Health Master Plan

No.

MINISTRY OF HEALTH, NUTRITION & WELFARE,
THE DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA (MOH)
JAPAN INTERNATIONAL COOPERATION AGENCY (JICA)

MASTER PLAN STUDY FOR STRENGTHENING HEALTH SYSTEM
IN THE DEMOCRATIC SOCIALIST REPUBLIC OF SRI LANKA

VOLUME III

PROJECT PROFILES

HEALTHY & SHINING ISLAND IN THE 21ST CENTURY

FINAL REPORT

NOVEMBER 2003
PACIFIC CONSULTANTS INTERNATIONAL

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The following foreign exchange rate is applied in the study:
US$ 1.00 = 95 Sri Lanka Rupees (as of November 2003)

Message from Vice President,
Japan International Cooperation Agency (JICA)

In response to a request from the Government of the Democratic Socialist Republic of Sri Lanka, the Government of Japan decided to provide technical cooperation for establishing of a health master plan which will be effective for the next decade for the improvement of the health system in Sri Lanka. JICA selected and dispatched the study team headed by Dr. Katsuhide Nagayama of Pacific Consultants International to Sri Lanka between March 2002 and November 2003.

I am pleased that the Health Master Plan, presented herewith by Ministry of Health, Nutrition and Welfare, was a fruit of close collaboration with the Study Team. I hope the Health Master Plan, whose ownership is assured by Ministry of Health, Nutrition and Welfare, will contribute to the promotion of the health system in Sri Lanka.

Finally, I wish to express my sincere appreciation to all the officials concerned of the Government of Sri Lanka for their enthusiastic effort exhibited in the process of formulating the Health Master Plan.

November 2003

Kazuhisa Matsuoka
Vice President
Japan International Cooperation Agency

November 2003

Mr. Kazuhisa MATSUOKA

Vice President

Japan International Cooperation Agency

Tokyo, Japan

Letter of Transmittal

Dear Sir,

We are pleased to formally submit herewith the Final Report of "The Master Plan Study for Strengthening Health System in the Democratic Socialist Republic of Sri Lanka."

This report compiles the results of the Study which was conducted from March 2002 through November 2003 by the Study Team organized by Pacific Consultants International under the contract with JICA.

The report compiles the Sri Lanka Health Master Plan covering both reform and development of the health sector in Sri Lanka. The plan consists of 1) vision, goals and objectives; 2) overall basic strategies; 3) frameworks for health sector reform and development; and 4) priority programmes.

We would like to express our sincere gratitude and appreciation to the officials of your agency and the JICA advisory Committee. We also would like to send our great appreciation to all those who extended their kind assistance and cooperation to the Study Team, in particular to the Ministry of Health, Nutrition & Welfare and provincial/district health officials concerned.

We hope that the Master Plan will be able to contribute significantly to the improvement of the health sector and development in Sri Lanka.

Very truly yours,

Katsuhide NAGAYAMA, Ph.D

Team Leader,

Master Plan Study for Strengthening Health System in the Democratic Socialist Republic of Sri Lanka

PREFACE

The outcomes of the Sri Lanka Health Master Plan Study, for which efforts were made from November 2001 through September 2003, are complied in six volumes of reports prepared by the JICA Study Team in close collaboration with Ministry of Health, Nutrition and Welfare.

The Health Master Plan addresses government polices and strategies based on such a long-term vision that the health service delivery system shall be improved for all people in Sri Lanka, regardless of sex, age, ethnicity and economic class. Necessary actions are delineated to achieve the vision in forms of programs and projects in the next decade time horizon. The Master Plan espouses the slogan *"Healthy & Shining Island in the 21st Century"*. This implies a hope that Sri Lanka will become a healthier, more secure and more liveable nation where all people can enjoy their vividly shining lives, overcoming latent constraints and difficulties lying on the currently transitional health situation in terms of demography and epidemiology. To this end, the Master Plan underlines an innovative challenge required by not only the government sector but also each community and individual.

This section provides with a general insight into the basic structure of the Master Plan, explaining:

- Structure of the Final Report;
- Synopsis of the Strategic Framework; and
- Profile of the Health Master Plan Study.

A. STRUCTURE OF THE FINAL REPORT

Health Master Plan (HMP). The HMP is composed of three volumes and three supporting documents (Table A.1).

Table A.1 Six Documents of the Health Master Plan

Volume Number	Title
I	HMP Summary
II	HMP Analysis, Strategies, and Programmes
III	HMP Project Profiles
Supporting Document I	HMP Situational Analysis
Supporting Document II	HMP Surveys and Study Datasets
Supporting Document III	HMP Maps

Volume I

This volume contains the main message of the Health Master plan (2004-2015). It summarizes the analytical framework of the health sector, the identified issues based on the analysis of the situation, the planning framework, the strategic objectives and approaches, and the policy recommendation for the implementation of the Health Master Plan.

Volume II

This volume presents the direction of the health sector of Sri Lanka by the strategic framework and describes the strategies and programmes/projects to achieve the strategic objectives of the health sector in the next 11 years. The aim of this particular discussion is to serve as a guide to future health development efforts.

The Basic Frame of the HMP Volume II;

Introduction:	**Key Principles in the Institutional Reform and in the Service Delivery Reform,**
Part 1:	**Situation Analysis and Identified Institutional Challenges, Future Perspective of Health Needs and Demands, and**
Part 2:	**Strategic Framework and Programs, and**
Part 3:	**Principles towards Implementation.**

Introduction: Key Principles in the Institutional Reform and in the Service Delivery Reform, discusses the future direction of the health sector in this country based on the global trends and experiences and lessons learned in other countries. The analyses lay out the scientific evidence of health transition along with the demographic, social and economic transition happening in this country, and also points out the fact that Sri Lanka is now at the turning point of low-cost service demands to high-cost service demands at the turn of the 21st century. The country's health services will soon face enormous financial gaps and their manipulation by any self-coping mechanisms would inevitably fail.

Part 1: Situation Analysis and Future Perspective of Health Needs and Demand, shows the evidences to prove the conclusion of the first part.

Part 2: Strategic Framework, discusses the strategic objectives of the health sector in the next 11 years and shows the strategic approaches to achieve these objectives by coming up with Strategic Programs. The Strategic Programs are divided into five areas, namely: Health Service Delivery, Community Empowerment and Client Satisfaction, Human Resource Development, Financing, Resource Allocation & Utilisation, and Stewardship & Management of the Health Sector. In each area, comprehensive programs are formed to achieve each sub-sector objectives.

Part 3: Principles Toward Implementation, lays out the steps towards implementation after drawing up the HMP. The steps are Platform Building for Political Endorsement of Policy Recommendations, Institutionalisation for the Master Plan, Social Mobilisation/Sensitisation, Formulation of Action Plan for Priority Programs/Area, Political Decision-making for the Implementation, Capacity Building for Program Management, Resource Mobilisation, Program Implementation, Monitoring/Supervision of the Implementation, and Evaluation. In Chapter 14, the policy recommendations as a base of implementation are spelled out in detail.

The HMP is a rolling plan and a midterm review will be necessary to evaluate the output of activities and make corrections on the plan according to the evaluation. Priority Projects are identified in the first five-year timeframe to achieve the five-year objectives in the long-term perspective of 10 years. The first mid-term review is expected to take place in 2006.

Volume III

The priority projects mentioned in Vol. II above are the subject of this volume. The profile for each project provided herein contains a Project Summary and the following items:

1) Project Title
2) Project Number
3) Project Priority
4) Focal Point
5) Implementing Agencies
6) Starting Fiscal Year
7) Project Duration
8) Target Areas and Beneficiaries
9) Justification
10) Important Assumptions/Risks/Conditions
11) Project Objective – including indicators and means of verification
12) Project Output/product – including indicators and means of verification
13) Related Projects – including ongoing projects and projects under the Health Master Plan
14) Relevant Agencies to be Coordinated
15) Monitoring and Evaluation
16) Major Activities – including expected results and process indicators

Supporting Document I

Supporting Document I, Situational Analysis, contains the review and analysis of present conditions of health sector in Sri Lanka. The structure of the volume is as follows.

1) Situation Analysis: Its Framework

   This chapter describes "research issues" which lead to the discussion of the following chapters.

2) The External Environment and its Effects on Health and Health System

   This chapter analyses various external environments and their effects on health in this country. These external environments are geography, socio-cultural environment, politics, policies and government, economics, and various marginalised groups.

3) Health system Activities

   This chapter analyses the existing activities of the public allopathic sector and indigenous systems of medicine and private sectors. It encompasses the broad spectrum of activities - preventive, promotive, curative, rehabilitative and social services.

4) Management of Resources for Health

   This chapter examines the management of the following resources: Human Resources, Drug, Medical Equipment, Physical Facility, Funds, and Foreign Aid.

5) Stewardship of the Health Sector

This chapter deals with the stewardship function of the MoH. These functions are policy formulation, planning, priority-setting and resource allocation, regulation, legislation, accountability, M&E, coordination, public/private partnership, information generation, dissemination and use, and resource and research management.

6) North and East Provinces

This chapter looks into the situation of health in N&E Provinces. The existing issues and the transitional strategies are identified.

7) Assessment of the Health System

This chapter analyses and assesses the health sector from the various dimensions of health outcome, responsiveness and patient satisfaction, fairness in financing and equity, quality and safety, and efficiency.

8) Health Transition and Future Health Needs and Demands

The chapter discusses the demographic transition and health transition in Sri Lanka and their implication on the service demands. In addition, the future health expenditures are projected by macro and micro approach for the next 10 years.

9) Opportunities for Consensus Building

This chapter discusses the consensus building within and without the health sector which is a key element in the implementation phase of the master plan. In order to do this, the planners need to consider the following: 1) Lessons learned from previous health sector program, 2) the stakeholders' involvement, and 3) public opinion.

10) Conclusions

This chapter provides answers to the "Research Issues" described in Chapter 1.

Supporting Document II

Supporting Document II: Surveys and Study Datasets, contains the activity records and outputs of surveys/review works/consultation meetings with stakeholders.

Twenty-five (25) surveys were carried out during the first phase of the study and the survey results are summarized in this volume.

Supporting Document III

Supporting Document III, HMP Maps, compiles Maps of GIS (Geographic Information System) database on health facilities and health indices, and the Dataset.

B. SYNOPSIS OF THE STRATEGIC FRAMEWORK

The major planning issues are:

1) Incomplete decentralization of the health sector
2) Lack of Monitoring & Evaluation mechanism
3) Insufficient management capacity at all levels
4) Compartmentalized functions at the central MoH
5) Weak intersectoral coordination on some important health issues
6) Weak coordination mechanism with other health sectors such as private sector and Indigenous Medicine sector
7) Weak coordination mechanism of Human Resource Development Functions at the central MoH level
8) No integration of curative and preventive services at any levels
9) No mechanism for people to participate for monitoring of services
10) Financial constraints in preventive services and primary level health care services.

