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NATIONAL HEALTH

STRATEGIC MASTER PLAN

2016 - 2025

Vol. III

Rehabilitative Services

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 III

Rehabilitation Care

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	**Stroke & Trauma Care**	
Focal point	DDG (MS 1)	
Consultant	DrUdayaRanawaka Consultant Neurologist Faculty of Medicine - Teaching Hospital Ragama	
Back ground / **Situation** Analysis *(**Problem Analysis**)	Prevalence of stroke is about 1% of the population (Surveillance done in 2001 & 2006- Results same even with aggressive preventive measures) Stroke units – Only units (TH Kurunegala – Custom based stroke unit with 20 beds). Others NHSL, THCN, SJGH, Rathnapura, Badulla, Kalutara. Recently started in Matara, Polonnaruwa&Baticoloa) Total bed strength 100 including TH Kurunegala for population of 21 million). In addition Five Rehabilitation hospitals – Ragama, Digana, Jayanthipura in Polonnaruwa, Kandagolla in Badulla district).	
GAP ANALYSIS by using UHC tool		
Target areas & Beneficiaries	Stroke & trauma care. Patients with strokes & patients at high risk of developing strokes	
Justification	Prevalence of strokes (in 2001) was about 1% of the population. Even after establishing stroke units and rehabilitation hospitals & stroke prevention activities in Sri Lanka, the prevalence remained same in 2006. Therefore it is necessary to have a proper strategic plan for organized preventive activities, Stroke centers &Neuro rehabilitation centres managed by multi-disciplinary teams.	
Important assumptions / Risks / Conditions	Need adequate financial allocation for infrastructure, modern high-tech equipment and trained man power.	
Vision	Improve stroke & trauma care in Sri Lanka	
Mission	Through establishment of equitable efficient accessible quality Stroke & trauma care in Sri Lanka.	
Goal	Improving Quality of Life in Patients with Stroke & Trauma care	
Programe Objectives	**Indicators for acute care**	**Means of Verification**
1. To provide equitable efficient quality of stroke care to people in Sri Lanka	**1.** No.of Stroke Units in Sri Lanka **2.** No.of Provincial Stroke centers in SL **3.** No of Thromboitic	**1.** Hospital patient registers – Stroke & Trauma registers **2.** IMMR returns 3. Research & Surveillance reports **4.** Clinical Audits

	Centers 4. No of centers with Mechanical Thrombectomy facilities **Indicators for Rehabilitative care** 1. No. of distric level rehabilitative units 2. No. Provincial level rehabilitative Units 3. No. of Community based rehabilitation clinics	
Output 1. **Established Stroke unit in each District General Hospital** 2. **Stroke center with 100 beds equipped with multi-disciplinary team in each province in Sri Lanka**	Indicators 1. # of strokes units / # of DGH 2. # of Stroke centers / 9 provinces	Means of Verification
Strategies / Major Activities	Provision of Improved Curative & rehabilitative care for stroke & trauma patients Activities **Acute care** 1. Establish a stroke Unit in each District General Hospital in Sri Lanka (Bed strength- Male beds 20, Female beds 20 2. Fully equipped one Comprehensive stroke center including Multi disciplinary Services (Neuro Radiologist, Neurosurgeon, Vascular Surgeon, Consultant in Neuro Rehabilitation & Cardiologist, Occupational Therapists, Speech Therapists) in each Province & in all Teaching Hospitals in Sri Lanka 3. Develop one Thrombolitic Center with IVTPA or Newer Thrombotic Cenin in Each Province 4. Developing Mechanical Thrombectomy Service for ischemic stroke with Interventional Neuro Radiological Service in Each Province **Rehabilitation care** 1. Acute phase 2. Medium term 3. Long term – Rehabilitation Hospital in each Province with separate units for Stroke, Spinal Injury & Other injuries. These Hospitals should be headed by a	

	Consultant in Neuro Rehabilitation. 4. Rehabilitation Unit to be established in each DGH headed by a Consultant in Neuro Rehabilitation and Consultant Rheumatologist 5. Community Based Rehabilitation Clinic to be established in each MOH division **<u>Preventive care</u>** **Primary prevention** a. Creative awareness on recognition of Stroke b. TIA services at separate clinic in each District General Hospital c. Control of risk factors in stroke **Secondary Prevention** a. Carotid end- arterectomy facilities & Vascular surgical Units to be established in each Provincial General Hospital **Training staff** a. PGIM training in specialized stroke & Rehabilitative care b. Development of Carder & norms for proposed centers **Research** Identify research area related to stroke & trauma care
Monitoring & Evaluation	Research & Clinical Audits – Regular National level clinical audits –
(*)Reference to Research	

Program Title	**National Mental Health Programme**
Focal Point	Directorate- Mental Health
Background	Worldwide the burden of mental disorders continues to grow with significant impacts on health and major social and economic consequences (WHO 2015). Mental, neurological, and substance use disorders are common in all regions of the world, affecting every community and age group across all income countries and 14% of the global burden of disease is attributed to these disorders. In Sri Lanka,it is estimated 10% of the population is affected by mental health problems and 2% of them suffering from major Psychiatric illnesses such as psychosis. Prevalence of alcohol consumption in Sri Lanka is 39.6% among males and 2.4% among females (Ministry of Health Sri Lanka, 2012). Alcohol is strongly linked with high suicide rate and Deliberate Self-Harm (DSH) in the country (Abeyasinghe R. 2008; Tropical Medicine Int. Health 10, 2005). It is a causative factor for domestic violence within families and there is a complex relationship between alcohol and poverty in Sri Lanka (Subramaniam P. 2001; De Silva V. 2011). Mental health promotion should target the whole population including interventions for improving life skills, parenting and healthy relationships. Furthermore, promotion of mental health and well-being among people with mental illness, their carers and families is also essential.
Gap Analysis	Attached (annex 1)
Target areas& beneficiaries	• Promotion and protection of human rights • Universal health coverage • Evidence-based policies and practices • A full life course approach • Multi-sectoral collaboration at all levels of care • Empowerment of and full participation by persons with mental disorders and psychosocial disabilities

Justification	Mental health problems and mental illnesses are influenced by a complex interplay of biological, psychological, social, environmental and economic factors. Therefore interventions related to mental health should be comprehensive, ranging from prevention and early intervention through treatment to continuing care including rehabilitation and prevention of relapse.
Important assumptions/risks	Strengthening of Directorate of Mental Health of the Ministry of Health with adequate human resources and required facilities to provide the leadership, direction and guidance to the national Mental Health Programme. Ensure availability of all categories of multidisciplinary team of workers in all health care settings covering all provinces of Sri Lanka Adequate infrastructure and transport facilities be made available to the national, district and institutional levels
Vision	Mental wellbeing for all
Mission	Establish an enabling environment for the enhancement of mental wellbeing for all, through mental health promotion, prevention, treatment and rehabilitation with inclusive participation.
Goal	To develop comprehensive and high quality mental health care services for health promotion, prevention of mental disorders, treatment and rehabilitation, that are effective, accessible, equitable and affordable for the whole population across their lifespan in a collaborative and multi-sectoral manner while preserving and promoting the human rights and dignity of individuals.

	Programme Objectives	**Indicators**	**Means of Verification**
Objective 1	To strengthen effective leadership and good governance for mental health at all levels of care.	Existence of MH policy Existence of MH act	Physical availability of policy Physical availability of MH act
Objective 2	To provide comprehensive, integrated and responsive mental health and	Proportion of persons with a severe mental disorder (psychosis) who are using	MH returns

	psychosocial care	services	
Objective 3	To implement mental health promotion and prevention strategies	Functioning of programmes of multi-sectoral mental health promotion and prevention in a district	MH district reviews MH project reports
Objective 4	To protect the human rights of persons with mental illness and psychosocial disabilities	No. of complaints from patients No. of complaints from service providers	Records of MH Unit
Objective 5	To strengthen resources required for the delivery of services	Existence of separate budget Line for Mental health	Availability of MH budget line and adequate allocation of funds
Intermediate Objective6 (Outcome 6)	To strengthen monitoring , evaluation and information system	Reporting of a set of identified mental health indicators - Admissions to hospitals - Training of human resources - Availability of psychotrophic drugs	MH quarterly return Special surveys
Objective 7	To promote research and evidence based practices in mental health	No. of research projects conducted	Research reports MH review Forum
Objective 8	To promote advocacy to reduce mental health treatment gap, stigma and discrimination	No. of advocacy meetings con Ducted	Minutes of advocacy meetings
	Output	**Indicators**	**Means of Verification**
Output 1.1	Develop, strengthen and implement policies, programmes, regulations etc relevant to mental health activities	Existence of an updated MH policy	Physical availability of an updated MH policy
Output 1.2	Review at the National Mental Health Advisory Committee	No. of meetings conducted	Minutes of the meetings
Output 1.3	Review at District Review Committees in each districts	No. of meetings conducted	Minutes of the meetings
Output 2.1	Shifting the locus of care	No. of established MH outreach	MH quarterly

	away from long stay mental hospitals towards non specialized health settings	clinics No. of district hospitals with mental health services	returns
Output 2.2	Strengthen integrated and responsive care for mental health	No. of multidisplinary teams established	MH district review reports
Output 2.3	Strengthen mental health services in humanitarian emergencies	Existence of guideline on MH and psychosocial support in emergency settings	Availability of guideline on MH and psychosocial support in emergency settings
Output 2.4	Capacity building (knowledge and skills) of health care workers on delivery of range of mental health care	No. of health care workers trained for psychosocial services No. of undergraduate/postgraduate curricula mental health component is incorporated No. of CPD programmes for MO/MH, nursing officers	MH district review reports Minutes of advocacy meetings MH quarterly return
Output 2.5	Provision of support for marginalized groups at risk of mental diseases.	No. of counseling programmes held No. of livelihood programmes held	MH district review reports
	Output	**Indicators**	**Means of Verification**
Output 3.1	Increase public awareness on mental health	No. of patients reported to mental health clinics No. of workplace wellness programmes	MH district review reports MH quarterly return
Output 3.2	Integration of mental health as part of MCH care	Prevalence of postpartum depression No. of maternal deaths due to suicides	MH quarterly return Maternal morality surveillance data of FHB
Output 3.3	Provide early childhood and school programmes for mental health promotion	Rate of Juvenile offending Behavioural problems among school children	Police reports SMI returns

