGHS , PDDHS ,RDDHS	
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Name of official who documented the profile =

Dr Athula Dangalla - Director / Policy Analysis & Development

Ministry of Health - SL

Program title	**Reforms** **Establishment of a separate Division for the supply of Pharmaceucal items & Surgical Consumables , under a separate Deputy Director General (Medical Supplies)**
Focal point	Ministry of Health Director General of Health Services Deputy Director General (Medical Supplies)
Back ground / **Situation** Analysis *(**Problem Analysis**)	**CABINET MEMORANDUM** **Upgrading the post of Director Medical supplies as the Deputy Director General Medical Supplies** **Background:** Medical Supplies Division is one of the most important institutes within the Ministry of Health and is responsible for supplying and managing all pharmaceuticals, surgical Devices and Laboratory consumables with glassware to each and every state sector Health Institutions in Sri Lanka. In addition it is the sole supplier of Dangerous and Narcotic Drugs to the private sector. Currently The Medical Supplies Division is managed by the Director (Medical supplies) who is directly responsible to Deputy Director General (Laboratory services). Director 9Medical Supplies) is the accounting officer for about one third of the National Health Budget and is responsible for managing a Human Resource Cadre of more than 500. There are around 30 central warehouses in 6 different locations in the country under his purview. In addition he has to supervise and coordinate the functions of 26 Regional Medical supplies Divisions in each District with the provincial management. As these supplies are coming through a multi stakeholder supply chain he must monitor and manage the supply chain carefully. There must be a proper and smooth coordination with state Pharmaceutical Corporation, National Drug Quality Assurance Laboratory and cosmetics Drugs Devices Regulatory Authority, import

	controller, customs, local agents, manufacturers, heads of institutions and end users. As the operational processes of this supply chain is more comprehensive medical Supplies Management Information system has been developed and introduces addressing all the complex situations. Director (Medical Supplies) also contributes to achieve the objectives of the National Drug policy by introducing and monitoring rational use of medicines, adhering to Essential Medicine List and establishment and adherence to standard treatment protocols and guidelines. One of the major duties of the director (Medical Supplies) is the selection of the most appropriate items into the formula of the Medical Supplies Division for supplying to state sector health institutions. This has to be done in a more professional and tactful way by getting the fullest commitment and corporation of the professional bodies at least once in three years. To maintain an uninterrupted supply throughout the year Director (Medical Supplies) has to do emergency purchases from the highly competitive market while minimizing malpractices and corruptions using his knowledge and experience on public procurement and contract administration procedures. **Justification:** Considering all the above responsibilities of Director (Medical Supplies), it is proposed that the post of Director (Medical Supplies) to be upgraded as a Deputy Director General (Medical Supplies) with adequate authority while attending to the same operations in the same institute. Also it is proposed to include Director (National Drug Quality Assurance Laboratory) in to the purview of Deputy Director General (Medical Supplies). Under the Deputy Director General (Medical Supplies), there will be two Directors (Senior Medical Administrative Grade) responsible for pharmaceuticals and surgical items respectively. In addition there will be two Accountants and ten assistant Directors relevant sections. The responsibilities of the Deputy Director General (Medical Supplies) will be; 1. Overall supervision of all the functions of the Medical Supplies Division 2. Supervision of the supply of medical supplies in all state sector health institutions in Sri Lanka. 3. Accounting officer for the total budget of Medical supplies (which is around one third of the total

	Health Budget) 4. Promoting and monitoring rational use of medicines and adhering to the Essential Medicines List through Drug and Therapeutic Committees in the institutions all over the country. 5. Coordinating all the stake holders in the supply chain such as state pharmaceutical corporation, state pharmaceutical Manufacturing corporation, NDQAL, cosmetic Devices and Drugs Regulating Authority, Customs, Department of Import control, local and foreign manufacturers and local agents. 6. Filling up the supply gaps through local purchases in an economical manner. The cabinet of Ministers has previously approved similar upgrading of the post of Mr. J.L.M.K. Jayathilake who was the Director (Bio Medical Engineering Services) to Deputy Director General (Bio Medical Engineering Services) and Dr. Hector Weerasinghe who was the Director National Hospital of Sri Lanka to the Deputy Director General Grade, by upgrading two institutions. **Recommendations** I seek approval from the cabinet of Ministers:- 1. To upgrade the post of Director (Medical Supplies) as the Deputy Director General (Medical Supplies) 2. For the creation of two new Directorates in the Medical Supplies Division for Senior Administration Grade Medical officers under the Deputy Director General (Medical Supplies) and to include Director (National Drug quality Assurance Laboratory) to the purview of Deputy Director General (Medical Supplies). Hon Dr. Rajitha Senarathne Ministry of Health and Indigenous Medicine
Certificate of Authorization **The above Cabinet Memorandum No 15/0626/616/034 dated 12th May 2015 , had been approved by the Cabinet of Ministers of Democratic Socialist Republic of Sri lanka on 10th June 2015**	