The Vision, Mission and Goal of the Master Plan are:

VISION:

A healthier nation that contributes to its economic, social, mental and spiritual development

MISSION:

To achieve the highest attainable health status by responding to people's needs, working in partnership, to ensure access to comprehensive, high quality, equitable, cost-effective and sustainable health services

GOAL:

A strengthened health system that strives for excellence to improve the health outcomes of the people in Sri Lanka

The vision of improving the health status of the people will be achieved through addressing the following strategic objectives:

1. To improve comprehensive health services delivery and health actions, which reduce the disease burden and promote health;

2. To empower community towards more active participation in maintaining and promoting their health;

3. To improve the management of human resources for health;

4. To improve health finance mobilisation, allocation and utilisation; and

5. To strengthen stewardship and management functions of the health system.

Figures B.1 and B.2 are diagrammatic representations of the dynamic relationships among the Strategic Objectives.

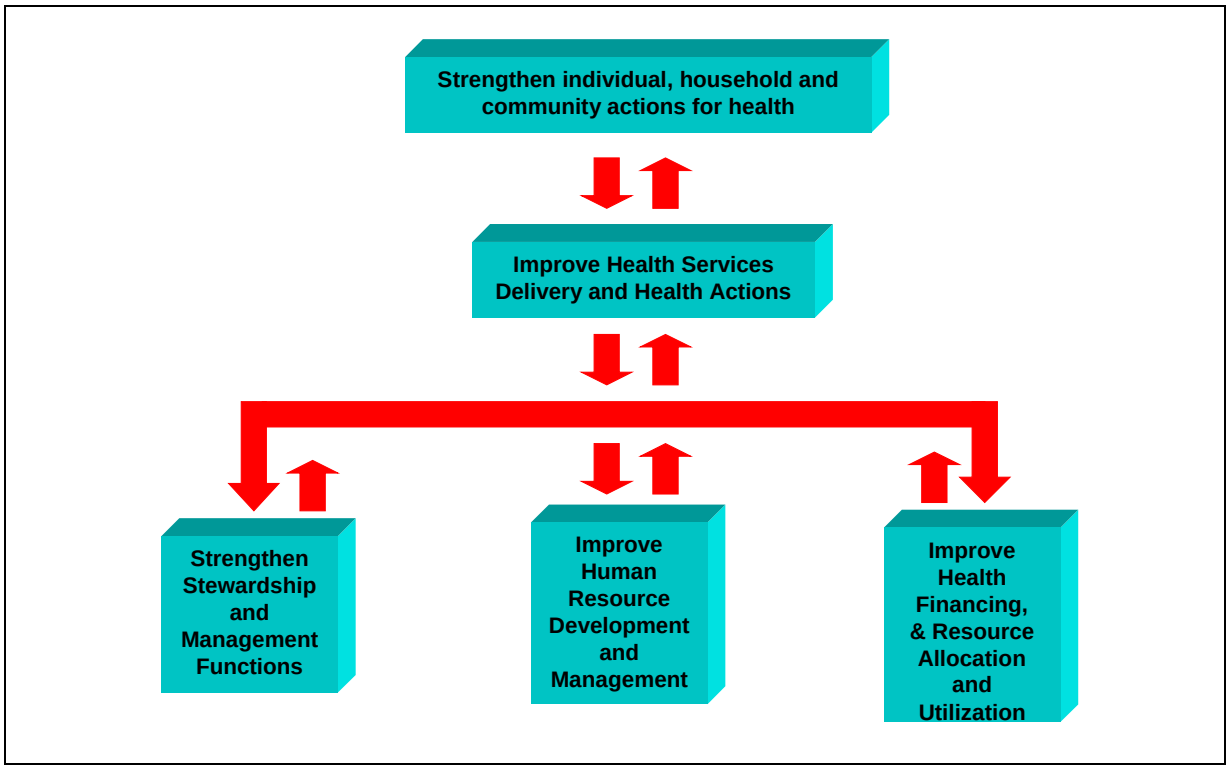

Figure B.1 Inter-relationships among the Five Strategic Objectives

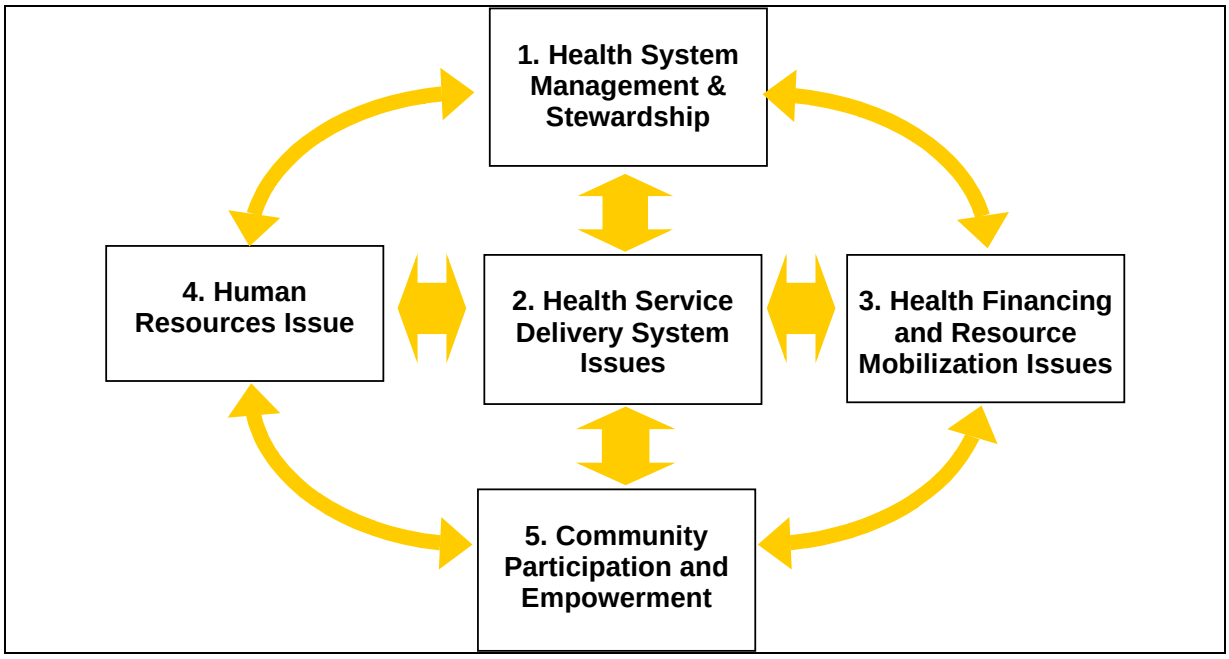

Figure B.2 Inter-relationships among the Five Strategic Objectives

C. PROFILE OF THE HEALTH MASTER PLAN STUDY

(1) Background

In response to the request of the Government of Democratic Socialist Republic of Sri Lanka (hereinafter referred to as "GOSL"), the Government of Japan (hereinafter referred to as "GOJ") decided to finance a "Master Plan Study for Strengthening of the Health System in the Democratic Socialist Republic of Sri Lanka" (hereinafter referred to as "the Study").

The Japan International Cooperation Agency (hereinafter referred to as "JICA") is the official agency responsible for the implementation of technical cooperation programs of the GOJ. On November 9, 2001, it undertook the Study in close cooperation with GOSL authorities based on the Scope of Work agreed upon between the JICA Preparatory Study Team and the GOSL, represented by the Ministry of Health, Indigenous Medicine and Social Services. According to the official regulations on consultant procurements, JICA selected Pacific Consultants International for the Study Team, headed by Dr. Katsuhide Nagayama, and dispatched the Study Team to Sri Lanka.

The Ministry of Health, Nutrition & Welfare (hereinafter referred to as "MoH") acts as the Counterpart Agency for the Study Team on behalf of the GOSL. The MoH is responsible for coordinating the implementation of the Study with other related government agencies, international donor agencies and international non-governmental organizations.

In the past, while the government of Sri Lanka pursued a policy of economic growth, equity has been emphasised as one of the primary concerns together with self-reliance. Even under the new economic policy the political commitment to equity remains.

The public health sector has provided not only basic but also higher-level health services and has built up an extensive network of health facilities. At the same time, private health providers have increased and flourished by attracting relatively affluent people residing in the greater Colombo area. As a result, Sri Lanka has achieved better health indicators than other comparable lower-middle income countries with relatively few resources.

However, it has become increasingly difficult to maintain this high performance with growing financial constraints and escalating prices for goods and services. The good performance contributed to the epidemiological transition; statistics show that more and more people are suffering from chronic diseases. With continuously declining mortality rates in association with lowered fertility, the national average life expectancy is expected to be at the level of the industrial countries by 2020. The rapid increase of the ageing population will necessitate public health policy change

In light of these trends past health policies must be reviewed and new policies issued to facilitate the country's continued progress in health in the opening decades of the 21st century.

(2) Study Objective

The objective of the Study is to formulate a Master Plan for strengthening and improving the health system in Sri Lanka, by 2015.

(3) Study Approaches

The Master plan Study has used four main approaches, to develop its work.

Locally-Initiated and Owned

The formulation of master plan was initiated by the Government of Sri Lanka asking the Government of Japan to give technical support in the process. The major steps to be taken to formulate the master plan were discussed and decided between MoH coordinators and JICA Study Team members. The question of fostering ownership has been discussed from the beginning of the study in order to ensure the Master Plan is adopted, advocated and implemented. This approach has been adopted throughout the planning work and promotes active participation of the MoH in the study. In conclusion, MoH and JICA have agreed to give authorship of the Master Plan to the Sri Lankans to increase the ownership and hopefully implementation of the plan.

Sector-Wide and Participatory

The planning process adopted a sector wide and participatory approach in order to solicit various stakeholders' opinions and ideas. The Study Team held various meetings and workshops to involve all health sector stakeholders from the beginning of the study. These stakeholders represent not only the national level MoH, but also different levels of sub-national health officials, private sector medical practitioners, traditional medicine sector, researchers and professional groups, other Ministries such as Ministry of Finance, other donor agencies, NGOs and communities. The issues existing in the health sector were widely discussed among stakeholders; the process of discussion was organized in a systematic way to improve the efficiency of the study process

Building on Achievements and Lessons Learned

In the 1990's, there were several health policy formulation exercises. Several different levels of plans were formulated, however, none of them have been implemented with any degree of consistency.

Lessons learned from the previous policies and plans are many. First, it is essential to involve key stakeholders in health sector in the planning process. Key stakeholders in health not involved in the planning would not be interested to implement the plans.

Second, previous experiences have taught that discussion and a participatory process are the best ways to address any significant policy changes. Again the discussions among key stakeholders are important because each stakeholder has different interests and information. There is a need to identify these differences in opinion and information and build consensus through further discussion. Without deep and serious discussion to minimize the conflict over policy issues, naturally it will not be easy to implement plans.