Output 3.4	Implement programmes to address domestic violence, harmful use of alcohol, substance abuse, suicide prevention etc.	Rate of suicide Attendance of GBV patients at MithuruPiyasacentres	Police reports FHB data
Output 4.1	Develop an admission mechanism to protect the rights of mentally ill persons and their properties	Rate of involuntary admissions	Survey
Output 4.2	Ensure proper care of persons with mental disorders in custody of the police, or in remand prison	No. of prisons with psychiatric units within the prison	Prison reports
Output 4.3	Upholding of current provisions of rights enshrined in the constitution and acts.	Existence of updated MH Act	Physical availability of updated MH Act
Output 5.1	Establish a separate budget line for mental health activities	Existence of MH budget line	Physical availability of MH budget line
Output 5.2	Advocacy to implement new cadres for different mental health work categories: psychiatric social workers, occupational therapists, clinical psychologists, counselors etc	No. of revised cadres	Minutes of advocacy meetings
	Output	**Indicators**	**Means of Verification**
Output 5.3	Capacity building of mental health care workers on delivery of range of mental health services	No. of in service programmes held	MH district review reports
Output 5.4	Strengthen the collaboration of other governmental and nongovernmental mental health workforces	No. of in multisectoral programmes held	MH district review reports
Output 6.1	Strengthen the routine mental health information system	Coverage and timeliness of MH reports Publishing an Annual Bulletin on MH	MH quarterly return Availability of Annual bulletin

Output 6.2	Establish detailed surveillance for selected secondary and tertiary services	Proportion of persons with a severe mental disorder (psychosis, severe depression) who are using services	Special surveys
Output 7.1	Improve research capacity on mental health with consultation of all stakeholders	No. of research projects conducted on MH No. of scientific publications on MH	MH district review reports MH review Forum
Output 8.1	Conduct advocacy meetings for policy makers/ administrators to reduce treatment gap, stigma and discrimination	No. of advocacy meetings conducted	Minutes of advocacy meetings

Strategies/activities	Provide leadership in their respective areas for the implementation of the policy at the respective level. Strengthen collaboration between health and non-health sectors. Establish a grievance mechanism at regional and national levels. Ensure a separate budget line. Preparation of a strategic plan for human resources in mental health will be formulated . Develop a capacity building plan for different mental health service staff categories. Adopt a collaborative approach involving relevant stakeholder to develop mental health promotion interventions in the following areas: violence prevention, suicide prevention,substance use and associated risk factors, community-based resilience,acceptance of diversity, including disability. Strengthen the capacity of mental health services for the assessment and management of mental health issues in primary care, secondary and tertiary care.

	Strengthen the information system to provide information and guidance to decision makers at national, provincial, district levels. Establish a Mental Health Research Committee
Monitoring & Evaluation	Regular review of the MIS followed by revision is mandatory for effective monitoring of the programme. Development of an e-based mental health information system, integrated with other e-health interventions of the Ministry of Health, is essential.

Programme Title	Health of Elderly
Focal Point	Director – Youth, Elderly & Disabled persons
Background	Population aging is a global reality and it applies to Sri Lankan contest as well. In 1971, Sri Lankan Elderly population was 6.3% of the total population and today it has become 12.5% of the total population. It is expected to be 20.7% by the year 2031. Demographic trend in which there is a decline in birth rates, death rates, fertility rate & extended life expectancy of elders are the major causative factor for rapidly increasing elderly population, with the increasing trends of elders in the country there are many challenges to face including health. Since last few decades directorate of Youth, Elderly and Disabled persons, Ministry of Health, Nutrition & Indigenous Medicine is carrying out many interventions & programmes to promote elderly health care in quantitative and qualitative manner, both in institutional and community level. Apart from many achievements in providing health care it is stated that there are many cross cutting areas of elderly health care are in suboptimal levels, which need to be addresses in a wider manner.
GAP ANALYSIS **by using UHC tool**	Attached separately
Target area and beneficiaries	Elderly persons in the country
Justification	It is evident that prevalence Non Communicable Diseases are high among elderly persons. Providing quality equally distributed health services in curative sector, promotion of preventive sector facilities are equally important in minimizing Non Communicable Diseases among elderly. Advocacy based on life course approach and

	appropriate interventions are important in providing elderly health care in preventive sector. Strategies for promotion of active healthy aging based on life course approach in essential. As a policy and programme planner at national level Directorate of Youth, Elderly and Disabled persons has a massive mandate on providing quality, sustainable equally distributed health service for the elderly persons both in the curative & preventive sector of the country.	
Important assumptions / Risks / Conditions	Directorate of Youth, Elderly & Disabled persons will receive inter and intra sector support to carry out identified activities behalf of the elderly persons in the country. Directorate of Youth, Elderly & Disabled persons will receive sustainable and adequate funding to carry out activities.	
Vision	Country with active healthy ageing population by 2030.	
Mission	Improve quality health care for elderly persons through improvement of health facilities, diseases prevention and health promotion and provision of technical guidance within the Health Maser Plan in Sri Lanka.	
Goal	Improve well-being of the elderly and to achieve a healthier more active & more production elderly population in future.	
Programme Objectives	Indicators	Means of verification
1. To formulate policy strategies & guidelines	Availability of elderly health policy & strategic plan.	Policy & strategic plan documents
2. To provide guidance to	% of districts healthy plan of actions to promote	Review and supervision

implement district level activities on promotion of Elderly health care including capacity building	elderly health care. % of elderly health clinics established at district level. % of establishing elderly friendly wards in hospitals at district level Number of TOT programmes conducted for Public Health Staff.	reports Review and supervision reports Reports returns
3. To strengthen advocacy and multi sectoral collaboration	Number of Medical Officer of Health areas implemented advocacy programmes for key stakeholders. Number of Medical Officers of Health areas implemented awareness programmes on active healthy ageing at community level.	Records & supervision reports Records & Supervision reports
4. To formulate national information management system	Availability of National Information Management System	Records & Supervision reports
5. To strength national & district level monitoring & evaluation system	Number of advisory committee meetings conducted Number of steering committee meetings conducted Number of district activity review meetings conducted.	Reports & records

Out Put	Indicators	Means of verification
1. Sensitization of health care persons on elderly health through advocacy	Number of orientation programmes conducted Number of Public Health Care workers trained on elderly health care	Programme records
2. Establishment of Elderly Friendly units in hospitals	Number of Elderly Friendly Health units established	Review reports
3. Establishments of center for excellence for elderly health unit at Handala, Wattala	Center for elderly health care	Supervision & reports
4. Strengthen Divisional level community based elderly health care. Through setting up of district & district level committee	Number of Medical Officer of Health areas established Elderly Health Care Committee Number of elderly health care committees established at district level.	Records &Review reports

5. Strengthen multi stakeholder collaboration on elderly health care	Number of activities conduct with the involvement of multi stakeholder Number of reviews conducted with multi stakeholders	Records & Reports
6. Facilitate to develop human resource for elderly health care	Number of carder increased for Physiotherapist, Occupational Therapists & Speech & Language Therapists	Records
7. Provision of Financial facilities to promote elderly health care	Proportion of money spent by each health institution out of total allocation for promotion of elderly health care.	Financial progress, reports & Super vision records
8. Promotion of evidence of based information mechanism	No of research completed on elderly care. Number of research on elderly care which received allocations from Ministry of Health, Nutrition & Indigenous Medicine.	Records

Monitoring & Evaluation:	District Action Plans Supervision visits & conducting progress review meeting with multi stakeholders. Establish & maintain Information Management System.
Research	Research will be conducted both in central & Provincial Level according to need based approach.
Preparation of the document	Director – Youth Elderly & Disabled persons: DrShiromiMadhuwage Consultant Community Physician – (Youth Elderly & Disabled persons)

GAP ANALYSIS

Activity Area	Equity Distribution	Accessibility to all	Quality of service
1. Allocation of funds to set up elderly friendly units	Allocated funds will be distributed to maintain equity Island wide service. Gaps delay in	Certain activities are not targeted on right based approach. All allocated funds are	Drawbacks in comprehensive monitoring system rather than quality.

2. Allocation of funds to set up accessible facilities for the elders.	receiving funds due to delay in submitting bills for re-imbursement.	not utilized at health institutional level on time.	
3. Caregiver Training Programme.	Selection of participants is done by the Ministry of Social Services Gaps in selection of participants.		
4. Human Resource Development & capacity building.	Unmet needs on human resource for elderly care Un equal distribution of existing carder.	Data are not receiving on time.	No regular funding system..

Youth, Elderly & Disabled persons(Disability Component)

Programme Title	Youth, Elderly & Disabled persons(Disability Component)
Focal Point	Directorate of Youth, Elderly & Disabled persons
Background	Disability is complex, dynamic and multidimensional. It is stated that disability prevalence in the country is 6-7% of the total population. Causes for disability are multi factorial. Rapid increasing elderly population & injuries have become major contributory factors for the country disability care & rehabilitation has become multi factorial. The UN convention on disability status that a person who has disabilities may be defined as those who have long term physical & mental, intellectual or sensory impairment, which is interaction with various barriers may hinder their full participation in society on equal basis. For many people with disabilities assistant and support are pre requisites for participating in society. The lack of necessary support services can make people with disabilities overly depend on family member and can prevent both the persons with disability and family member from becoming economically active and socially included. Throughout the world people with disabilities have significant unmet need for support and there are gaps in services everywhere. Directorate of Youth, Elderly & persons with Disabilities, Ministry of Health, Nutrition and Indigenous Medicine with other stakeholders carry out many programmes based on disability care & rehabilitation in par with National Action Plan on Disability and National Guideline on Disability Rehabilitation. However currently the magnitude of the unmet need for services including health is seen within the country. Directorate of Youth, Elderly & Disabled persons is working on right based and comprehensive multi sector approach to promote disability health care & rehabilitation in the country.
GAP ANALYSIS by using UHC tool	Attached Separately

Target area and beneficiaries	Persons with Disabilities of the country	
Justification	Being the national focal point for disability health care & rehabilitation, Directorate of Youth, Elderly & Disabled persons responsible in improving quality health care & rehabilitation for the persons with disabilities in par with National Action Plan on disability & National Guideline on rehabilitation.	
Important assumptions / Risks / Conditions	Directorate of Youth, Elderly & persons with Disabilities will get the support from all stakeholders in providing health care services for the persons with disabilities	
Vision	A country with optimize quality of life for persons with disabilities	
Mission	To improve quality of life of persons with disabilities through improvement of health facilities, disability prevention & health promotion according to the Health Master Plan in Sri Lanka	
Goal	To improve the health status of the persons with disabilities in Sri Lanka	
Programme Objectives	Indicator	Means of verification
To provide guidance for strategies and guidelines to promote health care facilities.	Number of strategies and guidelines developed	Reports & Records
To promote health service infrastructure facilities for persons with disabilities	Number of health institutions with accessibility facility for persons with disabilities. Number of health institutions with basic infrastructure facilities for disability care & rehabilitation	Reports & Records Supervision Notes

To strength human resource for disability care & rehabilitation	Proportion of Secondary level health institutions equipped with all categories of trained Human Resource for disability rehabilitation.	Records & Reports
To strength advocacy and multi sectoral coordination at all levels	Number of Medical Officer of Health areas implemented advocacy programmes for key stakeholders on disability care & rehabilitation. Number of multi stakeholder reviews conducted on disability care & rehabilitation. Number of Medical Officer of Health areas conducted community level programmes with multi sectoral approach.	Records & Reports Records & Reports
Establish a national surveillance system on disability & rehabilitation	Availability of functional surveillance system. Number of periodical review meeting held.	
Monitor & evaluation disability related activities at national & provincial level	Number of monitoring visits made annually.	Records & Reports
Out Put	Indicators	Means of verification

Availability of strategies & guidelines	Number of activities implemented under developed strategies	Reports
Developed health services infrastructure and human resource	Number of health facilities available with adequate equipment Number of health facilities available with adequate number of trained health personnel for rehabilitation service	Supervision Records & Returns
9. Strengthen provincial regional, divisional level multi sectoral disability care rehabilitation team	Number of provincial level disability care & rehabilitation teams established. Number of regional level disability care & rehabilitation teams established Number of divisional level disability care & rehabilitation teams established	Records & Returns
10. Availability of National surveillance system on disability & rehabilitation	Number of districts surveillance system implemented	Records & Returns

Activities	1. Providing technical guidance for developing strategy & guidelines. 2. Provide infrastructure facilities 3. Human Resource Development for disability care & rehabilitation 4. Capacity building on disability care & rehabilitation under multi stakeholder approach.