Program title	**Reforms** **Establishment of Environmental & Occupational Health and Food Safety Division , under** **Deputy Director General (E & OH and FS)**
Focal point	Ministry Of Health Director General of Health Services Deputy Director General (E & OH and FS)
Back ground / **Situation** Analysis *(**Problem Analysis**)	**Cabinet Memorandum** **Reorganization of Public Health services – Establishment of Deputy Director General (Environmental Health and Occupational Health)** **Background** Physical, mental, social and spiritual wellbeing is defined as health. Environment where human beings and animal live has major impact on their wellbeing. It is estimated that twenty five percent of human health issues are due to environmental factors. Among the diseases large number of communicable disease are food or waterborne. Vectors of communicable diseases are also live and thrive in the environment. Environmental causes contribute to the spread of diseases, through vectors. Large proportions of non- communicable diseases like cancers, kidney diseases, lung disease neurological diseases are also caused by environmental factors. Protection of environment from air pollution, water pollution, land pollution, sound pollution and visual pollution is not only important for the wellbeing of present generation but future generations too. Growing health sector is facing with ever increasing health care waste management issues and ministry of health has to find solutions for those issues also. Availability of safe food to the general public will not only safeguard them from food borne illnesses but ensure healthier nation with optimal nutrition. Sri Lanka has a workforce around nine million at present out of which around 60% belong to the informal sector. the ministry of health is responsible for looking after the health of the workers. Since healthcare in the government sector is provided free of charge, decreasing the number of occupational injuries and diseases will save millions of rupees from the health budget in addition to savings of out of pocket expenditure by the victims and lost opportunity

	costs. On the other hand, having a healthy workforce is an asset to the nation in the expected economic growth. National Occupational safety and Health policy had been approved by the cabinet in 2014. Ministry of health has been identified as joint key holder with the ministry of labour as the ministry of health is providing preventive, curative and rehabilitative services to all workers in Sri Lanka. Implementation of the activities recognized in the National Occupational safety and Health policy is also national requirement. At present all above subjects are managed by a Director environmental Health and Occupational Health without adequate financial, human, and other resources. Therefore directorate is not in a position to handle the tasks mentioned above. The present food control unit is headed by an assistant director. In addition a technical capacity of the unit is also insufficient to face present and future challenges. **Justification** Public health services need to be strengthened to address the present environmental and occupational health services. Provision of preventive care services is a responsibility of the government. Introduction of new policies, policy instruments, strategic planning and implementation of identified public health interventions are required to achieve optimal public health situation. Such activities need sufficient financial allocation and by creating separate Deputy Director General position, ear marked allocation can be made. Monetary allocations to public services need to be monitoring and evaluation of the social and health impact of the policies and new interventions are necessary. Further improvement of the public health services, by planning, research and development need to be carried out. Development of occupational health services according to the national policy is a priority. In the above context ministry of health has identified the necessity of reorganization of the managerial functions of the public health services to achieve the said objectives. It is proposed to upgrade the present environmental and occupational health unit by appointing New Deputy Director General in charge of the unit.

	Following new positions are proposed. 1. Deputy Director General (Environmental and Occupational Health and Food safety) 2. Two Assistant Director posts and 3. Two Food Safety Officers 4. Two public management assistants The presently existing posts of Director Environmental and occupational Health, Director Food safety, Deputy Director Environmental and Occupational Health will be incorporated in to the proposed unit under Deputy Director General (Environmental and Occupational health and food safety) according to the annexed organization chart. **Terms of reference of the proposed Deputy Director General (Environmental Occupational health and food safety)** 1. Report to the Director General of Health services. 2. Provide Technical, Managerial leadership in Environmental Health, Occupational Health and Food safety issues. 3. Provide advocacy to the other units of the ministry of health, other institutions and ministries of the government on Environmental Health, Occupational Health and Food safety issues. 4. Represent ministry of health in environmental Health, Occupational Health and Food safety issues. 5. Identify priority Environmental Health, Occupational Health and Food Safety issues and propose policy directions and develop strategic plans to address such issues. 6. Supervise, monitor and evaluate and follow-up work plans of submits under the directorate. **Recommendations** 1. Establishment of Deputy Director General (Environmental and Occupational Health and food safety) to manage the subjects of

	environmental health, Occupational Health and Food safety under the given term of reference is recommended. 2. Creation of new carder positions viz, Assistant Director Environmental health, Assistant Director legal and international affairs and two food safety officers with appropriate qualifications and experience also recommended to appoint under the new position recommended by above(1). 3. Appropriate budget heads to be assigned to the new programmers and adequate capital and recurrent budgetary allocation to be allocated from the year 2016. Hon Dr. Rajitha Senarathna Ministry of Health and Indigenous Medicine

Program title	Reforms **NUTRITION BUREAU**
Focal point	Director General of Health Services
Back ground / **Situation** Analysis *(**Problem Analysis**)	**(Text obtained from White paper to retrieval of Preventive Health Services - a publication of College of Community Physicians of Sri Lanka , 2015 , 17 – 18)** Currently the Nutrition programmer is fragmented and is managed by four different directorates that have led to lack of efficiency and ineffectiveness due to poor coordination. 1. FHB – all aspects of Maternal and child nutrition including policy and strategic direction, capacity building, guideline development, logistics support, monitoring and evaluation. 2. Nutrition Coordination division – Thriposha production and distribution, coordination with National Nutrition Secretariat (NNS) of Sri Lanka and stakeholders within the Ministry of Health, coordination of District Nutrition Action planning. 3. MRI - Nutrition research 4. Nutrition related areas not covered by the above units.
GAP ANALYSIS by using UHC tool	**(Text obtained from the publication of Government Medical Officer's Association (No GMOA/SH/2014/69 dated 23 May 2014) Titled - proposal to establish the nutrition service in the Health system of Sri Lanka)** Low and middle income countries such as Sri Lanka are currently experiencing a double burden of disease. Malnutrition and infections constitute one end of the disease burden, while non-communicable diseases such as Diabetes, Cardio vascular diseases constitute the growing burden of diseases among adults and elderly. (1). both burdens can be effectively addressed by appropriate nutrition interventions both curative and preventive sectors. Importance of dietary therapy in disease was addressed at ancient times by ancient Ayurveda therapy. Currently it is being replaced by modern nutrition therapy in allopathic medicine. It extends far more beyond than provision of a "diet" to a patient. The wide spectrum of nutritional interventions range from advises on health living to providing nutrition therapy to overcome from infectious diseases (2). Clinical nutrition was recognized as a sub specialty in allopathic