Third, it is necessary to have a proper monitoring system to ensure implementation. Measurable indicators of performance should be developed during the planning stage. The monitoring unit should be close to the planning unit and their activities need to be connected through a common flow of information

Evidence-Based Strategic Planning

The Study team collected most of the existing secondary data and literature. The Study team also conducted over 20 surveys and studies of various health sector issues. The situation of the health sector was analysed by looking at the physical reality, by analysing existing data and information, and by analysing data that came out of extensive field surveys. The plan has been designed based on scientific evidence and data

The Study team found out that some concerns are not covered by any data collection or have poor quality data in the existing MOH information system. These findings are important as they identify aspects that need to be strengthened in the existing information system so that ongoing evidence-based decision-making becomes possible.

(4) Phases of the Study

The Study for formulating the Health Master Plan was divided into three phases, namely:

Phase I: Review and Baseline Surveys of the Health Sector
(April, 2002-September, 2002, 6 months)

Phase II & III: Formulation of a Master Plan
(October 2002-August 2003, 10 months)

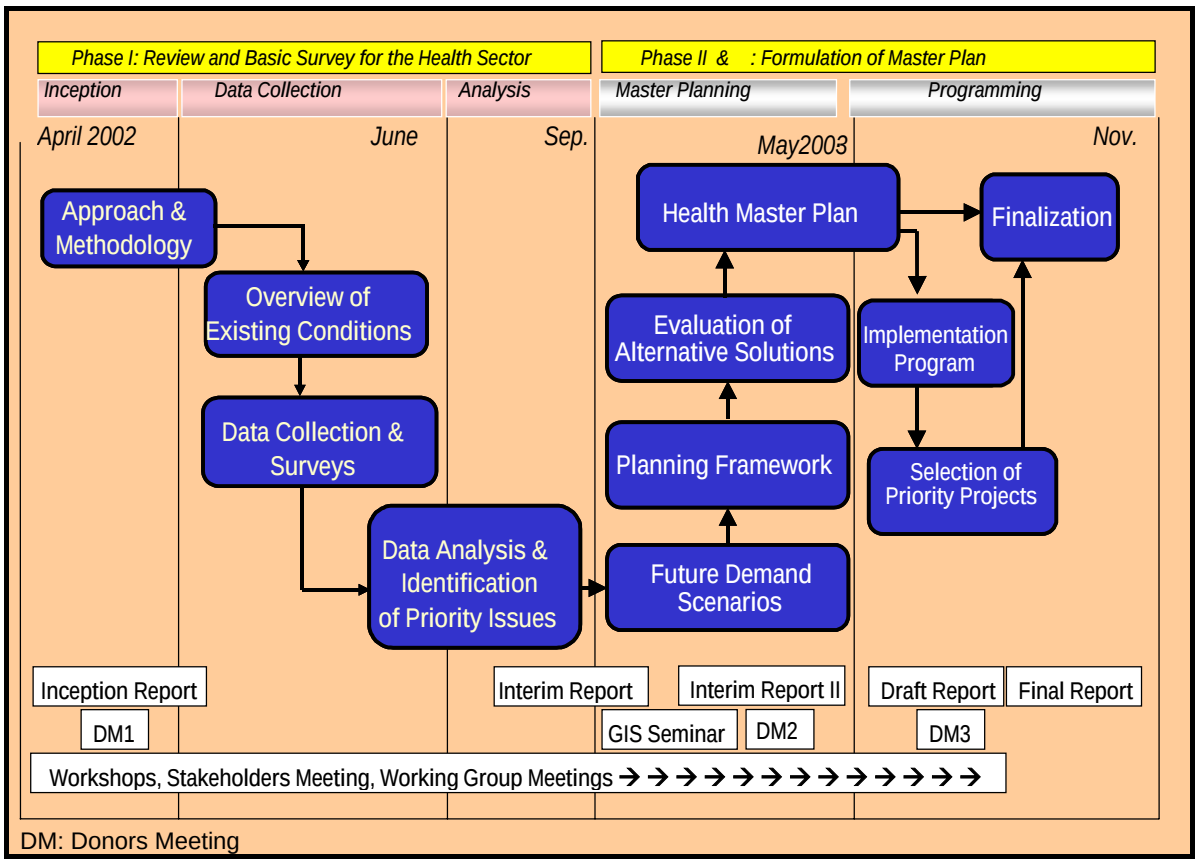

Figure C.1 Phases of the Study

Map of Sri Lanka

ABBREVIATION AND ACRONYM

ACCDC	All Ceylon Community Development Council
ACD	Ayurvedic Classification of Diseases
ADB	Asian Development Bank
AHPB	Ayuveda Health Promotion Bureau
AHPO	Ayurvedic Health Promotion Officer
AIDS	Acquired Immune Deficiency Syndrome
ALOS	Average Length Of Stay
AMO	Assistant Medical Officer
AMP	Assistant Medical Practitioner
ANC	Ante Natal Care
ARF	Ayurveda Research Fund
ARI	Acute Respiratory Infections
ARTI	Acute Respiratory tract infection
BAMS	Bachelor of Ayurvedic Medical Science
BC	Before Christ
BES	Bio-Medical Engineering Services or BMES
BH	Base Hospital
BMARI	Bandaranayakie Memorial Ayurveda Research Center
BMES	Bio-Medical Engineering Services or BES
BOI	Board of Investment
BS	Birth Spacing
BSMS	Bachelor of Siddha Medical Science
BUMS	Bachelor of Unani Medical Science
CADR	Cardiographer
CBO	Community Benefit Organization
CBO	Community Based Organization
CBR	Crude Birth Rate
CC	Conciliation Committee
CD	Compact Disc
CD	Central Dispensary
CD & MH	Central Dispensary and Maternity Home
CDD	Control of Diarrhoeal Diseases
CDDA	Cosmetics, Devices and Drugs Act
CDR	Crude Death Rate
CEA	Central Environmental Authority
CFR	Case Fatality Rate
CFS	Consumer Finance Survey
CHDR	Child Health Development Record
CIC	Ceylinco Insurance Co, Ltd.
CIC-E	CIC Eagle Insurance Co. Ltd.
CIGAS	Computerised Integrated Government Accounting System
CME	Continuous Medical Education
CMR	Child Mortality Rate

COHRD	Council on Health Research for Development
CPC	Committee for Planning and Cooperation
CPD	Continuous Professional Development
CWC	Ceylon Workers Congress
D/MTS	Director Medical Technology and Supplies
DALY	Disability Adjusted Life Year
DDHS	Divisional Director of Health Services
DDT	Dichlorodiphenyltrichloroethane
DGHS	Director General of Health Services
DH	District Hospital
DHO	District Health Office
DM	Diabetes Mellitus
DMO	District Medical Officer
DoA	Department of Ayurveda
DP	Divisional Pharmacist
DPMU	Drug Processing and Manufacturing Unit
DQAL	Drug Quality Assurance Laboratory
DRA	Drugs Regulatory Authority
DS	Dental Surgeon
DS	Divisional Secretariat
D-SNO	Staff Nursing Officer working in District Hospitals
DTRU	Demography, Demographic Training and Research Unit, University of Colombo
ECCD	Early Childhood Care and Development
EmOC	Emergency Obstetric Care
ENHR	Essential National Health Research
EPDP	Eelam People's Democratic Party
EPF	Employees Provident Fund
EPI	Expanded Programme of Immunization
EPR	Emergency Preparedness & Response
ETU	Emergency Treatment Unit
EU	European Union
FA	Field Assistant
FAO	Food and Agricultural Organization of the United Nations
FHB	Family Health Bureau
FP	Family Planning
F-PHM	Field Public Health Midwife
GAHR	Government Ayurvedic Health Resort
GAP	Good Agricultural Practices
GDCF	Gross Domestic Capital Formation
GDP	Gross Domestic Product
GFCP	Good Field Collection Practices
GFR	Gross Fertility Rate
GH	General Hospital
GMOA	Government Medical Officers Association
GMP	Good Manufacturing Practices
GNP	Gross National Product
GOSL	Government of Sri Lanka
GP	General Practitioner

G-SNO	Staff Nursing Officer working in General Hospitals & Base Hospitals
GST	General Sales Tax
GTZ	German Technical Cooperation Agency
GWAI	Gampaha Wickramarachchi Ayurveda Institute
HC	Health Centre
HCW	Health Care Worker
HDR	Human Development Report
HEB	Health Education Bureau
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRD	Human Resource Development
HSPI	Health Service Providing Institute
HSR	Health Systems Research
HVC	Health Vigilance Committee
IA	Impact Assessment
ICSL	Insurance Corporation of Sri Lanka
ICU	Intensive Care Unit
IDRC	International Development Research Center (Head Office locates in Ottawa, Canada)
IEC	Information, Education and Communication
InEC	Institutional Equipment Committee
IHD	Ischaemic Heart Disease
IIM	Institute of Indigenous Medicine
IK	Indigenous Knowledge
IMMR	Indoor Morbidity, Mortality Return
IMPA	Independent Medical Practitioners Association
IMR	Infant Mortality Rate
IP	Industrial Package
IPD	In Patient Department
I-PHM	Public Health Midwives working in hospitals
IPR	Intellectual Property Rights
IPS	Institute of Policy Studies
IPS HPP	IPS Health Policy Programme
ISM	Indigenous System of Medicine
JE	Japanese Encephalitis
JEDB	Janatha Estate Development Board
JICA	Japan International Cooperation Agency
JMO	Jurisdictional Medical Officer
JOCV	Japan Overseas Cooperation Volunteers
JVP	Janata Vimukti Peramuna
KAP	Knowledge, Attitudes and Practices
LAN	Local Area Network
LMP	Licensed Medical Practitioner
LSSP	Lanka Sama Samaja Party
LTTE	Liberation Tigers of Tamil Eelam
MC	Municipal Council
MCH	Maternal and Child Health
MCHC	Maternal and Child Health Centre

MDPU	Management Development and Planning Unit of MoH
MICR	Microscopist
MIM	Ministry of Indigenous Medicine
MIS	Management Information System
MLT	Medical Laboratory Technologist
MO/ MCH	Medical Offer, Maternal and Child Health
MoF	Ministry of Finance
MOH	Medical Officer of Health
MoH	Ministry of Health
MOHIM	Ministry of Health and Indigenous Medicine
MOMCH	Medical Officer for Maternal and Child Health
MoU	Memorandum of Understanding
MP	Medicinal Plants
MPCA	Medicinal Plant Conservation Area
MSD	Medical Supplies Division
MSF	Medicins Sans Frontieres
MSU	Medical Statistical Unit
MTIP	Medium Term Investment Programme
NA	Needs Assessment
NADCDA	National Ayurvedic Drugs, Cosmetics and Devices Authority
NAHF	National Ayurvedic Hospital Formulary
NEM	New Economic Mechanism
NEP	North and East Province(s)
NGO	Non Governmental Organization, (= NGOO)
NHA	National Health Accounts
NHC	National Health Council
NHE	National Health Expenditures
NHSL	National Hospital of Sri Lanka (formerly known as Colombo General Hospital)
NIC	National Insurance Corporation
NID	National Immunization Day
NIE	National Institute of Education
NIHS	National Institute of Health Science
NISD	National Institute of Social Development
NITM	National Institute of Traditional Medicine
NMR	Neonatal Mortality Rate
NNP	National Nutrition Programme
NO	Nursing Officer
NQAL	National Quality Assurance Laboratory
NSC	National Statistical Centre
NTRB	National Traditional Resource Bureau
OLS	Ordinary Least Square
OPD	Outpatient Department
ORS	Oral Rehydration Salt
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PA	People's Alliance
PAEHS	Planters Association Estates Health Scheme
PBN	The Post-Basic School of Nursing