	5. Financial assistance for promotion of disability care & rehabilitation. 6. Advocacy programme at central & provincial level i-on disability care & rehabilitation 7. Awareness & programme for caregivers on disability care & rehabilitation.
Monitoring & Evaluation:	Conducted periodical review meetings. Maintain return & records, Supervision visits & notes
Reference to research	Co-ordinate with education, training & research unit, Ministry of Health, Nutrition & indigenous medicine & academia
Prepared by	Director – Youth Elderly & Disabled persons Consultant Community Physician - Youth Elderly & Disabled persons

GAP ANALYSIS

Activity Area	Equity Distribution	Accessibility to all	Quality of service	Financial Protection
5. Implementation of National Guidelines on Rehabilitation	Annual allocation for GOSL Allocation from	All allocated funds are not utilized on time at	Assuring quality needs to be strengthened.	Funds received to directorate of Youth, Elderly & Disabled persons are allocated

	donor aging	provincial / district level		to provincial/ district level health institutions in need basis
6. Coordination & collaboration with multi stakeholders	Steering Committee for persons with disabilities Council for persons with disabilities Technical Guidance to other ministries Collaboration with UN and NGOs' GAP – no proper mechanism for intra-ministerial coordination	District level and divisional level teams and committees to be formulated.		
7. Allocation of funds to set up accessible facilities for the persons with disabilities.	Gaps delay in receiving funds due to delay in submitting bills for re-imbursement.	All allocated funds are not utilized at health institutional level on time.		
8. Caregiver Training Programme.	Selection of participants is done	Data are not	No regular funding system	

9. Human Resource Development & capacity building.	by the Ministry of Social Services Gaps in selection of participants. Unmet needs on human resource for Disability care Un equal distribution of existing carder.	receiving on time		

Program title	Clinical Genetics Services National Program for the Development and Expansion of Clinical Genetics Services in Sri Lanka.
Focal point	Deputy Director General Medical Services II
Back ground / **Situation** Analysis *(**Problem Analysis**)	The national health service of Sri Lanka does not have an organized system of Clinical Genetics Services to cater to patients with genetic conditions. Appropriate infrastructure and human resources need to be developed and streamlined to serve the needs of patients and families affected with genetic diseases as well as the general populace in the country.Patients do not have access to clinical genetics services at the district and provincial levels of care. Genetic testing which is only available at the tertiary level of health care is costly and unaffordable to most patients. Healthcare professionals lack core competencies in implementing medical genetics and genomics at various levels of healthcare delivery.Knowledge and awareness among the general public regarding genetic diseases, their prevention and where to access genetic services is minimal.
GAP ANALYSIS by using UHC tool	
Target areas & Beneficiaries	Patients and families affected with genetic disorders. The population at large. Healthcare professionals.
Justification	Patients with genetic disorders: Genetic disorders are rare. A rare disorder is defined as a disorder affecting less than 1 in 200,000 persons in the world. Taken as a whole however 1 in 10 persons suffer from a rare disorder. Therefore we can estimate that at least 2 million people in Sri Lanka suffer from such disorders and would need the help of clinical genetics services at some point in their lifetime. The population at large: The cost of looking after patients with genetic disorders is enormous. For example the 2000 to 3000 patients with thalassaemia in Sri Lanka take up 5% of the recurrent health budget. The cost of treatment for other disorders is even more expensive. Therefore reducing the burden of genetic disorders in the country would be financially very beneficial to the entire country as this would lead to a reduction in utilization of government resources to cater for patients debilitated with genetic diseases.
Important assumptions / Risks / Conditions	Provision of appropriate clinical genetic services at various levels of healthcare with the help of suitably trained personnel to provide affordable genetic testing, appropriate genetic counseling services, and information regarding adoption of alternative reproductive options will lead to a drastic reduction in the recurrence of these genetic conditions.
Vision	The vision of the programme is to ensure Universal Access to Clinical Genetics Services.
Mission	The mission of the programme is to ensure clinical genetics services are available across the country.

Goal	1. Establish a clinical genetics service in every district of the country by the year 2025. 2. Establish a clinical genetics service in every specialized hospital in the country – Cancer Institute Maharagama, Lady Ridgeway Hospital for Children, National Hospital, Sirimavo Bandaranaike Hospital for Children, Castle Street Hospital for Women, De Soysa Hospital for Women, National Eye Hospital, Dental Institute Colombo, and Dental Hospital Peradeniya. 3. Train 30 MD Qualified Clinical Geneticistsand set up a professional body of clinical geneticists in the country. 4. Development ofcorecompetencies in medical genetics/genomics through implementation of a uniform curriculum at undergraduate, and postgraduate medical and paramedical training institutions throughout the country. 5. Undertake cutting-edge translational research in clinical genetics at tertiary institutions. 6. Improve level of awareness of the general public regarding genetic diseases, their prevention and where to access genetic services.	
Programme Objectives	**Indicators** 1. Establishment of clinical genetic services at provincial and district levels, and at specialized hospitals throughout the country. 2. Human resources training and development. 3. Improve public awareness through mass media campaigns.	**Means of Verification** Set up a timeline to achieve objective e.g. short, medium & long term goals to be achieved within set time periods.
Output (Please prepare separate indicators for each output)	**Indicators** 1. Availability of centres providing clinical genetics services at provincial and district levels and at specialized hospitals. 2. Availability of adequate number of suitably trained personnel to provide appropriate clinical genetics services. 3. Availability of genetic testing at an affordable cost. 4. Enhanced public enlightenment and	**Means of Verification** Set up a timeline to achieve objective e.g. short, medium & long term goals to be achieved within set time periods.

	awareness about genetic diseases.	
Strategies / Major Activities	Development of adequate infrastructure and manpower to provide clinical genetics services at the district, provincial and national levels of healthcare in the country through the goals and objectives outlined above.	
Monitoring & Evaluation	Set up a timeline for monitoring and evaluation e.g. short, medium & long term goals to be achieved within set time periods using a Gantt chart.	
(*)Reference to Research	1. B. R. Korf, A. B. Berry, M. Limson, *et al.* Framework for development of physician competencies in genomic medicine: Report of the competencies working group of the inter-society coordinating committee for physician education in genomics. Genet. Med. 16, 804–809 (2014). 2. T. A. Manolio, R. L. Chisholm, B. Ozenberger, *et al.* Implementing genomic medicine in the clinic: The future is here. Genet. Med. 15, 258–267 (2013).	

Names of officials who documented the profile =

Prof .Vajira Dissanayaka

Faculty of Medicine - University of Colombo

GAP ANALYSIS by using UNIVERSAL HEALTH COVERAGE tool

Activity Area	**Equitable distribution of services to all patients of the country**	**Accessibility to all health services by all patients of the country**	**Quality of Serviceoffered to all patients of the country**	**Financial Protection** of all patients of the country
Clinical Genetics Services	All district, provincial, general, teaching and specialist hospitals (National Hospital, Cancer Institute Maharagama, De Soysa Hospital, Lady Ridgeway Hospital, Castle Street Hospital, National Eye Hospital, Sirimavo Bandaranaike Hospital) to have clinical genetics services established.	Public Transport Private Transport Establishment of clinical genetics services at district and provincial levels.	Availability of adequately trained personnel to provide appropriate clinical genetics services to all patients. Fully accredited genetic diagnostic centres.	Laboratory tests to be funded by government

Program Title	**Pulmonary Rehabilitation**
Focal Point	DDG(MS-I)
Proposal submitted by	**Sri Lanka College of Pulmonologists**
Background	Background/Situation Analysis There is an increasing incidence of chronic respiratory diseases in Sri Lanka such as Chronic obstructive airway diseases (COPD), poorly controlled Bronchial Asthma (Asthma COPD overlap syndrome), Bronchiectasis (post Tuberculosis and Idiopathic) ,Interstitial lung disease etc. These diseases have increasing morbidity to the patient leading to poorer quality of life. Reduce productivity, increase burden to the family and state and repeated hospital admissions. National Health systems though being able to provide drug treatment to these patients does not lead to expected outcomes specially with advance disease as these conditions are irreversible.
GAP ANALYSIS by using UHC tool	
Target areas and beneficiaries	All patients with Chronic Respiratory diseases
Justification	**"**Pulmonary rehabilitation is a comprehensive intervention based on a thorough patient assessment followed by patient tailored therapies that include, but are not limited to, exercise training, education, and behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors " Pulmonary rehabilitation has been clearly demonstrated to reduce dyspnea, increase exercise capacity, and improve quality of life in individuals with chronic obstructive pulmonary disease(COPD) Pulmonary rehabilitation provided to individuals with chronic respiratory diseases other than COPD (i.e. interstitial lung disease, bronchiectasis, cystic fibrosis, asthma, pulmonary hypertension, lung cancer, lung volume reduction surgery, and lung transplantation) has demonstrated improvements in symptoms, exercise tolerance, and quality of life. Symptomatic individuals with COPD who have lesser degrees of airflow limitation who participate in pulmonary rehabilitation derive similar improvements in symptoms, exercise tolerance, and quality

	of life as do those with more severe disease. d Pulmonary rehabilitation initiated shortly after a hospitalization for a COPD exacerbation is clinically effective, safe, and associated with a reduction in subsequent hospital admissions. d Exercise rehabilitation commenced during acute or critical illness reduces the extent of functional decline and fasten recovery
Important Assumptions/Risks /Conditions	Most Chronic Respiratory disease patients suffer from multiple comorbidities due to their respiratory illness Anxiety, depression and malnutrition and closely related with such illness Dependency on family and recurrent hospital admissions lead to significant socioeconomic burden on families and the health sector Pulmonary rehabilitation has been clearly demonstrated to reduce dyspnea, increase exercise capacity, and improve quality of life in individuals with chronic obstructive pulmonary disease(COPD) and Chronic Respiratory diseases other than COPD Addressing issues related to the disease such as smoking cessation, nutritional support, psychological support and providing long-term oxygen therapy would improve the quality of life of these patients
Vision	To improve the quality of life of patients with chronic respiratory diseases, decrease the recurrent hospital admissions and reduce the economic burden on the health sector and reduce the socioeconomic burden on the careers of these patients
Mission	To establish interdisciplinary teams on Pulmonary Rehabilitation to all Respiratory center's with in the country To extend this service to community based Pulmonary Rehabilitation teams lead by the General Physician for continued care of these patients
Goals	❖ Providing infrastructure to optimize medical management of COPD and other chronic Respiratory diseases ❖ Facilitating smoking cessation clinics ❖ Facilitating Nutritional care ❖ Liaising with the College of Psychiatrists and Psychologists for early intervention and continued care for Psychological problems related to chronic respiratory diseases