	medicine in 1979. (3) In comparison to other sectors, Sri Lankan health sector has greatly improved over past few decades providing our patients with best evidence based care. However for the past 35 years we have failed to introduce the specialty of clinical nutrition, which would have been contributed to optimum patient management for a long time. Multi-disciplinary approach is recommended in providing patient centered care for diabetic and other non-communicable diseases (4). Currently Sri Lankan health sector experience a large number of patients with non-communicable diseases both as in hospitals and in the community. 95) Providing them with optimum care becomes a difficult challenge if adequate specialists in relevant fields are not available. Nutrition clinic is a facility which can provide care for diagnosed patients with many disorders and to many health seeking individuals with many risk factors. It is capable of providing individual dietary assessments and make dietary and nutritional prescriptions for individuals. But it requires trained medical nutritionists for its functioning in full capabilities. Conducting medical research on nutrition and providing guidance for policy making in nutrition is also necessary. The growing body of nutrition research needs to be reviewed at national level and guide the policy makers in accordance. **Current Health System in Sri Lanka** There are multiple gaps in service provision in clinical nutrition in current hospital setting. 1. There are multiple institutions and committees work in improving the nutritional status of the community, but curative aspects in human nutrition is totally overlooked. 2. Nutrition in curative sector depends on a dietician who is trained on food technology, dietary aspects of food but not on human nutrition which is a medical specialty. As a result patients suffer with inaccurate dietary instructions and prolonged hospital stay. 3. Many medical disorders has dietary therapy and nutritional interventions as a component in non-pharmacological management of the disease (ref – national guidelines) We are unable to provide a total comprehensive patient oriented care in those burden of inappropriate care contributes on the cost of the health sector both directly and indirectly. 4. There are patient groups such as ICU patients, cancer patients, renal patients and surgical patients who require special nutritional care. Currently their nutrition is being looked after by other specialists. But there is a great need of medical nutritionists to take over the nutritional aspects of those patients. 5. Evidence based medicine on clinical nutrition hardly

	reaches the clinical practice due to lack of specialists in human nutrition. 6. Nutrition clinics currently operated at some hospitals lack human resources, appropriate training and dietary prescriptions are not made. Ultimately the facility which can contribute immensely to the community is highly under-utilized.	
Target areas & Beneficiaries		
Justification		
Important assumptions / Risks / Conditions		
Vision		
Mission		
Goal		
Programe Objectives (Please prepare separate indicators for each objective)	**Indicators**	**Means of Verification**
Output (Please prepare separate indicators for each output)	Indicators	Means of Verification
Strategies / Major Activities	**The CCPSL recommends** that the Nutrition Directorate should be the responsible agency that will coordinate all nutrition related issues for policy making and decision within the Ministry of Health. The Nutrition Directorate shall have the following staff. **Director Nutrition (Overall Program Manager):** • Director will lead the nutrition programmer and coordinate with other relevant units within and outside the Ministry of Health **Deputy Director:** • Responsible for logistics management of the programmer • Coordinate the Thriposha program **Program Coordinator / National Nutrition programe**	

development
Following are the key activities of NPM (National Nutrition programmer development),

- Develop food – based dietary guidelines
- Coordinate with other sectors under the mandate of the NNS; Minister of Health, Secretary Health
- Coordinate and be the focal point between the Ministry of Health and the NNS
- Be responsible for nutrition and nutrition related surveillance

Programe Coordinator / Clinical nutrition
The NPM for clinical nutrition will be responsible for implementing nutritional programmers for all target groups through the respective units of the Ministry of Health.

Programe Coordinator / Nutrition Research
Nutrition research should be a function of the MRI. The NPM for Nutrition research should be located at the MRI.

The GMOA recommends

Curative sector
To fulfill the gap in service provision in nutrition at the hospital setting we propose the following changes.

1. Establish a Nutrition team to all base hospitals and above. The team will function directly under the hospital administrative head (Director, MS) and will be headed by a consultant Nutrition physician. The following hierarchy will follow.