PC	Provincial Council
PDHS	Provincial Director of Health Services
PEM	Protein Energy Malnutrition
PERC	Provincial Equipment Review Committee
PG	Post Graduate
PH	Provincial Hospital
PHA	Provincial Health Authority
PHAR	Pharmacist
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PHI	Public Health Inspector
PHM	Public Health Midwife
PHNO	Public Health Nursing Officer
PHNS	Public Health Nursing Sister
PHO	Provincial Health Office
PHYS	Physiothetrapist
PIP	Public Investment Programme
PMEU	Planning Monitoring and Evaluation Unit
PMS	Performance Management System
PMU	Project Management Unit
PNC	Post Natal Clinic
PPO	Programme Planning Officer
PR	Proportional Representation
PR	Progress Review
PTC	Provincial Training Center
PTF	Presidential Task Force
PTF1	1992 Presidential Task Force on National Health Policy
PTF2	1997 Presidential Task Force on National Health Policy
QCS	Quality Control Specifications
RADI	Radiographer
RCS	Rehabilitative Care Services
RDF	Revolving Drug Fund
RE	Regional Epidemiologist
RH	Reproductive Health
RMO	Registered Medical Officer
RMSD	Regional Medical Supplies Division
RTC	Regional Training Center
SCFA	Save the Children Fund Australia
SHS	Superintendent of Health Service
SIDA	Swedish International Development Agency
SJGH	Sri Jayawardanapura General Hospital
SLAAS	Sri Lanka Association for Advanced Science
SLADC	Sri Lanka Ayurvedic Drugs Corporation
SLAMA	Sri Lanka Ayurveda Medical Association
SLFP	Sri Lanka Freedom Party
SLIC	Sri Lanka Insurance Corporation Ltd.
SLMA	Sri Lanka Medical Association
SLMC	Sri Lanka Muslim Congress

SLNHA	Sri Lanka National Health Accounts
SLSPC	Sri Lanka State Plantations Corporation
SNO	Staff Nursing Officer
SOP	Standard Operating Procedures
SPC	State Pharmaceutical Corporation
SPMC	State Pharmaceutical Manufacturer Corporation
SPHM	Supervising Public Health Midwife
SSO	Survey Statistical Officer
STD	Sexually Transmitted Disease
STDs	Sexually Transmitted Diseases
TAC	Technical Advisory Committee
Tb	Treasury bills
TB	Tuberculosis
TBA	Traditional Birth Attendant
TF	Task Force
TFR	Total Fertility Rate
TK	Traditional Knowledge
TM	Traditional Medicine
ToR	Terms of Reference
ToT	Training of Trainers
TP	Traditional Practitioners
TR	Traditional Resources
TULF	Tamil United Liberation Front
U5MR	Under-Five Mortality Rate
UAL	Union Assurance Ltd.
UG	Under Graduate
UGC	University Grant Commission
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNP	United National Party
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency
VHV	Village Health Volunteer
VMA	Value for Money Audit
WB	World Bank
WAN	Wider Area Network
WBC	Well Baby Clinic
WFP	World Food Programme
WHO	World Health Organization
WTO	World Trade Organization

Table of Contents:

Volume III (Project Profiles)

INTRODUCTION

INTRODUCTION

(1) PURPOSE OF THE VOLUME

This volume describes in detail the programmes/projects mentioned in Volume II. The profile for each project provided herein contains a Project Summary and the following components:

1) **Project Title**
2) **Project Number**
3) **Project Priority**
4) **Focal Point**
5) **Implementing Agencies**
6) **Starting Fiscal Year**
7) **Project Duration**
8) **Target Areas & Beneficiaries**.
9) **Justification**
10) **Important Assumptions / Risks / Conditions**
11) **Project Objective / Indicators / Means of Verification**
12) **Project Output / Product / Indicators / Means of Verification**
13) **Related Projects**
14) **Relevant Agencies to be Coordinated**
15) **Monitoring & Evaluation**
16) **Major Activities**
17) **Schedule of Detailed Activities**

(2) FORMULATION OF PROJECTS/PROGRAMMES

The strategic objectives in the next 10 years are identified in the strategic framework. These strategic objectives are:

1. To improve comprehensive health services delivery and health actions, which reduce the disease burden and promote health;
2. To empower community towards more active participation in maintaining and promoting their health;
3. To improve the management of human resources for health;
4. To improve health financing mobilisation, allocation and utilisation; and
5. To strengthen stewardship and management functions of the health system.

Several immediate objectives in line with expected broad outputs that together lead to achievement of each Strategic Objective are identified. The projects to achieve the immediate objectives are identified next. There are 76 projects in the Allopathic Health Sector and 14 projects in the Indigenous Health Sector identified. These projects are categorised into 19

programme areas and 5 programme areas for Allopathic Health Sector and Indigenous Health Sector, respectively.

The timeframe of objectives and programmes/projects are described in Figure 1.

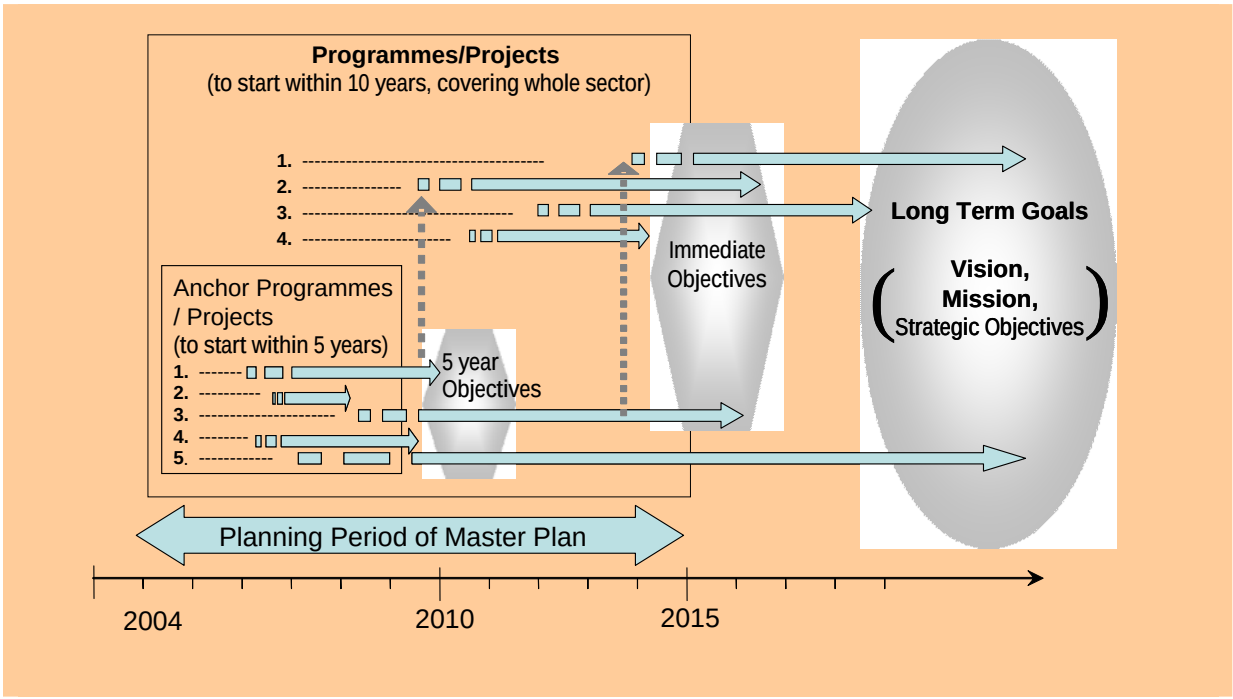

Figure 1 Programmes/Projects aiming for Vision, Mission and Strategic Objectives

Each program has several projects and a common focal point who will oversee the projects and coordinate the activities within the programme. The results of monitoring of each programme will be reviewed by DGHS periodically.

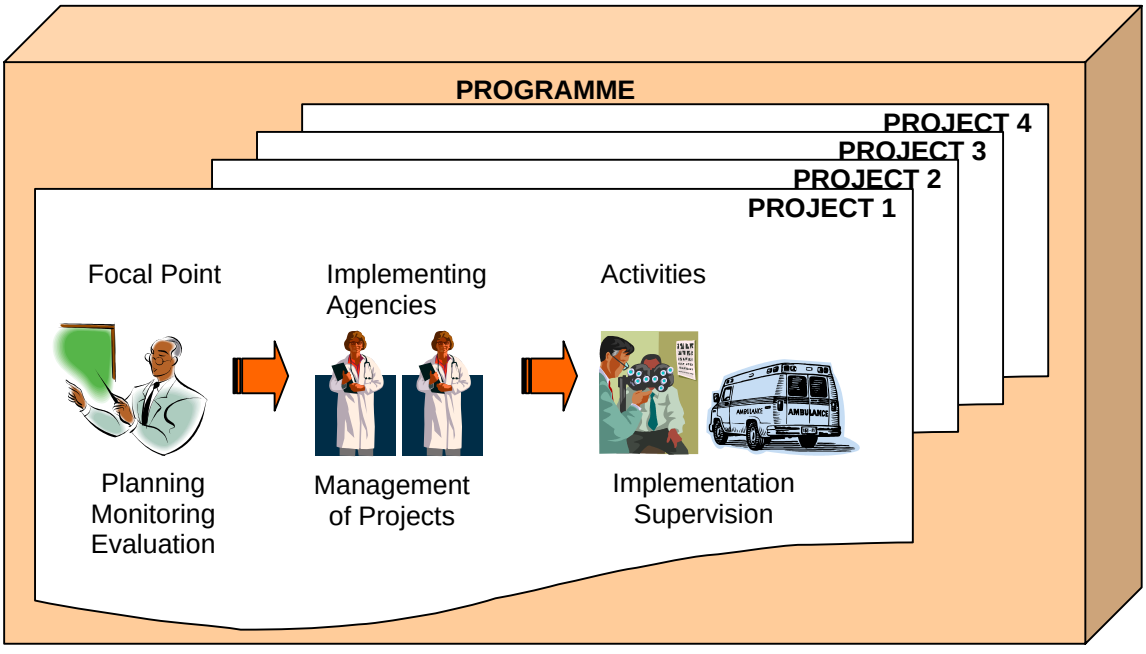

Figure 2 Formation of Programmes/Projects Implementation

Not all projects can or should be implemented immediately. There are not only financial but also human resources constraints in the development of supportive mechanisms that may delay service project implementation. So that prioritisation of projects is important. The other aspect of prioritisation is that some projects are strategically important to be implemented prior to others, for example, such projects for policy formulation or laying out the plans need to be implemented prior to others. Thus, prioritisation and sequencing of the projects/ activities are important inputs before the implementation phase of the HMP. The anchor projects with priorities are identified as in the following list.