	❖ Liaising with the College of Physiotherapist for the training of Respiratory Physiotherapists in the Country ❖ To establish interdisciplinary teams under the supervision of the Consultant Respiratory units to initiate the pulmonary rehabilitation program ❖ Facilitating continued care of these patients in the community thru the community based Pulmonary rehabilitation team ❖ Liaising with the College of General Practitioners for supporting the community rehabilitation program ❖ Setting up of Oxygen therapy clinics to provide long-term home oxygen ❖ Forming links with the Palliative care team for more holistic care of the physical, psychological, social and spiritual needs of these patients.	
Programe Objectives	***Indicators***	***Mean of verifications***
	Preserving the lung functions	by advocating smoking cessation
	Audit on number of patients attending the smoking cessation clinics	number of patients abstaining from smoking
	Preserving the lung functions	by providing long term domiciliary oxygen
	Audit on assessment of Pulmonary function tests	improvement in dyspnoea scale
	Provide symptomatic relief of dyspnoea	audit on improvement in the dyspnoea scale
	Increase in muscle strength and endurance	audit on improvement in the QOL questionnaire
	Improvement of co morbid conditions	such as anxiety, depression, malnutrition
	Audits	symptom scores and objective assessments
	Reduction in hospital admissions	hospital morbidity records
Output (Please prepare separate indicators for each output)	***Indicators***	***Mean of verifications***
Better clinical outcomes of chronic respiratory diseases		Reduced hospital admission, hospital morbidity and mortality data, audits
Better social wellbeing and quality of life		Quality of life questionnaire

Better health education		KAP study
Strategies / Major Activities		
Monitoring & Evaluation	1. Six-weeks of outpatient Pulmonary Rehabilitation program offered to eligible patient. Evaluation by clinical monitoring, symptom score and quality of life questionnaire. 2. Community based long-term rehab at community centers. This will be assessed in three to six months follow by Consultant Respiratory clinic or special rehab follow up clinic 3. Selected patients will be followed up and evaluated in special smoking cessation/Nutrition//oxygen/ Palliative care clinics.	
(*)Reference to Research		

Program title	'Creating safe communities for children' **A Project for the Protection of Children from Abuse, Exploitation, Violence and Neglect**
Focal point	Deputy Director General (Medical Services) and **Sri Lanka College of Paediatricians**
Back ground / **Situation** Analysis *(**Problem Analysis**)	The data from Women's and Children's' Bureau of the Sri Lanka Police confirms the fact that child abuse and neglect is being increasingly reported from all parts of the country at present. Hospital based data collaborates this fact (1,2,3). Sexual abuse is the commonest type of abuse reported to the police and to hospitals (2,3). The sexual abuse of the girl child is reported more to the police. They are brought into the system by the Police. They then receive the psycho-social rehabilitation and re-integration as necessary. However community based studies in Sri Lanka reveals the fact that the boy child suffers more sexual abuse than the girl child (4,5,6). These incidences are underreported. Fewer boys are brought into the system. Hence, the majority of boys do not receive the psycho-social rehabilitation that they need. They may be perpetuating the cycle of abuse (7,8,9,). Corporal punishment in schools in Sri Lanka has been banned by a circular issued by the Ministry of Education in 2001 (10). Alternative methods of discipline have been suggested. However children continue to suffer corporal punishment in schools. There are long delays in the legal system. Cases take up to 10 years for completion (11). The video recording of evidence of young victims is important until these delays are reduced as often the children are unable to recall details when cross-examined several years after the incident. There is also delayed healing on the part of the victims when these cases are heard over several years adding further trauma to the child. The deterrent effect of verdicts having an impact on prevention also is affected duet to these long delays.
Target areas & Beneficiaries	Children up to 18 years of age, their families and the society at large.

Justification	The programme Creating Safe Communities for Children has two main objectives 1. Better Management of Victims: Child abuse and neglect is a growing problem in the country. There is a lack of a well-coordinated programme for the management of victims and for prevention of child abuse. There is a great need for consistent psycho-social rehabilitation and re-integration of victims. If this service is not offered to the victims they grow up as maladjusted adults who will not be able to contribute to this country. They will be further victimized and will have a tendency to drug and alcohol abuse with all the untoward effects of theses (12). They are also known to have a higher chance of being perpetrators in adult life (12). 2. Prevention of child abuse: In addition to better management of victims once a report is made prevention of the problem is the key. Awareness of the problem amongst parents and teachers and the children themselves is paramount. Children should be taught how to protect themselves right from pre-school days. Some risk factors for the occurrence of child abuse have been identified. One important factor is a dysfunctional family unit. Parental separation, divorce, maternal employment aboard etc are some such factors (13). These need to be addressed in prevention programmes.
Important assumptions / Risks / Conditions	Inter-sectoral coordination is essential. All sectors involved should have a clear understanding of their roles of responsibilities. A child friendly approach in dealing with victims and maintenance of confidentiality is important. If these prerequisites are not met there will be a negative impact on reporting.
Vision	A safe childhood ensuring child rights for a secured and productive future.
Mission	Coordinated approach to the management of victims of abuse & neglect and reduction of the incidence of child abuse and neglect.
Goal	Equitable, accessible and comprehensive care for victims of child abuse

Programme Objectives 1. To reduce the incidence of child abuse with a well planned programme for its prevention. With an aim to protect child rights. 2. To encourage reporting of all incidents of abuse 3. To ensure coordinated child friendly responses by all sectors for each reported case. 4. To ensure the use of the National Guideline for the management of victims 5. To ensure proper investigation and appropriate management of all victims.	**Indicators** **1.** The number of reported cases of child abuse annually 2. The percentage of institutional case conferences conducted 3. Percentage of cases followed up	**Means of Verification** 1. Data from Women's and children's Bureau of Sri Lanka Police. 2. Hospital data
Output **1. Lama Piyasa in each District** **2.**	**Indicators** 1. Percentage of provinces with at least one "Lama Piyasa centers established 2. Percentage of well functioning "Lama Piyasa Child centers at MOH level 3. Percentage of provinces managing victims according to the National Guideline	**Means of Verification** 1. RDHS data
Strategies / Major Activities 1. Inter sectoral coordination	1. Implement the '*National guidelines for the Management of Child Abuse and Neglect.'* island wide. 2. To implement a social Marketing programme to	

2. Strengthening legal framework	create awareness among public with the assistance of private & public partnership 3. To establish one "Lama Piyasa" centre with inward facilities, Video evidence recording unit & follow up facilities in each Province in the next 2 years. This has to be expanded to each district in next 5 years. 4. Establish linkage between MOH and "Lama Piyasa" in prevention & identification of child abuse in next 2 years. 5. Human resource capacity building in all sectors involved in the management and prevention 6. To train a pro active group at community level for prevention & reporting 7. Establish a National Child abuse Registry 8. To establish a registry of perpetrators of child abuse in order to prevent further child abuse.
Monitoring & Evaluation	1. Review meetings District level (in 3 monthly) & National level annually 2. To establish a National Child abuse Registry 3. Strengthen the monitoring capacity of National Child Protection Authority
(*) Reference to Research	1 Profile Of Child Abuse And Neglect In A Tertiary Care Hospital: Fernando A.D., Karunasekera K.A.W., Fernando L., Samarasekera A. Annual Sessions, Sri Lanka Medical Association March 2005 2 Child Abuse And Neglect: Who Abuses Them And Who Gets Abused? Fernando A.D., Karunasekera K.A.W., Fernando L., Samarasekera A. Annual Sessions, Sri Lanka Medical Association March 2005 3 Victims of Child Sexual Maltreatment: Is The System Giving Them A Fair Deal? Fernando A.D., Karunasekera K.A.W., Fernando B.K.N. 12th Asia Pacific Congress of Paediatrics and the 2nd Asian Congress of Paediatric Nursing.12-15th March 2008, Colombo Sri Lanka 4 Broadening Gender: Why masculinities Matter Attitudes, Practices and Gender-Based Violence in Four Districts in Sri Lanka' Care International Sri Lanka, "(April 2013) 5 'Juvenile VicitimizationQuestionaire in a Group of Young Sri Lankan Adults' Fernando, A and Karunasekera**,** KAW(2009) 54(3) Ceylon Medical Journal 80 6 Harendra de Silva, D G 'Children Needing

	Protection: Experience from South Asia' *Arch Dis Child* (2007) 92, 931-934 7 Cashmore, J and Shackel, R 'Gender Differences in the Context and Consequences of Child Sexual Abuse' (2014) 26(1) Current Issues in Criminal Justice 75 8 Crome, S, 'Male Survivors of Sexual Assault and Rape' (Report, Australian Centre for the Study of Sexual Assault, 2006) 9 Frederick, J 'Sexual Abuse and Exploitation of Boys in South East Asia: A Review of Research Findings, Legislation, Policy and Programme Responses' (Innocenti Working Paper, UNICEF, 2010) 10 Ministry of Education, Sri Lanka. General circular No. 2001/ 11.30.03.2001. 11 Justice delayed –Justice denied; a study on time intervals of medico-legal examinations, reporting and giving evidence in cases of alleged child abuse victims. PAS Edirisinghe, IDG Kitulwatte, AAS Sihanada, BAAR Bulathsinhala, Medico-Legal Journal of Sri Lanka Vol. 1, No 1, Jan-April 12 World report on violence against children: United nationas secretary general's study on violence against children 2006 Paulo SérgioPinheiro Independent Expert for the United Nations Secretary-General's Study on Violence against Children 13Unpublished data from a data set of 500 victims of abuse. Asvini D Fernando

Name of official who documented the profile =

Prof. Asvini Dhammika Fernando, Associate Professor in Paediatrics

Department of Paediatrics, Faculty of Medicine, University of Kelaniya

Honorary Consultant Paediatrician, Colombo North Teaching Hospital, Ragama

Program Title	Uplifting of practices of **Plastic Surgery** in Sri Lanka in order to achieve world standards
Focal Point	DDG/ MS I **Collage of Plastic Surgeons.**
Background	. The practice of Plastic Surgery considered as a sub specialty in Sri Lanka. The practical problems associated with equity and accessibility to the service of plastic surgical specialty are universal or confined to the developing countries. As a middle income country Sri Lanka faced certain unique problems in initiating new treatment modalities. Even we have an established private sector in parallel to the public sector most of these problems are common to both sectors . Some of the highlighting problems mainly associated with unawareness , lack of infrastructure and lack of trained man power. Lack of coordination in between the other sectors with the plastic surgical specialty , poor allocation of finance and human resources to different subspecialties of Plastic Surgery by the health ministry is also a course for the failure of providing this services to the country.
Gap Analysis	Attached in a separate format
Target areas and beneficiaries	Patients who need Plastic surgical care
Justification	The general public of the country is affected adversely by being unaware of the services that Plastic Surgery units can offer to them . At the same time, the Plastic Surgeons and supporting staff in the country are unable to serve equally as limitations imposed upon them by shortage of staff, equipment and space etc. Plastic Surgeon to population ratio in Sri Lanka is not even close to the recommended value. There is a severe disparity in Sri Lanka in present days. Therefore, to bring the level of care close to the world standards we need a dual approach with public awareness and elevation of the level of care offered to the patients. Multi-stage well designed program is in needed with a finite time frame. This could be achieved by uplifting the existing Plastic surgical units and establishment of new units in suitable locations to serve better to the public.