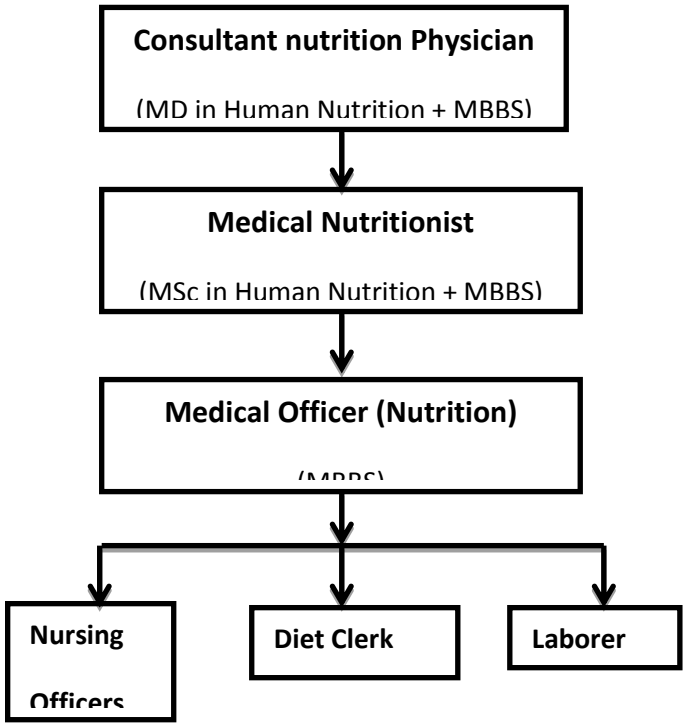


Figure 1 – Administrative hierarchy and basic qualifications of Nutrition team in the hospital

2. Job descriptions for the above categories will be as follows:

	Position	Job description
	Consultant Nutrition physician	• Work in collaboration with other specialties (pediatric, medical, renal, surgical, obstetric, endocrine) in providing optimum nutrition management for diseases • Provide nutrition prescriptions and optimal nutrition care for special groups of patients such as ICU patients, cancer patients etc. • Providing in patient and outpatient care for patients with eating related disorders and

			nutrition related disorders and arrange their follow up.
		Medical Nutritionist	• Contribute with in patient care on nutrition management on referral • Conduct a nutrition clinic within the hospital premises • Provide individual nutrition assessment and dietary prescriptions • Nutrition counseling services for both in ward and out patients in the hospital setting and on referrals by MOH • Providing technical guidance to Health Education Unit, NCD units and public health units regarding Nutrition • Contribution to capacity building of hospital staff regarding nutrition and public health staff on request by provincial health authorities • Provide expert opinion for authorities regarding nutrition and food related issues at central and provincial level.
		Medical officer (Nutrition)	• To assist consultant in ward rounds and provide in patient care • To conduct the nutrition clinic • Assist in outreach programmers on nutrition by the nutrition team in the hospital
		Nursing Officer	• Provide in patient nursing

		care • Organize nutrition clinic • Assist in the clinic with anthropometric measurements and providing clinic services • Provide routine services at ward setting
	Diet Clerk	• prepares summary sheets by calculating the total diets from each category or the total hospital • Maintain a record of special diets nutritionist and ensure availability and distribution • Assist in coordination of supplying diets to the patients in crisis situations • Communicate with nutrition team for better patient management in processing dietary information
	Laborer	• Assist in housekeeping of the clinic and wards • support in clinic organization • Provide routine supportive services

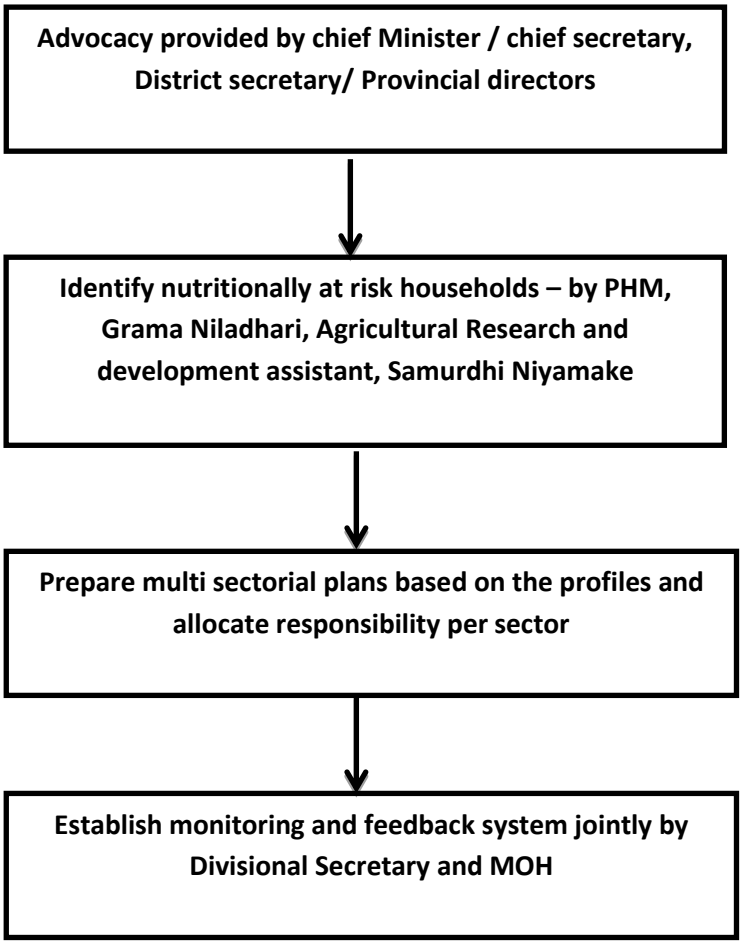
3. Cadre distribution

At the initial stages Medical nutritionists will be located at base hospitals and above in a nutrition unit in the hospital premises. They will fill the cadre by at covering at least one hospital in district. Proposed initial distribution is attached here with.