Anchor Projects

- Functional Rationalisation by Developing a New Health Services Delivery Plan
- Facility Development According to the Rationalised Health Service Delivery Plan
- Strengthening of Services for Mother & Child
- Strengthening of the Support Services:
  - Medical Supplies and Drugs
  -Medical Equipment
  -Laboratory & Diagnostic Services
- Total Quality Control/Management of Hospital Services
- Total Quality Control/Management of Promotive & Preventive Services
- Integrated Prevention of NCD
- Respiratory Diseases Control
- STD/AIDS Control
- Vector-Borne Diseases Control
- Food- and Water-Borne Diseases Control
- National Nutrition Programme
- Programme for Improved Community Involvement for Health Development
- Formulation Of HRD Policy
- Development of Health Financing Policy for National, Provincial & District levels
- Establishing an Improved Management System/s and Building the Capacities of Management Teams
- Strengthening the Existing Health Development Network at National, Provincial & Local Levels
- Public-Private Partnership Development at National & Provincial Levels

(3) STRATEGIC LINKAGES OF ANCHOR PROJECTS

The linkages are drawn, first, by classifying the projects into two categories, namely: 1) system projects such as formulation of policies; reform of health system, and 2) health service projects such as NCDs. HMP projects provide a pathway to impact on the chosen priorities. For this to be effective, it is also required to understand the linkages among the projects. Figure 3 shows linkages of projects with the system and services as well as with policies and projects improving efficiency, equity and quality. It is expected that the MoH and other stakeholders will link the priorities accordingly.

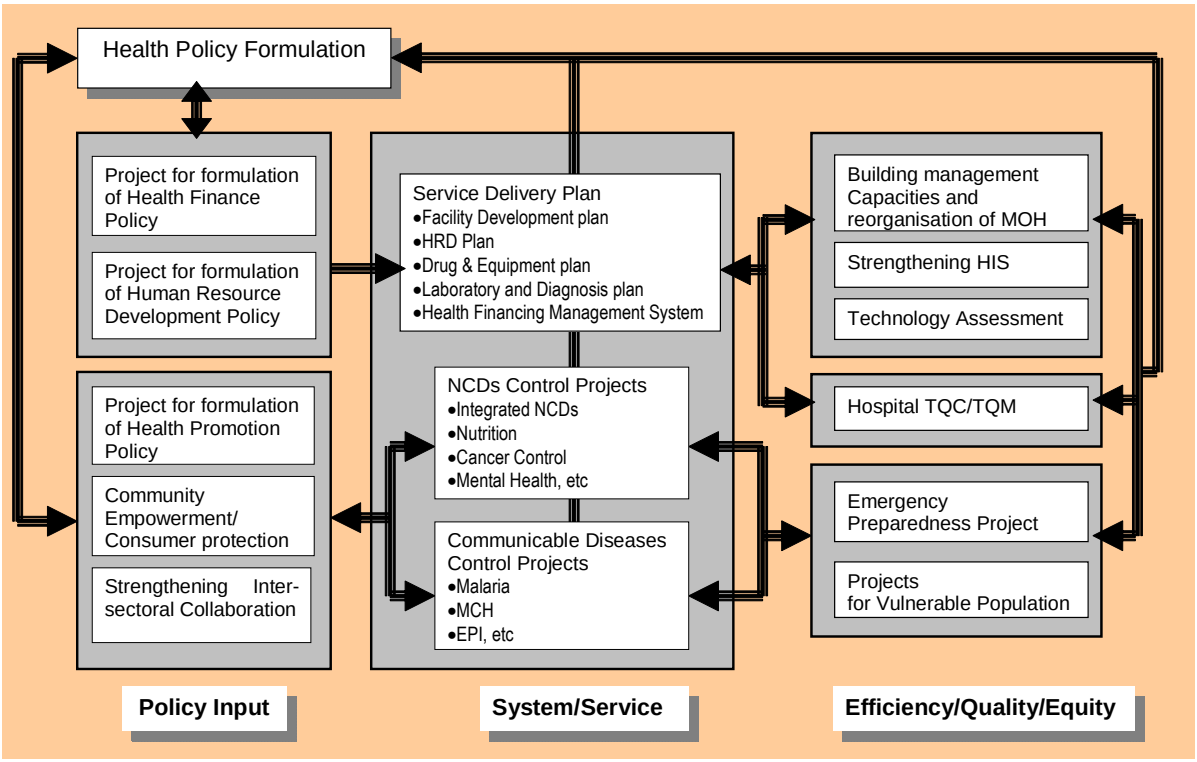

Figure 3 Linkage of Anchor Projects

(4) STATUS TO DATE

The profiles in this volume have been drafted by a selected profile writers under the direction of technical DDGs of MoH. Although an initial review of the profiles have been undertaken by a technical review panel, a further review is planned by MoH to finalise the profiles. Under these circumstances the profiles are published in draft form.

CHAPTER 1

PROFILES OF HEALTH SERVICES DELIVERY

1 PROFILES OF HEALTH SERVICES DELIVERY

1.1 PROGRAMME FOR ORGANIZATIONAL DEVELOPMENT

(1) **Project Title:**	Functional rationalization by developing a new health services Delivery Plan	(2) **Project Number:**	1.1.1
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG(P) assisted by DDG/MS, D/TCS	(6) **Starting Fiscal Year:**	1st Year (FY 2004)
(5) **Implementing Agencies:**	Central Ministry of Health MDPU Provincial MOH	(7) **Project Duration:**	10 Years

Project Summary

Systematizing and reorganizing the health system, both structurally and functionally, through networking of facilities and by an appropriate referral system is essential in order to strengthen the availability, accessibility and cost effectiveness of health services. A new health services delivery plan with a clear definition of levels of care and rules for referral and counter-referral will be developed.

The new heath service delivery plan shall be responsive to the current epidemiology, patients' expectations and efficiency of the system as a whole.

This new plan will be pilot tested in one District. Best practices for OPD, IPD & Community Services will be defined.

A referral system will also be pilot tested in one District and extended countrywide after evaluation.

Gradual adjustments of delivery systems to people's health seeking behaviour can be made in the light of the pilot test.

(8) **Target Areas & Beneficiaries:**

Selected District for Piloting. Subsequently, total population countrywide.

(9) **Justification:**

A functionally rationalised health service delivery system needs to be re-oriented to face the challenges of health transition, gearing with three requirements, namely: 1) responding to epidemiology; 2) responding to patients expectation; and 3) responding to efficacy of the system. These three should be major pillars of the new policy framework, and each includes three principles to guide the policy formulation as described below.

Pillar 1: Responding to Epidemiology (Service and System)

In order to meet the epidemiological changes, reorientation of the health care services and their delivery system is a must. This can be derived from the following three principles:

Principle 1: Prioritisation and Characterisation of Disease

Principle 2: Exploration and Development of a New Strategy

Principle 3: Linking and Integrating Services and Systems

Prioritisation and categorisation of the disease groups, which imply necessary interventions, health facilities and their network, would help in planning and managing the service delivery.

Meanwhile, every facility needs to work with others. By rationalisation of the whole network by linking and integrating services and systems, the relations among facilities will be clarified and formalised. The responsibilities and authorities of members of the network will be identified. Investment and other resources will be more efficiently allocated. A referral and counter-referral system should be implemented. In the end, the health network can work in unity towards providing better health services.

Pillar 2: Responding to Patients' Expectation (Culture and Care)

Not only through the global awakening of patient's right and equity, but also by looking at the characteristics of the disease itself, patient participation and satisfaction bears greater importance in the success of treatment. Greater efforts are needed in educating patients as well as health service providers to make better choices. This calls for reorientation of people's cultural norm on the health care in association with the following principles:

Principle 1: Improvement of "Quality and Safety"

Principle 2: Securing of "Patient Right"

Principle 3: Enhancement of "Client Satisfaction"

Systematic feedback from clients of a service about their satisfaction should be an integral part of the information system and quality assurance program. Provision of basic amenities, cutting down the waiting times, quick response to their needs, good communication and courteousness must improve patient satisfaction.

Pillar 3: Responding to Efficacy of the System (Mission and Management)

Reorientation of the health sector organisation, management and information systems is required to respond to efficacy of the system. In the changing situation, it must reframe the entire management system to:

Principle 1: Be Accountable

Principle 2: Be Flexible

Principle 3: Be Efficient

Selection of cost-effective interventions by technological assessment is essential. Even in the current services, management should be reoriented toward efficiency. To become efficient, continuous analysis of demand and the effort to match supply to demand is needed. To use limited resources in changing environment, flexibility is a useful operation principle. The system has to be accountable to people who receive the care and pay for the service. Transparency and information openness should be a policy.

The issue of rationalisation embedded by the above rationales is relevant to improve overall responsiveness to needs, efficiency, effectiveness and equity as well as effectiveness. For one, it is envisioned this will decrease administrative or political interventions in the construction and upgrading of health facilities without real attention to the above considerations. It is hoped to address the problem of over-utilisation of some facilities, mainly the higher levels, and the under-utilisation of others, often the lower levels. The bottom line is to provide guidance to all parties concerned for physical and functional development of health facilities to cope with current and future demands.

(10) Important Assumptions/Risks/Conditions:

Integration of the Indigenous Systems of Medicine and Private Sector for the Primary level care.

Incentives to be provided for Medical Officers to set-up Family Practices in Rural Areas.

Private Practice by Government Medical Officers.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ To strengthen the availability, accessibility and cost-effectiveness of health services by functional rationalisation of health care delivery through a new health services delivery plan.	Health facility utilisation rates	HIS, Periodic surveys
	Unit cost of services	Periodic surveys

(12) Project Output/Product:

Output	Indicators	Means of Verification
1. Performance database for health care services for priority diseases at	Cost-effectiveness, Service-efficiency, Work efficiency (productivity),	Methodological and analytical appropriateness and significance

different level facilities	Facility/equipment utilization rates	
2. Plan for re-categorisation of health care facilities with clear definition of levels of care.	Plans developed for re-categorisation of health facilities (curative, preventive, laboratory, supportive services)	Approved plan documents
3. Pilot testing the new models in a District.	Status of implementation	Progress review reports
4. Referral System Introduced in Pilot District.	Hospital utilisation rates	Hospital Statistics
5. Referral System extended to the other Districts.	Hospital utilisation rates	Hospital Statistics

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1.1.2	Facility Development According to the Rationalised Health Services Delivery Plan
2.1.2	Raising Awareness of the Community Regarding Health Needs & Services
4.2.1	Strengthening & Reorganising the DDG Finance Office and DDG Planning for Health Service Delivery & Inter-sectoral Health Issues within the Context of Health Economic Reality and with Full Accountability

(14) **Relevant Agencies to be Coordinated:**

Central MOH

Provincial Ministries of Health

(15) **Monitoring & Evaluation:**

1. Who? - National Health Development Committee, MDPU, PDHS,
2. When? -Monthly, Quarterly, Annually
3. What actions to be taken based on results of monitoring & evaluation?
   - Revision of Re-Categorisation Plan
   - Revision of best practice guidelines
   - Re-allocation of funds

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1.1 Review the health services delivery norms by different levels (Primary, Secondary and Tertiary) of care.	Health Services Delivery Norms Developed	No. of review meetings held.