Important Assumptions/Risks/Conditions	Proper diagnosis, effective referral system and Shared care including follow up and rehabilitation. Unshakeable prioritization practices in the health ministry	
Vision	To make the practice of specialty of Plastic surgery in Sri Lanka on par with that in the advanced countries by the year 2025	
Mission	To step-wise improve the existing Plastic Surgery units as outlined elsewhere and build new units following the principles outlined elsewhere while educating the public on the available services	
Goal	To establish well equipped, adequately staffed, multi-disciplined Plastic Surgery units with advanced trainees in each province of the country, preferably inside provincial general or teaching hospitals	
Program Objectives 1. Improving the Number of equipped Units with adequate trained staff.	Indicators	Means of Verification
	• Number of Patients registered for Plastic surgical care • Number of Surgical interventions related to the course	IMMR
Output	Establishment of Plastic surgical specialized Units In a Island wise basis	
Program Strategies and activities	**1.** Early assessment and proper referral system a. Encouraging the population to seek early medical intervention. b. Dissemination of information regarding available services (e.g. at OPDs/Clinics) . c. Encourage the medical practitioners to refer at correct time. **2.**Initiation of early intervention with appropriate escalation of care **3.**Monitoring and detecting complications **4**.Follow up	

	Standards follow up care according to the Guidelines and protocols. 5. Rehabilitation
Monitoring and evaluation of the program	Quarterly review meetings and clinical audits in institutional level Annual review meeting in National level at the collage of Plastic Surgeons and the ministry of Health.
References and Research	Annual Health Bulletin

Gap Analysis

Activity area	**Equity of distribution**	**Accessibility to all**	**Quality of service**	**Financial protection of the patient**
Closed unit with ward, clinic, Dressing area, and operating theatre	Within a distance that can be covered in one to two hours	Public transport Private transport Ambulance at smaller hospital ? Heli-Ambulance (emergencies)	Pre-operative, operative and Post-operative care under one roof	All these services provided free or based on insurance scheme similar to a system practiced in a country such as Singapore
Occupational therapy unit adjacent to above	do	Public transport Private transport	Holistic management	do

Program title	**Endocrinology and Diabetes** (2016-2025)
Focal point	*Specialist* endocrine and diabetes units in specified categories of hospitals in the government sector manned by board certified consultant endocrinologist/s delivering *specialist care in diabetes* *(next stage – develop community Endocrinology & Diabetes)*
Proposal submitted by	**Sri Lanka College of Endocrinologists**
Back ground / **Situation** Analysis (**Problem Analysis**)	Need of having a long term pre-defined and a predictable strategy (a ten year cardre projection set in priority basis) for appointing specialist endocrinologists rather than following an ad hoc personalized method Need of identifying a framework for the minimum development level of each category of hospitals, which is preferably implemented within a given time period after appointing a specialist (lack of identified minimum facilities should not preclude appointing a specialist) • a physical space adequate to run a specialist clinic • A minimum number of medical officers Need to define the minimum level for the quality of care expected from such units • 4 to 5 specialist diabetes clinics a week • Foot clinic Establish a process by which the ministry facilitates such level of care • provision of financial back up to establish a foot clinic Need to have an official networking system of coordinating with lower grade hospitals in the catchment area (A method to cater to a wider area) • monthly specialist clinics in base hospitals in the relevant geographical area
GAP ANALYSIS by using UHC	**<u>Equitability</u>**

tool	Mal distribution of specialists based on following criteria • The population density of each geographical area (e.g. in each province) • The patient population catered to by each hospital (e.g. teaching hospitals) **<u>Accessability</u>** Mal distribution based on the population density of each geographical area • Based on the geographical area of each province eg North Central Province • Could have remote clinics by the specialist endocrinologist once a month Absence of a networking system to extend specialist care to lower grade hospitals **<u>Financial protection</u>** Unavailability of Essential investigations in the government sector • HbA1c • Urine micro albimun Unavailability of easy accessibility to centres which perform essential investigation to lower grade hospitals • Immunoassays for hormones • Nuclear medicine imaging • Magnetic resonance imaging
Target areas & Beneficiaries	at risk population
Justification	High risk ethnicity in general with pockets of higher prevalence in urban areas Prevalence – 11% Urban areas_ 15% Projected prevalence in year 2030 – 20% Current prevalence of Pre diabetes plus diabetes _20%
Important assumptions / Risks / Conditions	Prevalence of diabetes is already high Current trend is an increase of prevalence Prevention of diabetes is important by treating and prevention obesity Prevention of complications of diabetes

	Proper management of complications	
Vision	The specialist endocrinologist to assume the role of a leader in delivering standard care to manage and/or prevent diabetes	
Mission	• Identify and prioritize the geographical areas and establish endocrine and diabetes units in relevant hospitals with defined minimum framework of facilities in order to deliver specialist care • Establish identified centres of excellence in E & D • Establish a networking system with local levels hospitals involved in diabetes care	
Goal	Establish endocrine & diabetes units in teaching, provincial general and district general hospitals manned with a specialist endocrinologist/s with minimum defined facilities catered to each level	
Programe Objectives (Please prepare separate indicators for each objective) 1. Identify the cadre projection to appoint specialist endocrinologists for the next ten years 2. Prioritize the above based on below mentioned criteria • Different levels of hospitals • Demand based on the population of a given geographical area 3. Identify the minimum level of facilities to provide to an endocrine & diabetes unit of each level of hospital setting 4. Identify the minimum standard of care that	***Indicators***	**Means of Verification**

should be provided by an E & D unit of different level 5. Formulate method/s to evaluate and monitor the outcome of objective 4 6. Establish a networking system to cater to the lower grade hospitals inclusive of a properly functioning back referral system		
Output (Please prepare separate indicators for each output) Step 1 - Appoint an endocrinologist to all teaching hospitals and provincial general hospitals (done already) Step 2 – appoint a minimum of 2 and maximum of 3 endocrinologists to teaching hospitals Step 3 - appoint an endocrinologist to all district general hospitals Step 4 – while filling up the above mentioned cadre positions in district general depending, based on the requirement consider appointing a maximum of 2 endocrinologists to provincial general hospitals Other lower grade hospitals The endocrinologist based in the higher scale hospital in a particular catchment area has the option of serving other smaller scale hospitals • Eg; endocrinologist based in Ratnapura	Indicators	Means of Verification

could conduct a specialized clinic in Balangoda base hospital once a month Back referral system to lower scale hospitals with annual screening in endocrine units *<u>Matters to discuss</u>* *1. In the presence of more than 1 consultant (either transferable or non-transferrable, issues related to distribution of resources and administrative responsibilities and practicality of maintaining autonomy of each consultant) The above are important as the long term goal is to promote multi-manned units verses multiple units in major hospitals. We could follow a similar overseas endocrine unit to set our goals in this regard We could use a university type model with Non-Transferrable Post and Transferrable (Resident Endocrinologist). Physically resource sharing with autonomy. However if units are sharing resources these have to have policies on how this is done- either a permanent policy or allow the units to work it out among themselves* **2. <u>Identify the resources related to endocrinology and diabetes needed (need to list out the requirements)</u>** **<u>MRI</u>** To be developed with endocrine and biochemical tests for access for all hospitals in the country.		

NHSL Develop as centre of excellence with all facilities and specialized endocrine and biochemistry tests, PET scan, facilities for nuclear medicine scan, I131 therapy, access to radiology and interventional radiology services. **Teaching hospital** 1. Facilities to carry out biochemistry Eg. Immunoassays, HbA1c 2. Develop neurosurgery a. Appointing a neurosurgeon b. MRI 3. Equipped foot care clinic and training of nurses and medical officers 4. Develop vascular surgery a. appointing a vascular surgeon 5. equipped eye unit and training of medical officers 6. DXA scanner and training of medical officers 7. A uniform annual screening protocol 8. A uniform training module for the medical officers attached to endocrine units 9. A central training program for diabetes educators 10. Podiatry service and podiatry workshop Other hospitals (provincial general and district general) 1. Develop resources as mentioned in the above section and tailor to a lesser degree 2. Utilize services for neurosurgery and vascular surgery at the teaching hospital for the province		

Essential services that need to be developed *<u>*Shared care for gestational diabetes mellitus (GDM).*</u> Establish specialised/multidisciplinary (VOG/ Endocrinologist/ specialized nurse/ dietician/ midwife) GDM clinics at each hospital setting with an Endocrinologist. *<u>*Foot care*</u> Properly equipped foot care unit (basic equipment needed for a foot care unit is annexed) Introduce a shared care model with surgeons and facilitate the infrastructure to implement this concept based structure Provision of trained doctors and/ or nurses for foot ulcer care A central training program with periodic updating for medical officers and nursing officers engaged in diabetic foot ulcer management A formal training program for 'podiatrists' and incorporate their service to diabetic foot clinics under the supervision of endocrinologists. Until such time to bridge the gap... nurses/other personnel could be trained for this purpose Introduce a service for the provision of Government supported custom made foot wear production at provincial		

level. *<u>*Adolescent / transition clinics*</u> Set up clinics with the participation of the Paediatrians with regards to childhood diabetes and endocrine problems to prevent defaulting of proper clinic follow up during the transition to adult care *<u>*Retinopathy screening*</u> Set up centres at the teaching hospitals with several trained doctors under the regional endocrinologist who would screen and refer to the regional ophthalmologists. This would reduce the burden on the ophthalmologists. Mobile retinopathy screening programmes where a mobile unit could be sent to each PU and the patients can get their annual screening done when notified by that centre. These mobile units can move weekly within the province or district. <u>Establish criteria and periodic updating regarding carrying out of basic biochemistry (financial protection of patients)</u> Eg HbAic – in well controlled patients maximum of 2/year to a minimum of 1/year TSH – in stable patients maximum of 3/ year to a minimum of 1/year Urine micro albumin		