Preventive Health Sector

National nutrition steering committee has initiated a national nutrition strategic plan for nutrition which is based on the multi sectoral model. It is operated at provincial level and below based on nutrition needs identification and individual interventions by variety of stakeholders 96).

Figure 2 – Level of activity in the multi sectorial approach in improving nutrition



To operate this system of activity, we require a coordinator to operate at divisional level, to create links at different stakeholders acting on nutrition. A qualified nutrition graduate would be the ideal person to fill this gap in services.

Job description of Nutrition coordinator

- Create the link between the divisional nutrition committee with district and provincial level.
- Coordinate nutrition interventions between various stakeholders operating at both village and divisional level
- Contribute actively in nutrition review meetings conducted at Divisional and district level.
- Participate and contribute at the monitoring and feed back system operated at the divisional level.

	Summary In the current context, sri Lankan health system lacks Medical nutritionist and related nutrition team in the hospital sector, to a level with compromised patient care. The proposed nutrition team in the hospital setting will be capable of providing best evidence based nutrition care for the patients. Simultaneously nutritionally trained graduates can be in cooperated to the evolving multispectral nutrition programmer to improve its efficiency and efficacy.
Monitoring & Evaluation	
(*)Reference to Research	1. Bygbjerg IC. Double burden of non-communicable and infectious diseases in developing countries. Science (New York, NY). 2012; 337 (6101):1499-501. Epub 2012/09/22. 2. Burris J, Rietkerk W, Woolf K. Acne: the role of medical nutrition therapy. Journal of the Academy of Nutrition and Dietetics. 2013;113(3):416-30. Epub 2013/02/27. 3. Herman RH, Hagler L. Clinical Nutrition is a Medical Specialty – Introductory remarks (symposium on clinical nutrition). Western journal of Medicine. 1979;130:93-4. 4. Clinical Guidelines Task Force. In patient care. Brussels, Belgium: International Diabetes Federation : 2012. 5. Department of census and statistics. Annual Bulletin of Medical statistics. Colombo: Ministry of Finance and Planning, 2009. 6. Presidential Secretariat, National Nutrition council of Sri Lanka. About Us. Presidential secretariat; 2013 [cited 2014 13/03/2014; available from: http://www.nutrition.gov.lk/index.php/about-us.

Name of official who documented the profile =

With acknowledgements to Government Medical Officer's Association and College of Community Physicians of Sri Lanka ; the aforementioned reform – proposal was documented by DrD.A.B.Dangalla Director / Policy Analysis & Development - Ministry of Health

Program Title	**Incorporation of Geographical Information System (GIS) in to Health Information System**	
Focal Point	**DDG (Planning)/ Director (Information)**	
Background	Most of the diseases are related with environment. GIS is increasingly used in health sectors in developed countries. This will help in many areas such as disease mapping, disaster management, epidemiological trend analysis, information sharing etc. Public health is an area where GIS can be applied in decision making to give maximum output with limited resources. Data sharing through web GIS is another area need to be developed in Sri Lanka. Currently application of GIS using e software is limited and not sustainable.	
Issues identified	1. Knowledge on GIS software among health staff is very limited 2. Application of GIS software in health system is limited 3. Training opportunities in GIS is limited in Health sector 4. GIS licensed software is expensive therefore usage is limited 5. No proper GIS training module for health sector is available yet 6. Web GIS is limited in Sri Lanka	
Target areas and beneficiaries	Public health programmes related to environment impact Disaster management Shared care cluster system	
Justification	GIS has to be incorporated into health sector in large scale. But trained staff with GIS software manipulation is very limited in health sector in Sri Lanka. Therefore systematic approach should be implemented to capacity building of health staff in GIS.	
Important Assumptions/Risks/Conditions	Retaining of trained staff in health service is essential to achieve expected outcomes	
Vision	Wider use of GIS in Health System in Sri Lanka	
Mission	Systematic training of health staff in GIS	
Programme Objectives 1. To train health stain GIS 2. To establish web GIS in Ministry of Health	Indicators 1. Percentage of RDHS offices practicing GIS software 2. Percentage of MOH Offices	Means of verification 1. FHB 2.

	Practicing GIS software 3. Percentage of Health staff with capacity to work in GIS software	
Output 1. Web GIS implemented to share information in Ministry of Health	Indicators- (%) 1. Number of RDHS offices sharing information in Web GIS	Means of verification 1. Information Unit of Ministry of Health
Strategies / Major Activities	Major activities 1. Preparation of a GIS training module applicable to Ministry requirements (Open source software training module eg. QGIS is better option than licensed software0 2. Establish a training GIS training center in NIHS 3. District level GIS training programmes for public health staff- MOH, PPA, DA attached to MOH offices to be conducted (At least one officer from each MOH should have trained in GIS 4. Preparation of Public Health layers (MOH, PHI & PHM layers) in GIS 5. Web GIS system to be implemented National level & District level to share information	
Monitoring & Evaluation	Periodic reviews to be conducted to assess a. Progress of training of staff in GIS b. Percentage of RDHS offices implemented GIS in their routine systems c. Percentage of trained officers practicing GIS in MOH offices d. Progress of web GIS system at National and district levels.	
(*)Reference to Research		

Prepared by –

Dr. K.D. N.P.Ranaweera – Senior Registrar in Community Medicine/ Policy Analysis & Development Unit under the guidance of Dr. D. A. B. Dangalla, Director/ Policy Analysis & Development