Activities	Expected Results	Process Indicators
1.2 Based on the Health Facilities Survey findings, redesign hospital and health care facilities.	Modifications needed to health facilities identified	Formal approval for the modifications from central & prov. ministries
1.3 Select District for pilot testing	District for pilot testing selected	District for pilot testing selected
1.4 Design plan for Re-categorisation of health facilities in the pilot District.	A plan for re-categorisation of health facilities in the pilot district.	Plan for the pilot district available
2.1 Setting up a Task Force for implementation of the plan in the pilot district.	Task force set up for implementation of the plan.	Task Force set up
2.2 Create Awareness on the reforms among the stakeholders in the pilot district.	Awareness on the reforms among stakeholders	No. of stakeholder meetings / seminars held
2.3 Re-categorising the health facilities in the pilot district.	Health facilities in the pilot district re-categorised	No. of facilities recategorised
3.1 Development of guidelines for the referral system	Guidelines developed	Approval of guidelines
3.2 Provision of printed documents necessary for the referral process.	Printed documents for the referral process available	Adequate amount of printed forms printed
3.3 Introduction of the Referral system in the pilot District.	Referral system introduced in the pilot district	
3.4 Evaluation of the referral system in the pilot district.	An assessment of the referral system	Evaluation Report
4.1 Revision of the Referral system based on the pilot project.	Revised referral system	No. of Review Meetings
4.2 Extend the Referral System to the other districts / provinces	Referral system extended to other districts	No. of Districts adopting referral system

(1) **Project Title:**	Facility Development According to the Rationalized Health Services Delivery Plan	(2) **Project Number:**	1.1.2
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DGHS, DDG(Logistics), PDHS	(6) **Starting Fiscal Year:**	2005
(5) **Implementing Agencies:**	DDG(Logistics), D/Buildings, PDHS	(7) **Project Duration:**	15 Years

(8) **Target Areas & Beneficiaries:**

All health facilities under the Central and Provincial MOH, General population

(9) **Justification:**

Currently Sri Lanka has a multiplicity of categories of health facilities and therefore it is often confusing to patients where to get appropriate care. The services in the state sector are characterised by a busy and overcrowded system of National, Provincial, General, and Base Hospitals and a widely spread network of District Hospitals and health care units operating at lower levels of occupancy.

Sri Lanka provides around 0.2 inpatient admissions per capita annually. This heavy demand may be due to a number of factors including: lower primary care and outpatient visits estimated as 4 per capita; and patients being admitted when with better primary care, they could have been treated on an ambulatory basis. Also it is observed that patients bypass the lower level services keeping occupancy rates low at peripheral hospitals, in favour of larger city and provincial hospitals, thereby causing overcrowding at these facilities. This is aggravated by an absence of clear admission and referral policies.

(10) **Important Assumptions/Risks/Conditions:**

N.I.L.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To develop health facilities according to the rationalised health services delivery plan.	% of facilities conforming to the norms and standards.	HIS Periodic Surveys

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Primary Care facilities Developed in pilot district.	% of Primary Care facilities rehabilitated / constructed.	Provincial Planning Unit Records
2. Secondary Care Facilities Developed in pilot district.	% of Secondary Care facilities rehabilitated / constructed	Provincial Planning Unit Records

Output	Indicators	Means of Verification
3. Tertiary Care Facilities Developed in pilot district.	% of Tertiary Care facilities rehabilitated / constructed	Central MOH Records
4. Evaluation of the pilot project	% facilities evaluated	Evaluation Report
5. Extension to other districts	% of facilities rehabilitated / constructed.	Central & Provincial MOH Records

(13) **Related Projects:**

Project No.	Project Title
1.1.1	Functional rationalisation by developing a new health services delivery plan.

(14) **Relevant Agencies to be Coordinated:**

Central MOH, DDG(Logistics), Prov. MOH, CECB

(15) **Monitoring & Evaluation:**

1. Who? NHDC, DGHS, DDG(Logistics)
2. When? Monthly, Quarterly, Annually
3. What actions to be taken based on results of monitoring & evaluation?
    i. Ensure financial allocation
    ii. Facilitation of constructions lagging behind through closer supervision
    iii. Ensure human, and physical resource allocation and provision to the facilities completed.
    iv. Ensure appropriate use of facilities by the community through awareness creation.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1.1 Identify the primary care facilities need improvement, facilities to be newly constructed from the facilities plan.	List of facilities identified to be included in the annual PIP.	Annual estimates for rehabilitation and construction
1.2 Tender procedures	Tenders awarded	% Tenders awarded
1.3 Rehabilitation and construction of primary care facilities.	Identified primary care facilities rehabilitated / constructed.	% of primary care facilities rehabilitated % constructed
2.1 Identify the secondary care facilities need improvement, facilities to be newly constructed from the facilities plan.	List of facilities identified to be included in the annual PIP.	Annual estimates for rehabilitation and construction
2.2 Tender procedures	Tenders awarded	% Tenders awarded
2.3 Rehabilitation and construction of	Identified primary care	% of secondary care

secondary care facilities.	facilities rehabilitated / constructed.	facilities rehabilitated % constructed
3.1 Identify the tertiary care facilities need improvement, facilities to be newly constructed from the facilities plan.	List of facilities identified to be included in the annual PIP.	Annual estimates for rehabilitation and construction
3.2 Tender procedures	Tenders awarded	% Tenders awarded
3.3 Rehabilitation and construction of tertiary care facilities.	Identified primary care facilities rehabilitated / constructed.	% of tertiary care facilities rehabilitated % constructed

(1) **Project Title:**	Strengthening of Maternal Health Services	(2) **Project Number:**	1.1.3.a.1)
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG.PHS II	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	FHB with provincial health authorities	(7) **Project Duration:**	5 years

Project Summary

Maternal health programme aims to improve the well-being of the mother and the newborn. In the past few decades Sri Lanka's maternal mortality ratio has made a significant decline from 1650 per 100,000 live births in 1946 to the current level of 58 per 100,000 live births. Deliveries in health facilities has become established practice(96%).In spite of all these achievements, issues related to quality of service delivery, management practices within hospitals and quality of care given to clients continued to remain major challengers in delivery of maternal health services in Sri Lanka. Significant differences also exist between socio economic groups as well as between geographic areas. Although the antenatal coverage is high, (90%) the quality is not satisfactory. Still anemia is a common problem among pregnant mothers (30%) and it is seen that maternal weight gain during pregnancy is not adequate as majority of mothers gain only 7-8 kg and around 30% of them have less than 18.5 BMI at first trimester. However maternal under nutrition together with a high incidence of anaemia has resulted the high prevalence of low birth weight babies (16%).

Therefore interventions are needed to Improve the quality of antenatal care. Reduce the prevalence of anaemia among pregnant mothers, achievement of adequate weight gain during pregnancy and sustainable supply of micronutrients are some of the major concerns in the present situation in order to improve the quality of maternal care.It is a felt need to introduce new strategies on improving the antenatal and post natal services.

Introduction of referral system, surveillance system on maternal morbidity and sensitize the communities on male participation on family health is another important component that should be addressed in near future. Women's right to life and health is also an important issue that will enhance the quality of maternal health services.

(8) **Target Areas & Beneficiaries:**

In a first phase (upto 2007) target areas will be 6 pilot zones representative of different types of vulnerable and normal populations, each covering one division at least. Mothers and new born children will be the beneficiaries of this project. In the second phase this will be expanded to cover at least all major vulnerable populations such as urban slums, areas with high NNMR and MMR, or reach all the vulnerable populations and upto 25% of the nation?

(9) **Justification:**

Family Health Bureau delivers preventive and promotive health services for mothers and children. The need to increase quality of maternal health services in order to improve health status of mothers and thus reach millennium development goals, changing demographics, changing fertility, changing role of women in society ask for adaptation of delivery methods

and addition of new services. Sri Lanka has a well developed information system and FHB is the focal point of surveillance and evaluation on maternal health services. It has revealed that there are some deficiencies in ANC and delivery care, and nutrition education as well as in coverage of working poor, language minorities and remote communities. The Med Officers of health need to reorient their role to community care and community dialogue and mobilisation. The outreach workers (PHM) need to be retrained to be able to deliver more intensive nutrition education, new services in ANC and children

(10) **Important Assumptions/Risks/Conditions:**

Primary prevention in the community will rather be organized with local government and community groups

The PHM need to have newly designed populations to be able to carry out the new tasks. Field Logistics need to be improved for MOH an PHM especially in rural and remote areas so that remote areas are covered and working schedules and facilities need to be adapted to assure access to working mothers.

Monitoring and Evaluation needs to become a regular part of MOH job and substantial supervisory reports need to be used for quality assurance

First three years can be reserved to pilot, monitor and evaluate and cost alternative delivery methods in 6 pilot zones covering each one division of average 60.000 people) in different areas: urban slum, Estate, NE, remote rural, normal rural and one normal urban. The fourth year will be transitional.