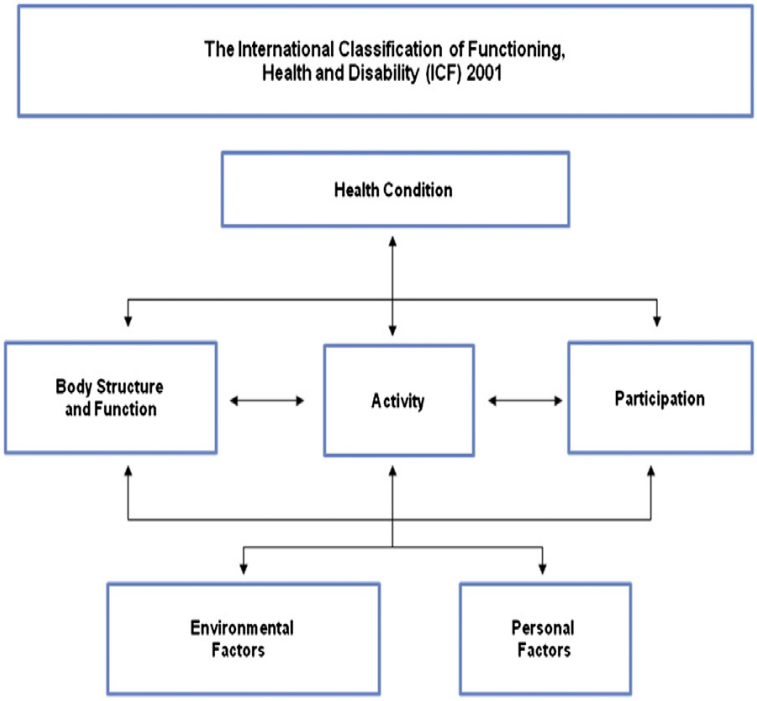
Identify the cardre projection for the medical offices in endocrine units in different levels of hospital settings NHSL 25-35 Teaching hospital – 15 to 20 Provincial general - 5 to 10 District general – up to 5		

Programme Title	**Thalassemia Control Programme**
Focal Point	DDG(PHS) 1
Background	Thalassemia was identified in Sri Lanka in 1951 for the first time (De Silva et al. 2000). There are about 1000 Thalassemia patients in Sri Lanka and around 100 new patients add every year (Perera et al. 2000). It is predicted according to the average gene frequencies that there will be more than 2000 patients needing treatment any time in the future (De Silva et al 2000). The disease is more prevalent in North Western, North Central and Uwa provinces (De Silva et al. 2000). The number of server Thalassemia patients reported to the institutions from all over Sri Lanka was increased during past few years (De Silva et al. 2000). National Thalassemia centre is established in the teaching hospital, Kurunegala where the most of the thalassaemics get treatments in the country. Research shows that many thalassemia patients in Sri Lanka received blood transfusion unnecessarily. on the other hand, there are substantial numbers of patients who have not yet been diagnosed. These two groups must be identified, because then the limited resources can be utilized to gain maximum benefit to the needy children (De Silva et al. 2000)
Target area & beneficiaries	North Western and North Central, Southern and Uva province
Justification	The economic and social cost of the disease is high due to patients'

	lifelong need for monthly blood transfusions and treatment. So, excessive cost for managing these Thalassemia patients is a one of the major health care problem in Sri Lankan. Periodically conducting screening programmes, health education programme and counseling programmes, need to reduce the burden of Thalassemia in future.
Important Assumptions/Risks/Conditions	Assumptions • Availability of dedicated, skilled health staff • availability of drugs and iron chelating machine • Continued funding support from both government and international partners Risks • Discontinuation of the drugs for all the thalassemia patients due to lack of availability of drugs
Vision	Reduce the number of Thalassemia patients to very low levels through means of prevention activities where it will not be a burden to health sector in Sri Lanka.
Mission	Plan and implement a comprehensive programme to reduce the burden of Thalassemia and to prevent Thalassemia in future by educating people and early detection of the Thalassemia agent by effective screening programmes.
Goal	Provide best possible care for Thalassemia patients in Sri Lanka
Programme Objectives	1. Reduction of mortality and morbidity due to Thalassemia 2. To distribute the Thalassemia equipments for hospitals in

	affected areas 3. To enhance the Thalassemia screening programmers 4. to develop and disseminate the education materials for Thalassemia 5. To conduct the Thalassemia education programmes for people
M & E	National and district level Thalassemia review meeting
Reference to Research	De Silva, S., Fisher, C.A., Premawardhena, A., Lamabadusuriya, S.P., Peto, T.E.A., Perera, G., Old, J.M., Clegg, J.B., Olivieri, N.F., Weatherall, D.J et al 2000 Thalassemia in Sri Lanka: implications for the future health burden of Asian populations. *Lancet*, **355**,786-791.

Program Title	Strategic framework on prevention and management of **childhood disabilities including Autism**.
Focal Point	Deputy Director General (Medical Services-I)
Background	1. "Disability" is a term encompassing impairments, activity limitations and participation restrictions. Childhood disabilities are conditions that do, or are highly likely to; affect the trajectories of children's development into adulthood. Many have a neurological basis and are commonly referred to as 'neurodevelopmental' disabilities. However certain acquired conditions may also result in disabilities in childhood. 2. Childhood disability continues to be a significant public health issue in Sri Lanka and across the world. Wide range of impairments and conditions are associated with childhood disability, with neurodevelopmental conditions forming the largest group. No nationwide studies of the prevalence of neurodevelopmental disorders are available for SL. However information on the prevalence of trends in childhood disability is important for the development of effective policies and interventions to reduce it and improve the outcome of children with disabilities. 3. The good news is that in the 21st century there are important new ideas about health and childhood disability that are helping us to expand our thinking. In 2001, the World Health Organization published a set of ideas about how we might think about health. This is the view taken in the most recent classification of disability (ICF) published by the World Health Organization. Disability is an umbrella term used to describe the situation of each person in a wide area, and is used within the context of personal and environmental factors. Environmental factors are those that lie outside the individual and "make up the physical, social and attitudinal environment in which people live and conduct their lives". These in turn are influenced by cultural and religious practices and beliefs. The ICF clearly presents the opportunity to consider all health issues within a broader social-ecological context that could be considered to turn the framework 'upside down'. This suggests that, within this 'dynamic system', changes in any area of the framework may potentially have influences elsewhere in the system.



4. Data from the recent study showed that developmental disabilities (DDs) are common: about 1 in 6 children in the U.S. had a Developmental Disability in 2006–2008. These data also showed that prevalence of parent-reported DDs has increased 17.1% from 1997 to 2008. Over the last 12 years, the prevalence of DDs has increased 17.1% that is about 1.8 million more children with DDs in 2006–2008 compared to a decade earlier; specially a marked increase was seen in conditions like Autism and ADHD, which were risen to 289.5% and 33.0% respectively.**http://www.cdc.gov/ncbddd/developmentaldisabilities/features/birthdefects-dd-keyfindings.html**

Cerebral palsy is also on the rise in the low and middle income countries because the neonatal care is improving and the survival of extreme preterm infants is higher. It is also reported that with such advancement of care in the acute care settings a rise in the prevalence of such conditions is to be anticipated.

According to the local data it is estimated that road traffic and other types of accidents contribute to acquire disabilities amongst children.

GAP ANALYSIS by using UHC tool	**Equitable distribution of services to all patients of the country**	**Accessibility to all health services by all patients of the country**	**Quality of Service offered to all patients of the country**	**Financial Protection** of all patients of the country
	Only limited services for detection, diagnosis and intervention available at selected hospitals in the a few urban settings in Sri Lanka.	The services are limited to urban locations and the majorities are located in the Western Province.	Due to the lack of training in child development and disability care of the staff in all categories of doctors including Paedaitricians and all types of allied health staff are inadequate in the numbers, skills knowledge and attitudes.	Due to the lack of services in the government sector and the availability of multiple services within the private sector patients seek services in this sector which is costly and sometimes not the best.
Target areas and beneficiaries	Children with disabilities including autism and other neuro developmental disorders and acquired disabilities and their families			
Justification	Higher numbers of children at risk of developmental disorders are surviving in the world (approx. 15.1 million) and if detection and intervention takes place early their outcomes are better. At present there are no national statistics for Sri Lanka. Also there is no developmental surveillance and a referral system for interventions therefore many children and families end up dependent with less functional abilities. For example in small studies conducted in Sri Lanka on Autism shows the mean age of parental concern was 27.49 (SD ± 9.566) months and the mean age of diagnosis was 33.19 (SD ± 10.499) months. There was a significant delay in seeking services. The mean duration taken to seek services after identifying the problem was 21.83 (SD ± 29.535) weeks. Therefore the time to build new synapses in the brain was lost.			
Important Assumptions/Risks/Conditions	Lack of a national programme to deal with these conditions is a major deterrent to achieve the best management of these children. The capacity building of doctors of all levels and the community based staff from the level of the public health mid wife is extremely important in the early detection.			

	The need for organized referral systems and establishment of specialized centers are also mandatory requirements for the smooth continuation of care over the life span for these children and their families. Multisector collaboration is the other most vital component for successful provision of services and better social functioning of these children. Lack of awareness of all categories of health and other sector officers about the need to ensure rights based services for these children and their families.	
Vision	To provide holistic rights based multi-disciplinary care across lifespan to children with neurodevelopmental disorders and autistic spectrum disorder	
Mission	Implementation of standard care to all children with disabilities through capacity building, infrastructure development and multisector collaboration.	
Goal	To ensure all children with disabilities to live an optimally functional capacity throughout life.	
Programe Objectives	**Indicators**	**Mean of Verifications**
1. To build awareness amongst the general public to detect developmental disorders at the earliest stage.	Number of awareness programmes conducted per annum	Ministry of health planning unit IMMR
2. To establish an island wide community based screening and surveillance programmes to identify developmental delay and disorders early.	Proportion of districts with established specialized centres.	
3. To develop and implement national guidelines on detection, diagnosis and management of children with disabilities.	Number of districts which have implemented the national guidelines.	
4. To develop a national data base on children with disabilities	Number of children registered.	
Output **(Please prepare separate indicators for each output)**	**Indicators**	**Mean of Verifications**
1. Early detection of children with developmental delay and disorders.	No of children referred by parents and the number detected by the primary health care workers.	Statistics Unit MOH
2. Number of fully functioning specialized centres.	No. of children and the family attending the per center	

	❖ Number of active collaborations conducted by the centre ❖ Proportion of children being regularly followed up in these centres.	
3. Number of children who achieve the age specific best functional capacity using the ICF.	Use ICF coding to measure the functional capacity	
4. The availability of trained staff at the specialized centres.	Number of health personnel who have undergone training	
Strategies / Major Activities	**Indicators**	**Mean of Verifications**
1. Awareness and screening programmes: a. Create awareness amongst the general public including the parents. b. Training of public health staff and primary health care workers on early detection, referral and intervention		
2. Service provision to be upgraded phase wise a. Development of standard protocols and guidelines to detect, diagnose and manage and continuity of care of different conditions leading to childhood disabilities b. Health personnel i. Capacity of all levels of presently available health staff: doctors, nurses, allied health professionals. ii. Revise the cadre of the following subspecialties: Paediatric neurologists, Community paediatricians, Child psychiatrists, Speech and language therapists, occupational therapists, Physio therapists, prosthetics and orthotics iii. Capacity building of the specialists: Short term overseas training programmes iv. Introduce new cadre and new categories of		

specialists: Paediatric rehabilitation specialists, child psychologists, audiologists v. Introduce a community team attached to each RDHS office to provide community based services to the children and the families (Community Paediatrician and a team) c. Infra structure i. To establish community based centres in each MOH area to provide screening and intervention on a regular basis. ii. Establish a national centre of Excellence in Sri Lanka to provide the state of the art services, training and research. iii. Establish at least one center of excellence in each district affiliated to the district general hospital consisting of the entire team to provide comprehensive standard care for these children. iv. To prepare a national level e based information system.		
3. Intersectoral collaboration a. Provision for care with children with disabilities always involvemultisector collaboration. The main sectors involved are health, education, social welfare and child development. b. Establishment of a district level coordinating unit to implement the community based multisector service provision.		