Program Title	**Proposal to establish a Procurement Monitoring Coordinating Unit at the Ministry of Health**
Focal Point	**Secretary of Health/ DGHS**
Background	Procurement of drugs for Health department is mainly done through the State Pharmaceutical Corporation at three levels of tenders namely Cabinet level, Ministry level & Departmental level. Procurement of Drugs involves several steps – a. Ordering of items by Medical Supplies Division b. Preparation of Specifications c. Approval of Tender documents by the Tender Board d. Tender calling , tender opening e. Technical Evaluation f. Tender awarding The above activities are conducted by different units a. Medical Supplies Division b. State Pharmaceuticals Corporation c. Procurement Branch d. Technical Evaluation Committee Coordination Unit e. Drugs Regulatory Authority f. NDQAL Lack of coordination among the above units lead to a delay in procurement of resulting shortage of medicines in health institutions. Inability to award tenders within the bidding period give rooms to the bidders to increase their bidding prices leading additional cost for drugs Ministry of Health has to local purchase drugs at higher prices to overcome drug shortages making the financial situation worst.
Issues identified	1. Delay in preparation of Specifications 2. Some consultants made suggestions in specifications which are difficult to incorporate 3. Refuse or inability of some consultants to participate for Technical Evaluation Committees after they were appointed 4. inability to award tenders within the bidding period giving room for bidders to increase their bidding prices

	5. Delay in laboratory testing of quality of medicines leading 6. Lack of coordination between units involved in procurement process	
Target areas and beneficiaries	Target area - Medicines purchased by the Ministry of Health through the State Pharmaceuticals Corporation at Ministry & Cabinet level tenders& Essential medicines with frequent shortages. Beneficiaries – Patients attending Government Health Institutions seeking treatment	
Justification	Proper monitoring & coordination between different units involving procurement of Medicines is essential to avoid to delay in tender process.	
Important Assumptions/Risks/Conditions	High level commitment is essential.	
Vision	Provision of uninterrupted quality assured medicines for government health institutions	
Mission	Improve coordination & Monitoring of procurement of Medicines	
Programme Objectives 1. To minimize delay in procurement of medicines beyond the bid validity periods.	Indicators 1. Percentage of cabinet & Ministry level tenders awarded within the bid validity period	Means of verification 1. State Pharmaceuticals corporation
Output 1. Reduction of number of medicines locally purchased to avoid shortages 2. Reduction of local purchase drug cost	Indicators- (%) 1. Number of drugs locally purchased/ Total number of drugs purchased in cabinet & Ministry level tenders 2. Cost spent for local purchase of drugs/ Total cost of drugs spent for Cabinet & Ministry level tenders	Means of verification 1. State Pharmaceuticals Corporation 2. Finance division of Ministry of Health
Strategies / Major Activities	**Strategy** -Establishment of Procurement Monitoring Coordinating Unit (PMCU) at the Ministry of Health **Composition of PMCU** • PMCU should be Directly under the Supervision of Secretary of Health/ DGHS • DDG (Laboratory Services) • One Representative from following Units (above the level of Assistant Director or Senior Medical Officer)	

	- Drugs Regulatory Authority - Medical Supplies Division - State Pharmaceuticals Corporation - Procurement Branch of Ministry of Health - Technical Evaluation Committee Coordinating Unit - Finance Division of Ministry of Health • Secretary to the PMCU – Senior Medical Officer Qualified in Medical Administration and procurement PMCU should meet once in two weeks at the office of Secretary of Health/ DGHS **Major Activities** • Identify Medical Supplies coming under purview of PMCU - Cabinet level tenders - Ministry level tenders - Essential Medicines with frequent shortages • Preparation of updated database on a. List of Medicines under purview of PMCU and their monthly requirement , consumption & stock positions b. Consultants to be invited for technical evaluation of medicines c. Registered suppliers list d. Testing capacity of NDQAL and SPC e. Testing institutions for medicines where testing is not available in Sri Lanka • Monitor the progress of procurement of identified medicines to ensure their availability on time • Establish an electronic bar code system using GPS technology to locate each tender file • Identify procurement files stagnant unreasonably in one unit • To coordinate with relevant stakeholders to ensure the timely availability of Medicines. • To make necessary recommendations to Secretary of Health/ DGHS to improve the efficiency of Procurements • To report to Secretary of Health/ DGHS on progress of procurement of medicines monthly.
Monitoring & Evaluation	Secretary of Health / DGHS should monitor & evaluate the progress of PMCU.
(*)Reference to Research	

Prepared by –

Dr. K.D. N.P.Ranaweera – Senior Registrar in Community Medicine/ Policy Analysis & Development Unit under the guidance of Dr. D. A. B. Dangalla, Director/ Policy Analysis & Development