Expansion of the experience will be prepared from the second year onwards. New job descriptions and cadres will be agreed upon by trade unions and civil service commission in time to start expansion in the 4th year and continue in the 5th year.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To improve service delivery for pregnant mothers in order to improve their health and wellbeing at an affordable cost, with special focus on the vulnerable and privileged	Maternal mortality Rate	MIS, special studies Vital registration, M.M.Review at FHB
	Maternal morbidity Rate	
	Perinatal Mortality Rate	
	Neonatal mortality Rate	
	Post neonatal mortality	
	Antenatal, post natal coverage.	MIS Assessment of Quality of Care of MD Review

	BMI of mothers at 8 month pregnancy and before 12 weeks.	MIS
	Anaemia mothers at first ANC and at 8 MOs of pregnancy	Surveys
	Weight gain of mother from 3rd to 9th month of pregnancy	MIS
	Birth weight	H 830 Return
	% of new cases of hypertension and diabetes, referred by and to PHM	MIS H830

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1.Established the policies on maternal care services	Existence of policies on maternal care services.	Policy report from Ministry of Health/FHB
2. Improved quality of antenatal services in terms of service provision, health promotion and accessibility of services at domiciliary and field care.	Guideline and indicators are established to assess the quality.	Reports by MOH areas
3.Established system of screening for eligible couples so that the medical conditions that could complicate pregnancy could be diagnosed early.(Hypertension, Heart Disease and Diabetes)	Availability of guidelines on screening and management % of new cases of hypertension and diabetes, referred by and to PHM	Reports by MOH areas through eligible couple register
4. Established programme to improve the nutritional status of pregnant mothers and to reduce the prevalence of anaemia among pregnant women and protein energy mal nutrition and there by reduction of LBW established.	1. No of completed community education programmes on nutrition . 2. Proportion of clinics having adequate supply of micro nutrients 3. % of clinics having facility for HB testing 4. % of outlets with stock outs 5. Percentage of pregnant mothers weight gain is adequate .	Stock return from RMSD and RMSD Special surveys
5. A surveillance system to monitor ante natal & post natal	1. Existence of a surveillance system	Reports by MOH/ PHM

morbidities established.	on maternal morbidity 2. Proportion of MOH areas report on morbidity	
6.Quality of postnatal care improved	Availability of guideline and indicators to assess quality	Routine MIS
7.1 Implemented the capacity building programmes for programme planners at central level and district level on planning and evaluation on MCH Programme	1.Percentage of staff who are competent on planning and evaluation on maternal care	FHB Reports.
7.2 Implemented the capacity building programmes for service providers at district level on antenatal and post natal services.	1.No. of Completed programmes 2. Percentage of staff who are competent on Antenatal and post natal service delivery	FHB Reports.
8.Positive health seeking behaviour of community in relation to maternal health enhanced	1.No of community awareness programmes completed 2.. Percentage of mothers who are aware about danger signals on maternal care 3.No of IEC materials produced	Periodic surveys. FHB reports
9. Male participation in maternal care programme Improved .	1.Proportion of males who participated in community health activities in relation to maternal health. 2.Proportion of males who accompanied their wives at ANC 3.No of health education programmes conducted for males at divisional level	Report from MOH Periodical surveys.
10.Referral system established in order to address the bypass phenomena in maternal care	1. No of hospitals practising referral system. 2. Proportion of mothers who bypass the primary/ secondary care institution.	Reports from hospitals
11. Home deliveries in underserved and special communities reduced.	1.Existing of guideline to reduce home deliveries. 2. % of reduction of home deliverers in under served and special communities.	MIS
12 Laws to protect the rights	Establishment of a system on	Reports from Ministry of labour

in relation to maternal care are in placed	protection of human right in maternal health.	
13. The existing system of maternal care service delivery and strategies reformed	Availability of new strategies for service delivery	Reports from Ministry
14. Cross cutting issues such as MCH management, mobility of health workers and work load of health workers are addressed .	Work load of PHMM was assessed. Availability of duty list of PHM. Crosscutting issues that were identified were dealt.	Report from Ministry of Health
15. Confidential enquiry on maternal death investigation. Established.	Report on CEMD is available every 3 yrs	

Strengthen the central level, district level project focal point

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	**Project Title**
1.5.1.	Estate Health
1.5.7.	Health of people in urban slums
1.3.3	Emergency Obstetric care and neonatal care.

(14) **Relevant Agencies to be Coordinated:**

Ministry o f Health, Nutrition & Welfare

Provincial Government

(15) **Monitoring & Evaluation:**

1.Who: Central Level – Ministry of Health (Family Health Bureau),

Provincial, District Level – PDHS, DPDHS, Overall and detail supervision supervision by MO.MCH

2. When: Monthly, annually reports – Periodical Reports and routine District MCH Reviews (Annually/ Biannually)

Periodical survey

4. What actions to be taken based on results of monitoring & evaluation:

Relevant actions will be taken to overcome the identified deficiencies to improve the existing system.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1) Study and analyse the existing policies on maternal care services	Identify the weaknesses and strength and reformulate new policies	Availability of new policy document
2) a).Improvement of quality on, antenatal services I(domiciliary and clinic care.) b)Establishing sustainable antenatal service delivery in underserved areas.	Establishment of guideline on quality ANC so that service providers will follow it. Strengthen the antenatal services in underserved areas.	Availability of guidelines Improvement of quality of antenatal care Availability of antenatal services in underserved areas.
3)Establishing screening programmes for eligible couples before they get pregnant	To identify the medical conditions that could complicate the pregnancy and manage them appropriately.	Production of guidelines. No.of mothers identified with medical conditions
4).Infra structure development and supply of essential equipment to ANC	AN clinics buildings are available and fully eqipped	No clinics build No of equipment provided
5)Establishment of nutritional programme for under nourished mothers (BMI < 18.5) in the community.(Behavioural intervention for target groups.)	Improve the nutritional status of pregnant mothers to achieve the adequate weight gain during pregnancy and to deliver healthy babies.	No.of programme conducted
6). Improving basic investigation of pregnant mothers	All pregnant mothers basic investigation are completed	Routine investigation procedure available
7).Development of surveillance system for maternal morbidity	Early identification of morbidities of pregnant/ post partum mothers	Existing of surveillance system
8). Improving the quality of post natal services.	Establish a quality assurance system and relevant guideline.	Existence of indicators to assess quality of services and necessary guidelines.
9)-1 Capacity building of central level and district level programme planners	Strengthen the competence of programme planners on planning and evaluation	Availability of qualified trained programme planners
9)-2 Training programmes for service providers on provision of quality antenatal care	Strengthen the knowledge, work capacity and practices of service providers in relation to their duties & responsibilities	No.of training programmes completed. Availability of Adequate staff and other facilities.
10) Enhancing community dialogue between service providers & community.	Strengthen the knowledge of the community and inculcate the positive attitudes towards the better health of a family and to	No.of programme conducted

Activities	Expected Results	Process Indicators
	increase the demand for services.	
11) .Improving male participation in family health	Male participation improved.	No.of programme conducted
12) Development of referral and back referral system on antenatal care	To establish a referral and back referral system to avoid bypass for antenatal care.	Existing of referral and back referral system.
13)Reduction of home deliveries in selected pockets.	To minimize the home deliveries	Reduction of home deliveries
14) Formulation of policies on protection of human rights in maternal care	Improve quality maternal health services.	Existence of favourable laws and policies on human rights in maternal health.
15).Reforming the existence service delivery system on maternal care.	Improve quality maternal health services.	Existence of new service delivery system on maternal care services.
16) Strengthen the central level, district level, MCH Focal point		
17) Strengthen the cross cutting issues such as improvement MCH management at district & peripheral level	To enhance the efficiency of work performance of the service providers and planers	Availability of MCH work plan for the district
18) Establishment of confidential enquiry system of Maternal Deaths	Investigate all maternal deaths confidentially and identify all preventable causes	Existence of Confidential inquiry on maternal death

(1) **Project Title:**	Strengthening of Maternal Health Services (Strengthening of Management information system on MCH/FP)	(2) **Project Number:**	1.1.3.a.2)
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/PHSII	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Family Health Bureau	(7) **Project Duration:**	5 years

Project Summary

Since the establishment of the Family Health Bureau in the late 1960s, a separate section was developed (the Evaluation and Research Unit) to undertake the function of continuous monitoring and evaluation of the MCH/FP programme. Parallel to this a series of returns, records and registers were carefully developed to collect information on MCH/FP activities right from the Public Health Midwife areas through the health information system. A computerized database was developed for MCH/FP information as early as 1979. This was the first computerized database established in the Ministry of Health.

Since 1980's a well-established Management Information System (MIS) is existent in Sri Lanka. This system provides vital information on service delivery of Maternal & child health and family planning in all the districts of the country. It yields data on outcome and impact indicators, which are being used by national and international agencies in setting targets, developing policies and strategies and also selecting priorities for donor assistance. The information derived from the system is used by divisional/ district & provincial supervisors and programme managers to uplift the service delivery in deficient areas.

This project proposal is developed on strengthening of Management Information System aims at human resource development, improving logistical support, strengthening supervision, monitoring and evaluation of Maternal and Child Health activities at periphery. It also focus on conducting operational research in relation to MCH/FP services with a view to improving service delivery system in Sri Lanka.

(8) Target Areas & Beneficiaries:

1) Health staff involved in MCH /FP programme at periphery
2) Supervisory and programme managers working at divisional, district, provincial and national level

a. Justification:

Continuous monitoring and evaluation of MCH/ FP programme is important to achieve a reduction in maternal and childhood morbidity and mortality. Therefore, Management Information system presently being implemented needs to be strengthened in order to achieve the above. The contents and forms in the present information system need to be reviewed critically in order to identify any changes that are required to make the system more user friendly. Through this project health personnel will be trained on handling of data, management

of information, supervision, monitoring and evaluation in order to improve the quality of data and use of information in programme management.

The present system of supervision and monitoring by public health staff has strengths and weaknesses. Therefore new tools for supervision especially self evaluatory stools need to be developed under this project. The health care providers will be able to improve the coverage and the quality of the service delivery through these new inputs.

(9) **Important Assumptions/Risks/Conditions:**

The health staff should be in place according to the approved cadre positions. The printed forms required for implementation should be available in required quantities. Logistics system should be streamlined in distribution of forms and other supplies.

(10) **Project Objective:**

Objective	Indicators	Means of Verification
To strengthen the implementation of MCH/FP Management Information System at all levels thereby improving monitoring and evaluation of MCH/FP services and supervision with a view to enhancing coverage and quality of RH service delivery	Percentage of returns submitted in time	FHB Evaluation unit records
	Percentage of supervisions carried out	MIS forms - Form C
	Quality indicators on MCH/FP	Special surveys/ reports
	No. of self evaluatory tools developed	Special reports
	No. of review meetings conducted	Progress reports/ minutes of meetings

(11) **Project Output/Product:**

Output	Indicators	Means of Verification
Revised Information system which is more user friendly in place	No. of returns and records revised	MIS records
Capacity of Health staff managing and implementing MIS improved	Percentage of heath staff trained No. of training programmes held for field staff/ district level and central level managers	Special reports
Quality of information submitted in returns improved	Completeness/ timeliness and accuracy of reporting	MIS Supervision reports
Logistic system of printed forms improved at all levels	Stock outs in MIS forms	Reports of MO.MCH District reviews
Computerized MIS established and functioning at divisional level Information submitted electronically from all the divisions to the central level	No. of computers available at every level percentage of areas sending information electronically	Special reports

New supervision tools and self evaluatory tools in place	New indicators/ targets revised and used No. of self evaluation tools developed and used No. of supervisory tools developed and in place	Supervision reports Self evaluation tools Special reports
Regular meetings conducted to review the progress of programme implementation at different levels	No. of review meetings conducted Percentage of recommendations implemented	Minutes of meetings special reports
Relevant operational research studies conducted on Family health	No. of research conducted No. of research papers submitted No. of recommendations implemented	Research reports and research papers
Timely reporting of feed back reports & national statistics	Percentage of reports published in time	Reports

(12) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	**Project Title**
1	Health information system - D/Information

(13) **Relevant Agencies to be Coordinated:**

Director / Information, Ministry of Health, Epidemiological unit

International agencies – UNFPA

(14) **Monitoring & Evaluation:**

1. Who? Central level – Ministry of Health, FHB District level – DPDHS & MOO.MCH

   Divisional level – MOH/DDHS, PHNS/ SPHM

2. When? Quarterly/ Annually

(15) What actions to be taken based on results of monitoring & evaluation?