c. Each centre should also coordinate and appoint officials from each of these sectors to provide collaborated care.		
4. Research a. Conduct prevalence studies to define the magnitude of difference types of childhood disabilities b. Conduct condition specific national research and save in an accessible national platform		
Monitoring & Evaluation	Periodic review by the Ministry of Health together with the College of Paediatricians, the College of Psychiatrists, the College of Rheumatologists and other relevant professional organizations.	
(*)Reference to Research	**1.** *Alfred L Scherzer, MeeraChhagan, ShuaibKauchali, Ezra Susser. Global Perspective of early diagnosis and intervention for children with developmental delays and disabilities: feasibility of early detection and intervention. Developmental Medicine and child Neurology 2012, 54:1079-1084* *2. K.M.Milner, E.F.G.Neal, G.Roberts, A.C.Steer, T.Duke. Long-term neurodevelopmental outcome in high-risk newborns in resource-limited settings: a systemic review of th literature. Paediatrics and international chid health2015, vol-35:227-242* **3.** **http://www.cdc.gov/ncbddd/developmentaldisabilities/features/birthdefects-dd-keyfindings.html** **4.** Convention on the rights of persons with disabilities. Geneva, United Nations, 2006 5. Autism spectrum disorders & other developmental disorders From raising awareness to building capacity:World Health Organization, Geneva, Switzerland ,16 -18 September 2013 6. Diagnostic and Statistical manual of Mental health, Fifth Edition DSM-5 7. "International Classification of Diseases (ICD)". World Health Organization. Retrieved 23 November 2010	

Profile written by

1. Dr. Samanmali P. Sumanasena
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3. Dr. Sudarshi Seneviratne

Program Title	**Vision 2020** National Programme for Prevention of Avoidable Blindness
NationalFocal Point	Director General of Health Services
Background	Vision 2020 is a global initiative launched in 1999.The main focus is to eliminate the avoidable blindness among citizens by the year 2020. Under this project there were 3 element identified as important a. Cost effective control interventions for blinding priority eye diseases b. human resource development c. Infrastructure development with the maximum community participation. Sri Lanka launched this programme in year 2007 by the Ministry of Health in collaboration with the College of Ophthalmologists of Sri Lanka. This is a joint project of GoSL, WHO and INGO's interested in prevention of blindness. Operations of the programme are adhered to a five year action plan formulated according to global strategies of eye care. Ministry of Health supports this programme by allocating necessary staffs, establishing and maintaining well equipped eye units at government hospitals across the island and providing necessary drugs and consumables. All other necessary funding was done by the donororganizations. Vision 2020 Programme was able to make a significant difference in the eye care services in Sri Lanka over the last nine years. Thousands of school children with vision defects were benefited with free eye glasses in every district of the country. A large number of patients with blinding cataract were benefited with free intra ocular lenses provided by Vision 2020 and regained sight. Many undiagnosed glaucoma and diabetic retinopathy cases were diagnosed and treated accordingly and people with low vision were given services. Many new eye units were established and existing units were renovated and equipped. A national blindness survey has taken place for the first time in the history enabling better future planning of eye care services. Sight for Life Project has been launched to establish to build a mobile cataract surgical unit.
Target areas and beneficiaries	All categories of patients with visual impairment or diseases leading to blindness, including cataract, glaucoma, diabetic retinopathy, childhood blindness, refractive errors & low vision. School children having refractive errors and elderly people having blinding cataract were given priority in these projects.

Gap Analysis	
1.Equitable distribution of services to all patients of the country	No equitable services, services and dependent on the affordability accessibility and other barriers to access eye care.
2.Accessibility to all health services by all patients of the country	Because of the limited services less accessibility to the public due to number of barriers,
3. Quality of service offered to all patients of the country	Quality services are not available in certain hospitals. Due to unavailability of adequate HR, infrastructure facilities including instrument equipment and buildings.
4.Financial protection of all patients of the country	High out of pocket expenditure for intraocular lenses consumable and eye drops..
Justification	There are many reasons that lead to visual impairment or blindness. It is varying according to the health coverage of each country. According to the WHO global estimates approximately 314 million people live with serious vision impairment. Among these 37 million are blind and 124million are suffering from low vision. Uncorrected refractive errors in 153 million people. Out of these 75% of blindness is avoidable. Worst is those 90% of people live in low income countries. The risk of visual impairment is common to all the age groups but more in elderly population. Sri Lanka is a country still offering free health facilities to its citizens. Sri Lanka has one of the fastest aging populations in the Asia. The population of age over 60yrs is 12.4% in 2015 and this is estimated to reach 21% in 2030. This is mainly because of the long life expectancy and reduced birth rate. The detection rate of problems lead to blindness is high with the screening programmes conducted by the GoSL. As the increasing of aged population the rate of prevalence of chronic diseases are also high. These chronic diseases may lead to eye problems as a complication. And also if not treated properly will ended up as visual impairment or blindness. The low vision is defined as visual impairment not corrected by standard glasses, contact lenses, medicine or surgery and interfere with person's ability to perform the daily activities. The estimation of low vision is 140,000 people among the Sri Lankan population and this number will increase with time. Vision is one of the most important human perceptions. Visual impairment will lead to total dependency if unattended. With rising elderly population and NCD this problem will become a number one burden to the Ministry of health where health cost is concerned. The early detection and intervention with simple surgical measures will solve the major part of the problem.

Important Assumptions/Risks/Conditions	. Following problems are identified a. Improper resource allocation b. Improper implementation of guidelines island wide c. insufficient number of eye surgeons and other eye care staffs These are seems to be the limiting factors for achieving the goal.	
Vision	Total elimination of avoidable blindness in Sri Lanka.	
Mission	Incorporate primary eye care in to existing primary health care system to, provide universal and equitable eye care services, fill the gap of human resources and delivery of cost effective cataract surgeries.	
Goal	Accessible, equitable, efficient and effective eye care to preserve vision of Sri Lankan citizens by conducting screening programs in community and schools, low vision services, cataract surgical programmes, infrastructure and human resource development covering the entire country.	
Program Objectives	Indicator	Means of verifications
1. Increase awareness of diseases causing blindness and visual impairment, preventive measures and treatment options among the public	Fund allocation and utilization per annum for vision 2020 programme	Review meetings Supervision reports
2. Strengthen the diagnosis and management of Glaucoma	Number of awareness programmes conducted	M &EClinic registries Surgical registries IMMR ?
3. Manage the incidence of childhood blindness related to congenital and acquired conditions.	Number of surgeries Number of clinic attendees Number of CME programmes	Vision 2020 web database Low vision web database
4. Prevent the functional low vision among children and adults.		
5. Strengthen the measures to prevent blindness related to refractive errors by improving optical services.	Disease specific prevalence rates	
6. Prevent diabetic retinopathy and related	Policies and regulations	

visual loss. 7. Improve infrastructure and human resource facilities to cater the needs. 8. **to provide all requirements of surgical items (including LENSES) used in Cataract Surgery through the budget of Medical Supplies Division (MoH – GoSL)**	Protocols Guidelines **Percentage of MoH _ GoSL budget allocation for purchase of <u>standard quality lenses for cataract surgery</u>**	MSD statistics monitored by Vision 2020 Secretariat and DGHS DDG (NCD)
Output	Indicator	Means of verification
1.Number of cataract surgeries conducted 2. Number of new eye care units established per year Number of units renovated 3. Number of Ophthalmic Instrument and equipment supplied 4.Number of eye care intra ocular lensespurchased 5.Number of Ophthalmologists, Optometrists trained per year Number of eye nurses trained 6.Number of awareness programmes and training programmes conducted per year For public health staffs general public	Number of surgeries per month Number of hospitals with eye care facilities. Number of standard units with equipments Number of people who received the care Number of new appointment of Ophthalmologists and Optometrists Financial allocations per year	Quarterly and annual reports send to the ministry and Vision 2020 head office
Strategies and major activities	1.Provision of free eye care Services 2.Upgrade of eye care units in Sri Lanka	
Monitoring and evaluation of the program	Ministry of health and Vision 2020 secretariat	
References and Research	1. Annual report Vision 2020 2. Policy Brief of The Fred Hollows Foundation and Burnet Institute 3. Recommendations of national blindness survey	

Programme Title	Health Sector Disaster Preparedness and Response
Focal Point	National Coordinator – Disaster Preparedness and Response Division
Background	Sri Lankan disaster profile is characterized by disasters such as floods, landslides, droughts, Tsunami, epidemics, industrial and chemical accidents and internal conflict. In addition, events that threaten continuity of health services are also considered as emergencies by the health sector. In the aftermath of 2004 Tsunami, disaster management system of the country has seen many improvements including the adoption of the Disaster Management Act No. 13 and establishment of disaster management organizational framework. In parallel with these national level developments, the health sector also adopted a number of measures to enhance disaster preparedness and response. The Strategic Plan for Health Sector Disaster/Emergency Preparedness – 2011 provided the guidance to the health sector in disaster management. Disaster Preparedness and Response Division (DPRD) has been established within the Ministry of Health to coordinate the disaster preparedness and response activities. An Emergency Operations Room with trained staff is available to be activated during emergencies and disasters. Standard Operating Procedures (SOP) have been established by the health sector during emergencies and disasters. Enhancing the capacity of health staff has been a key means of making health sector prepared for disasters. Health Sector Disaster Management Diploma program has been established in collaboration with the Post Graduate Institute of Medicine to train medical officers on disaster management. In addition, training programs are being conducted regularly for capacity building of hospital and field level staff on disaster management. Disaster Preparedness and Response Plans have been developed for major hospitals in the country. The level of preparedness of these institutions have been regularly tested through disaster management drills. Preparedness for infectious disease outbreaks that could grow into epidemic proportions has been a priority area of concern for the health sector. DPRD has worked closely with the Epidemiological Unit and the Unit of Director Quarantine in this regards.
Gap Analysis	The Climate Change has become a challenge of present day humanity. Sri Lanka being an island nation, it is vulnerability to consequences of Climate Change are inevitable. Sea level rise, extreme weather events, water and food scarcity and disease outbreaks could have serious health consequences. This signals for much larger surge capacity of the health sector than it has at present.