Acknowledgement - Dr. H.D.B. Herath – Director / Anti Malaria Campaig

Program Title	Proposal to strengthen the primary care delivery through family practice approach and work towards universal health coverage : 2017 and beyond **(Reforms of Primary health care delivery system)**
Focal Point	D/Primary Health Care Services
Proposal Submitted by	Sri Lanka College of General Practitioners
Background	A high-quality primary care service is a tested system to bring out optimal outcomes to maintain and improve population health. This type of care is best known to save healthcare costs, control access to secondary care services, tailor services to local population needs and help patients make use of an increasingly complex healthcare system. According to the Annual Health Bulletin 2012, over 100 million consultations take place as outpatients every year .Majority of these consultations are carried out at primary level both in the private and state sector. Services that were traditionally provided in a secondary care setting are also moving closer to home into the community. We have a fast growing ageing population with multiple health problems. There are also increasing financial constraints specially for the majority poor .Cost-effective, integrated care is an answer to these problems. Family practice is a unique specialty with its own characteristics. Its foundation is based on basic principles such as first contact care, personalized and family care, continuation of care, comprehensive care, coordination of care, and preventive care. It aims to provide first contact patient centered care, irrespective of age, gender, illness or disease on a continued basis for patients and families. Correct application of this concept to our resource poor out-patient settings will benefit the patients as well as the state. It is this approach which is adapted in developed countries to achieve universal health coverage.Majority of the problems that we in Sri Lanka face at present could be managed efficiently and cost effectively at primary level if the doctors who deliver primary care are trained in this approach as well as they are given opportunities to update themselves in clinical medicine

GAP ANALYSIS by using UHC tool	
Target areas and beneficiaries	1. Organized outpatient services will minimize patient waiting time, unnecessary admissions, drug wastage and proper utilization of laboratory facilities. 2. This system will provide opportunistic and population level screening of NCD and proper utilization and management of resources. 3. This System will also provide an organized referral system. 4. Electronic Medical Record (EMR) – Will ensure establishment of a health information system. It will help the clinician to retrieve data quickly and enable proper patient management, appropriate referral, avoid unnecessary admissions, efficient prescription of drugs and minimize wastage of resources and duplication. 5. EMR will facilitate continuity of care of patients and families and also enable follow-up and screening of NCDs and patients with chronic diseases. 6. Giving personalized care will improve patient satisfaction and compliance with health promotive disease preventive strategies at primary secondary and tertiary levels of prevention 7. Each person will have a physician accountable for his/her health. Continuity of long term care will be established. and there will be a doctor to whom secondary and tertiary care referrals can be made 8. Ageing Population will be better looked after with provision of home visits 9. More people will utilize facilities at primary care level and decrease over crowding of facilities at 2ry and 3ry care level 10. Universal health coverage will no more be a dream
Justification	The burden of Non Communicable Diseases (NCDs) which require care for long periods or even throughout life is increasing in the country. The demographic transition projects an increasing population of the elderly with multiple diseases .These diseases are best managed throughout patient consultations. According to the latest data available, there were 50.6 million primary care (first contact) consultations at the Outpatient Department (OPD) of the public sector hospitals while only 5.8

	million patients were given inward care (Annual Health Bulletin 2012). This shows the magnitude of the outpatient services rendered by the public sector throughout patient departments. These consultations are carried out by doctors without specialty training in primary care. This vital component of patient care services and the vast potential in primary care has not been recognized and measures have not been adopted to upgrade it to its maximum capacity in the Sri Lankan health sector. The need of a strong primary care system has been long understood by the developed world. Presently these countries have a systematic well developed primary care system which is a pivotal component in their health care service. Patient record keeping, research and teaching are essential components in the development of Primary Care which is presently lacking in state outpatient settings.
Important Assumptions/Risks/Conditions	There are Hospitals with different facilities and different cadre positions for Medical officers and specialists . Services are fragmented and episodic. Out of pocket expenditure for the patient is a known component of the system even though the health services are free of charge. There is no proper forward or back referral system and patients refer themselves to health care facilities There is no doctor accountable for the health of a given patient or to monitor one long term We still run on a clinic system which are highly congested and only drugs are repeated The smaller hospitals are grossly underutilized and larger hospitals are overcrowded. Our Doctors are still some of the best trained in the Region if not in the World. Majority deliver primary care but have no access to post graduate training and little recognition for the work they do. The PGIM has a training programme to board certify specialists in Family Medicine. In the next ten years we envisage a minimum of 35 doctors who will be specialists, at least 500 diplomats .CGPSL will also train at least 350 doctors at Diploma level. College will train more if given the infrastructure and funds. Every year a minimum of 1200 doctors are registered by the SLMC . These doctors are registered to provide unsupervised primary care without any further post graduate training.
Vision	Our vision is to develop a strong primary led patient care services in the country where every citizen has access to a family doctor.
Mission	Our mission is to achieve as far as possible universal health coverage for all citizens of Sri Lanka with doctors trained in the family practice approach working in state and private sector providing accessible cost effective quality primary care services to all citizens of Sri Lanka.
Goal	To provide Comprehensive care, continuity of care, coordination of care, a patient centered personalized approach, health

	promotion and disease prevention practiced for a cohort of patients who wish to register at this family medical unit.	
Programe Objectives (Please prepare separate indicators for each objective)	**Indicators**	**Mean of Verifications**
1. To Re organization of Out Patient department with family practices approach and patient centered personalized approach. 2. To Establish a referral and back referral system of primary level care institutes 3. To improve Capacity building and professional development of the family medical disciples 4. To Establish monitoring and evaluating services rendered to the public through this system with the specialist family physician 5. Strengthening the Primary care services in all primary care institute without upgrading	No of Family medicine unit established No of referral and back referral in each level of hospital No of Training programme conducted	
Output **(Please prepare separate indicators for each output)**	**Indicators**	**Mean of Verifications**
1. establish a family practice unit within the already existent Outpatient Departments of largest hospitals as a pilot project 2. Appoint a family medical specialist for each family practice unit 3. Assign a personal doctor for individual/ family for preserved a continuity of care 4. Capacity building and professional development of family medicine 5. introduce family medical approach to all primary care institute 6. To demarcated an area around the primary care institute and	No of family practices unit established No of Consultants appointed GP/Population Ratio No of Medical officers trained No of hospital adopted family medical approach	