	The year 2015 marked the end of the Hyogo Framework for Action (HFA) and the adoption of the Sendai Framework for Action (SFA). In contrast to the HFA, SFA has highlighted the importance of shifting the attention from disaster response to disaster risk reduction at all levels. Importance of making critical facilities such as hospitals safe through integrating disaster risk reduction has been highlighted in the SFA. Safe Hospitals Initiative (SHI) advocated by the World Health Organization (WHO) promotes structural, non-structural and functional integrity of health facilities through disasters. Even though some work has been done to integrate SHI to Sri Lankan health sector, much work needs to be done. Even though extensive work has been done to develop human resources of health sector disaster management, there are significant areas for improvement. Human resource development needs to expand across all categories of health staff who are critical elements of a disaster response team. In the meantime, sustainability of such trainings needs to be ensured. Health sector needs support and coordination of all stakeholders in carrying out the required activities in relation to disasters. Recent disasters have demonstrated gaps in coordination between health sector and other stakeholders. Information management, knowledge management and research are essential during health sector disaster response. Existing means for information management and knowledge management needs to be improved in parallel to the rapid changes occurring in the above fields. Sri Lanka Comprehensive Disaster Management Program (SLCDMP) has been a major strategic development that has happened in the disaster management sector of Sri Lanka in the recent years. One of the key proposals under the SLCDMP for which the Ministry of Health is responsible is the development of prehospital care system of Sri Lanka. This proposal highlights the importance of obtaining of community participation towards the health sector disaster response activities. Means to cater to the need has to be figured out by the health sector. = Results-based monitoring and evaluation is essential to ensure efficient and effective use of resources as well as ensuring accountability. Health sector has to integrate results based disaster management. Above mentioned gaps and needs have been incorporated in to the Strategic Plan for Health Sector Disaster/Emergency Preparedness – 2015 which will be valid for a period of 5 years after which it needs to be revised based on the disaster management environment.
Target Area and Beneficiaries	Health Sector Disaster Preparedness and Response is addressing critical needs in creating a Safer Sri Lanka. It will benefit the people of the country who are vulnerable to emergencies and disasters. The Health Sector Disaster Preparedness and Response System will ensure the protection of special groups such as children, women, disabled and elderly.

Justification	Vulnerability of Sri Lanka to disasters has been clearly demonstrated over the last few decades. Health sector plays a critical role in responding to disasters. In addition, health institutions needs to continue their critical operation disasters and in their aftermath. Health institutions needs to be resilient to withstand the shocks of disasters. Structural, non-structural and functional aspects of resilience are critical to ensure the continuity of businesses by the health sector. Providing emergency trauma care, ensuring environmental health services for disaster affected persons, supplying with psychosocial and rehabilitation services are some of the duties entrusted upon the health sector in relation to emergencies and disasters. Hence, heath sector disaster preparedness and response program is a critical programme that is essential both by the national disaster management system as well as the health sector itself.
Important assumptions/risk/conditions	Continuous support at policy, administrative, logistics, financial and operational level is available to run the disaster preparedness and response programme. Non-health stakeholders continue to support the health sector activities in cooperative and collaborative manner.

Vision	Resilient health sector for safer communities.
Mission	To contribute towards a safer Sri Lanka through improving health sector functioning in relation to disasters, integrating disaster risk reduction into health sector and empowering communities as supporters on health sector disaster response.
Goal	1. To reduce morbidity, mortality, disability and other forms of human suffering due to disasters. 2. To promote continuity of health services through disasters. 3. To improve community participation for health sector disaster response.
Objective	1. To improve structural, non-structural and functional capacity of health facilities through safe hospitals initiative. 2. To improve human resources for health sector disaster management. 3. To promote stakeholder coordination for health sector disaster management. 4. To improve information support, knowledge management and research for health sector disaster management. 5. To improve community participation towards health sector disaster management. 6. To integrate results-based monitoring and evaluation to health sector disaster management.

Objective	Indicators	Means of verification
1. To improve structural, non-structural and functional capacity of health facilities through safe hospitals initiative.	Percentage of health facilities with improved structural, non-structural and functional capacity enhanced through safe hospitals initiative	DPRD, Hospital reporting
2. To improve human resources for health sector disaster management.	Percentage of health personnel trained on health sector disaster management	DPRD, Database of health staff trained on health sector disaster management
3. To promote stakeholder coordination for health sector disaster management.	Level of stakeholder coordination for health sector disaster management	DPRD, Ministry of Disaster Management and other stakeholders
4. To improve information support, knowledge management and research for health sector disaster management.	Availability of information management and knowledge management systems and research in the field of health sector disaster management	DPRD
5. To improve community participation towards health sector disaster management.	Percentage of health institutions with health sector disaster management volunteers. Percentage of PHM areas in which active community participation towards health sector disaster management is available	Health institutions, Medical Officers of Health, Volunteer database
6. Integrate results based monitoring and evaluation to health sector disaster management	Availability of a functional results based monitoring and evaluation system for health sector disaster management	DPRD
Output	**Indicators**	**Means of verification**
1. Advocacy done for safe hospitals initiative.	Percentage of hospitals for which advocacy done for safe hospitals initiative.	Hospitals DPRD
2. Safe Hospital Indicators Checklist for Sri Lanka is available.	Availability of Safe Hospital Indicators Checklist for Sri Lanka.	DPRD

3. Training on Safe Hospitals Initiative conducted.	Percentage of planned training on Safe Hospitals Initiative completed.	DPRD
4. Safe structural indicators of hospitals improved.	Percentage improvement of Safe structural indicators of hospitals.	Hospitals DPRD
5. Safe non-structural indicators of hospitals improved.	Percentage improvement of safe non-structural indicators.	Hospitals DPRD
6. Safe functional indicators of hospitals improved.	Percentage improvement of sage functional indicators of hospitals.	Hospitals DPRD
7. Independent audit and accreditation of hospitals on Safe Hospitals Initiative done.	Percentage completion of planned independent audits and accreditations done on safe hospitals initiative.	DPRD Hospitals
8. Training needs assessment conducted for health sector disaster management.	Availability of training needs assessment for health sector disaster management	DPRD
9. Training programs continued, developed and offered through existing and new training platforms for critical human resource categories.	Percentage completion of training programs continued, developed and offered through existing and new training platforms for critical human resource categories	DPRD
10. A pool of national and regional level trainers trained in health sector disaster management.	Availability of a pool of national and regional level trainers trained in health sector disaster management.	DPRD
11. A data-base of trainers and persons trained in health sector disaster management established.	Availability of a data-base of trainers and persons trained in health sector disaster management.	DPRD
12. Overlapping roles of different stakeholders with roles of health sector disaster management mapped.	Map of roles of different stakeholders with roles of health sector disaster management	DPRD
13. Coordination platforms for health sector and non-health sector stakeholders identified.	Availability of platforms for health sector and non-health sector stakeholders	DPRD
14. Advocacy package developed to inform of the role of non-health stakeholders in heath sector disaster response.	Availability of advocacy package to inform of the role of non-health stakeholders in heath sector disaster response.	DPRD

15. Information awareness and communication package developed to inform non-health stakeholders in health sector disaster response.	Availability of information awareness and communication package to inform non-health stakeholders in health sector disaster response.	DPRD
16. Advocacy and training programs conducted for non-health sector stakeholders on their role in health sector disaster management.	Percentage completion of planned advocacy and training programs conducted for non-health sector stakeholders on their role in health sector disaster management.	DPRD
17. Web-based disaster health information management plat form established.	Availability of web-based disaster health information management platform.	DPRD
18. Disaster health information management mechanism established.	Availability of disaster health information management system.	DPRD
19. Disaster knowledge management platform established.	Availability of disaster knowledge management platform established.	DPRD
20. Disaster health surveillance system established.	Availability of disaster health surveillance system.	DPRD
21. Disaster health research grant system established.	Availability of disaster health research grant system.	DPRD
22. Annual disaster health research for a conducted.	Completion of Annual disaster health research fora conducted.	DPRD
23. Annual disaster health research publication published.	Availability of Annual disaster health research publication.	DPRD
24. Training priorities for communities to be an asset in health sector disaster response identified.	Availability of a list of Training priorities for communities to be an asset in health sector disaster response	DPRD, Medical Officers of Health
25. Training modules developed for community awareness on health sector disaster response.	Availability of Training modules for community awareness on health sector disaster response.	DPRD
26. Health sector disaster management related competencies such as pre hospital care integrated into school	Level of integration of competencies such as pre hospital care integrated into school health program.	DPRD, FHB

health program.		
27. Health related competencies such as pre-hospital care integrated into the community-based environmental and occupational health programs.	Level of integration of health related competencies such as pre-hospital care integrated into the community-based environmental and occupational health programs.	DPRD, Medical Officers of Health
28. A results-based monitoring framework for health sector established.	Availability of results-based monitoring framework for health sector	DPRD
29. Health staff trained on the use of above framework.	Percentage of health staff trained on the use of above framework	DPRD
30. Regular review meetings held to assess the progress of the implementation of the Strategic Plan for Health Sector Disaster/Emergency Management.	Percentage completion of planned regular review meetings held to assess the progress of the implementation of the Strategic Plan for Health Sector Disaster/Emergency Management.	DPRD
31. Review meetings are conducted after each major disaster.	Completion of a review meeting after each major disaster.	DPRD
32. Relevant sections of the framework integrated into monitoring and evaluation frameworks of other stakeholders.	Level of integration of the relevant sections of the framework into monitoring and evaluation frameworks of other stakeholders.	DPRD, Other stakeholders
Strategies/ Major activities	1. To improve structural, non-structural and functional capacity of health facilities through safe hospitals initiative. 2. To improve human resources for health sector disaster management. 3. To promote stakeholder coordination for health sector disaster management. 4. To improve information support, knowledge management and research for health sector disaster management. 5. To improve community participation towards health sector disaster management. 6. To integrate results-based monitoring and evaluation to health sector disaster management. 7.	

Monitoring and Evaluation	**Action**	**Who**	**When**
	DPRD level review of health sector disaster	DPRD	Monthly

	management		
	Institutional level review of health sector disaster management activities at hospitals and health institutions	Disaster Management Focal Point	Quarterly
	Progress review of health sector disaster management	DPRD, all focal points of health institutions	Quarterly
	Progress review of health sector disaster management	DPRD, Disaster Management Focal Pont, RDHS, Head of Institution of hospitals, MOH of the affected area	After every major disaster

Activity Area	Equitable distribution of services to all patients of the country	Accessibility to all health services by all patients of the country	Quality of services offered to all patients of the country	Financial protection of all patients of the country
Health Sector Disaster Management	Health sector disaster management system covers all parts of the country before, during and after disasters.	Through coordinating with all health institutions in the country through the disaster management focal point system, health sector disaster management system has ensured accessibility to health services in emergencies and disasters.	Through Standard Operating Procedures, quality of health services provides to citizens have been ensured in emergencies and disasters.	All health services in relation to emergencies and disasters will be provided to the affected persons free of charge.