assign a medical officer for the demarcated population. 7. Provide a personal and clinic health records to all registered patients in Primary health Clines and future introduce an electronic record. 8. Appoint a Medical officer for coordinate primary care services activity with central level	No of personal health records and clinic health records issued No of MO/PCS appointed (One per district)	
Strategies / Major Activities	**Indicators**	**Mean of Verifications**
1. To establish a family practice unit within the already existent Outpatient Departments of largest hospitals as a pilot project. 2. OPD reorganized as the Primary Care Department and appoint a specialist Family Physician board certified by the PGIM as the leader of the Family practice unit and conduct this unit as a model family practice unit. 3. To introduce the family practice approach to the smaller hospitals where patients will be registered, clinic and a person held records introduced and continue services for them using the family practice approach. The smaller hospitals will have a designated referral hospital for forward and back referral and staffs who need to visit the community. 4. To continue appointment of specialist family physicians in the divisional hospitals as of now and ensure that these hospitals to provide care in their areas using the family practice approach ensuring referrals are seen by the Consultant Family Physician and team and problems attended to and	No of hospitals selected for pilot project No of existent OPD converted to family medical unit No of health records issued No of referrals and back referrals for each level of hospitals	

referred back or referred for secondary or tertiary care services in the main hospital and back referrals made . 5. These hospitals should be developed and equipped to deliver quality primary care services. Here too staff should be designated to visit the community. 6. To provide all doctors in primary care in both the state and the private sector , means of career progress and capacity building by giving them access to training programs such as the Diploma in Family Medicine , MCGP of the College of General Practitioners of Sri Lanka providing them with necessary leave and access to training units . 7. To maintain a first contact care service as it is now established in the outpatient departments of large hospitals till such time the whole outpatients department will function as a group family practice and providing emergency care services and out of hours services . 8. The Ministry of Health to establish monitoring and evaluating services rendered to the public through this system with the specialist family physician as a part of the team with support from the professional body, the College of General Practitioners of Sri Lanka . 9. To establish a strong primary care system with a community hospital in the area which will be developed as a primary care hospital and not upgraded as		

secondary care hospital? 10. To support the already existent private general practices which would also function as model family practices and allow patient registration in these practices 11. To ultimately provide a system where each person of this country has a doctor to whom he can go to for first contact who will be accountable for his/her health . 12. To give the Private GP also direct referral to specialist clinics for his patients that the larger hospital provides, provided he/ she formal qualifications in Family Medicine. Thus the private sector also becomes a part of the referral system. 13. Incentives to be given to those doctors who choose to reside in a community and serve a population continuously in the capacity of a full time GP.		
Monitoring & Evaluation	Central Level – Ministry of Health (Director Primary Healthcare Services),Provincial, District Level – PDHS, DPDHS, Overall and detail supervision by MO/PCS. Monthly, annually reports – Periodical Reports and routine report through District MO/PCS	
(*)Reference to Research		

Program Title	**Methodology to ensure availability of Medicines in hospitals with district**
Focal Point	**Regional Director of Health Services (RDHS)**
Background	Drugs shortage is a common issue in most of the health institutions. While one institution facing a shortage of medicines, other institutions may have excess of stocks of the same drug leading to destroy excess stocks after passing the expiry date. Rational use of drugs may have economic savings without affecting patients. Ministry of Health has taken various steps to overcome institution drug shortages. RDHSs can play a key role in ensuring essential medicines in health institutions under their purview.
Issues identified	7. Frequent shortage of some medicines 8. Excess of stocks of some medicine 9. No proper mechanism to interchanging of medicines between institutions in the same RDHS region 10. System of failure in reporting about stock positions 11. No accepted methodology to compare overall availability of medicines between health institutions in district.
Target areas and beneficiaries	Target area - Medicines availability in Health institutions in RDHS region Beneficiaries – Patients attending government health institutions
Justification	A methodology is required for RDHS to monitor the availability and adequacy of medicines in health institutions under their purview. This will help to overcome shortage as well as wastage of medicines.
Methodology	**Drugs Adequacy Index** (DAI) Balance stock of a drug at the end of a month DAI = —————————————————— Average monthly consumption during last 3 months If DAI < 1 →stocks Inadequate DAI 1-3→May adequate up to next 3 months DAI 4– 6 → Risk of overstock DAI > 6 → Overstock Drugs with DAI < 1 are at risk of a shortage of that drug with in the same month if actions not taken. Institutions with DAI > 6 of the same drug may request to shift their excess stocks to institutions with DAI <1 to

	overcome possible shortage. • Institutions should send monthly return of DAI of each medicine use in their institutions to the Divisional Pharmacist. • Divisional Pharmacist should maintain computational data base (excel sheet) to summarize the ADIs of the district in each month (A colour code may use for easy identification) • This summary sheet can be used to advise RMSD to shift drugs between institutions to avoid shortage and wastage of drugs.

Prepared by Dr. K.D. N.P.Ranaweera – Senior Registrar in Community Medicine/ Policy Analysis & Development Unit based on MD thesis submitted to Post Graduate Institute of Medicine, University of Colombo in 2014.(prasadrana@hotmai.com)

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