Plan strategies to improve service delivery Basic and in- services training for the staff

(16) **Major Activities:**

Activities	**Expected Results**	**Process Indicators**
1. Review existing records and returns used in Reproductive Health MIS and make necessary revisions.	Revised MIS records and returns are in place	No. of returns/ records revised
2. Improve skills among managerial and operational staff to ensure	All health staff are trained in MIS and its use	No. of staff trained

proper management and use of the MCH/FP information system		
3. Supply of computers to		
3. Organize periodic reviews to monitor the performance and to plan strategies to overcome the problems in service delivery	Service delivery problems are identified and corrected	No. of reviews conducted Minutes of the meetings
4. Strengthen supervision of divisional grass root health workers by national, provincial health authorities through revised indicators and targets	Improved coverage and quality of the service delivery	No. of supervisions done
5. Provide feed back periodically to the grass root level, programme managers, policy planners and international donor agencies on the progress of service delivery and national level health indicators	Timely reporting of feed back reports	Timeliness of publishing of reports
6. Conduct operational research related to Reproductive Health with a view to determining the progress and the quality of the MCH/FP service delivery system	Research reports published Recommendations are implemented	No. of research conducted Implementation if recommendations

(1) **Project Title:**	Health Care Needs of Women with attention to Special Groups	(2) **Project Number:**	1.1.3.b
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG./PHS II	(6) **Starting Fiscal Year:**	1st Year
(5) **Implementing Agencies:**	Family Health Bureau, Provincial, District and Divisional level health staff	(7) **Project Duration:**	10 years

Project Summary

Several important issues that cause considerable burden of disease and death, had been identified in relation to health of women. The categories include 1. Migrant women and their families. 2. Female workers in free trade zone. 3. Working women 4.Females who experience domestic violence. 5. Teenagers with reproductive health problems.
6. All women over 35 years of age. These women experience problems specific to their own contexts and special programs has to launch to address these problems.

The women migrating to Middle East countries experience numerous health problems, mental health problems, sexual health problems, etc .In addition to that the family member left behind especially children face numerous problems such as sexual abuse, nutrition problems, mental health problems etc.. Under this project awareness programmes, development of IEC material, training of PHC staff will be carried out.

Female workers in FTZ area are reported to be experiencing number of reproductive health problems and mental health problems. Lack of awareness, attention and training of these females give rise to catastrophic results to them. Training of public health staff, health clinics at free trade zone and printing of education manuals are some of the activities undertaken under this project.

Information on Intimate partner violence is yet unknown. The current situation related to violence against women due to various social factors are primary disadvantageous to the victims and their families when such cases are reported to the authority. Taking necessary policy decisions, discussions with male partners and training of trainers to reduce IPV are some of the important steps in reducing violence and will be undertaken in this project.

The importance of reproductive health problems among teenagers are addressed under this project. Teenage pregnancies, abortions, sexual problems and other health related issues of this group should be studied and addressed promptly. Identification of problems by undertaking small scale surveys, development of health education material, training of public health staff are some of the activities carried out within this project.

Well woman clinic programme aims at improving the health of women in the middle age groups by reducing the morbidity and mortality associated with common non-communicable diseases and reproductive organ malignancies. Well woman clinics are held at Offices of Medical Officers of Health (MOH) to provide screening services among women above 35 years against common non-communicable diseases. Diseases that are screened in these clinics are diabetes mellitus, hypertension, breast and cervical cancers. At present 330 Well woman clinics are functioning in the country mostly based at MOH offices and of which 160 clinics provide Pap smear screening facilities.

The women reported to have positive test results are referred to specialized clinics namely medical, surgical and gynaecological clinics for further investigations and treatment. Twelve cervical screening laboratories have been implemented for examination and reporting of cervical smears that are taken in well woman clinics. In addition a special information system is in place for monitoring

and evaluation of clinic activities at national, district and divisional levels.
This project plan is aiming at improving the service delivery in Well woman clinics by addressing the current problems experienced in all sectors and at different levels

(8) Target Areas & Beneficiaries:

All MOH areas in the country

Beneficiaries are:

1. Migrant women and their families
2. Female workers in the free trade zone
3. Women who experience domestic violence
4. Working women
5. Teenagers with reproductive health problems.
6. All women above 35 years of age

(9) Justification:

Research and surveys reveal that female Middle East migrants face numerous problems at the country of destination. Migration could adversely affect the families that were left behind, especially their children. Sudden cessation of breast feeding, delay in immunization, school dropouts and child abuse are some of the adverse implications of female migration. Lack of adequate information and lack of attention paid to these issues will reflect badly on the society as a whole.

Workers in the free trade zone have to face occupational hazards as well as problems related to health. Being single and belonging to the actively young age group it is necessary to address these issues effectively.

Insights gained through PHC staff and other research suggests a high prevalence of domestic violence in Sri Lanka. Most of these problems could be eliminated by proper and adequate services provided by the PHC staff.

Teenage pregnancies comprise about 10% of the total pregnancies and could end up as a maternal death. This is easily preventable by proper health education and education of the PHC staff. Strategies should be developed to minimise teenage pregnancies and thereby maternal complications and deaths.

Well woman clinics (WWCs) are not well established in the North and east provinces in Sri Lanka. In addition service delivery system is not very much satisfactory in some areas where manpower resources and infrastructure facilities are poor. Therefore it is very essential to establish new clinics and improve service delivery in the areas where women as a whole should receive these services island wide. Although cervical screening laboratories are functioning under limited resources special inputs are required to improve the situation. Further, close monitoring and supervision is very essential to enhance and uplift the service delivery system in all districts of the country.

(10) **Important Assumption and Risk conditions:**

It is expected that all human resource categories are available in adequate cadres in all MOH areas of the country.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
To improve quality of life of vulnerable groups of females such as migrant workers, females working in the free trade zones, women who experience domestic violence working women and teenage girls by providing information based care through PHC staff and also to improve health of women over 35 years of age by providing screening services for common non-communicable diseases thereby reducing the morbidity and mortality associated with these diseases	Number / % districts where health promotion programs conducted for migrating women and their families	Periodical surveys
	number & % of DDHS areas where inter-sectoral programs(education & health) are carried out for children of migrating women. % of workers in FTZ area who has access to PHC services/ counselling centres Number of awareness programs conducted in FTZ	Periodical surveys
	Number of MOH areas where the reproductive problems of teenage girls are addressed Percentage of teenage pregnancies.	Surveys Routine information system (H-509)
	Number of research conducted on IPV Number of MOH areas where interventions are conducted to promote intimate partner harmony , relationships. % Females experiencing IPV No of Intimate partner violence cases reported to the police	Research Police reports Special surveys
	Incidence of breast and cervical cancers	Indoor morbidity and mortality return
	Incidence of diabetes and hypertension	Cancer registry
	Mortality & case fatality rates	RH- MIS – H 509
	Population coverage of screening of the target group	Reports submitted at district review meetings

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Health needs of the migrant women and their families addressed.	Number and types of PHC workers trained in managing the health problems of migrant women and their families. Number of districts in which these programmes are conducted. Number of families benefited	Periodic surveys. Periodic surveys
Health needs of the women working in the free trade zone	Number of awareness programmes conducted.	Project report

Output	Indicators	Means of Verification
and other industrial areas addressed	Number of workers participated in awareness programmes.	Project report
Accessibility to health services improved.	Number of IEC materials developed. Number of individuals seeking health care facilities per health centre	Project report
Health systems recognition of various forms of Violence Against Women (VAW) as major health issue by the health system and capacity to address them improved.	Number of health decision makers participating in VAW orientation activities. Number of health programmes and tools in which VAW is specifically acknowledged. Number of MCH/FP clinics and other health facilities with programmes to manage VAW	Project reports Project reports
Reproductive health problems among teenagers addressed.	Number of health workers trained to address teenage health problems. Number of pre marital counselling programmes conducted per MOH area. Percentage of teenage pregnancies reported in H-509	Evaluating H-509 Project reports Project reports
Women's empowerment for health is improved	Number of programmes carried out to improve their awareness about major health issues	Special studies.
Capacity of health staff managing and conducting Well woman clinics are improved	No. of staff trained No. of training programmes conducted	Training reports Special reports
Fully equipped well woman clinics established in all MOH areas	No. of clinics with all facilities	Supervision reports and RH-MIS Facility audits
A Quality assurance system for WWCs and cervical screening laboratories established	Performance by individual clinics No. of clinics providing quality services Percentage of clients satisfied with services	Supervision reports Special surveys
Performance in all WWCs reported thro' MIS	Percentage of MOH submitting returns on time	Special reports
Cervical screening laboratories established and functioning in all districts	No. of Laboratories established & functioning % of backlog	Returns from laboratories
Mean time of reporting of Pap smears reduced to one month	Mean gap between taking the smear and reporting	Special surveys
IEC materials developed and distributed to the public and health staff	No. of IEC materials developed	Special reports

(13) Related Projects *(include ongoing projects & projects under the Health Master Plan)*:

Project No.	Project Title
1.1.3	Programs for strengthening the health of the mother & child
1.7	Health promotion programme

	Programmes conducted on Control of cancers by NCCP
	NCD prevention by D/NCD

(14) Relevant Agencies to be Coordinated:

Provincial Government, Sri Lanka Bureau of Foreign Employment

Ministry of Labour, NGO's, Private sector

National Cancer Control Programme

Sri Lanka College of Pathologists

Sri Lanka College of Obstetricians and Gynaecologists

Laboratory services

(15) Monitoring & Evaluation:

1. Who Family Health Bureau, MO/MCH
2. When Annual project report, Periodic and ad-hoc survey, Pre and post evaluation survey.
3. What actions to be taken based on results of monitoring & evaluation?

   Implement additional activities

   Further Improvement of training activities

   Develop(intersectoral)proposals

(16) Major Activities :

Activities	Expected Results	Process Indicators
Sensitisation of policy makers, administrators and programme managers on the problems of migrant women & their families and formulation of policies related to the issue	Policy makers, administrators and programme mangers are proactive in managing the health issues of migrant women & their families Initiation of programs that address the issues	number/types of the personnel sensitised
Preparation of IEC materials for migrant women and their families on health related matters.	Documented health related information exist for migrant women	Number and types of IEC materials
To prepare a manual for health staff for empowering FTZ workers on common health problems.	working manuals exist for FTZ PHC workers	Presence of the manual.
Awareness raising among FTZ workers	FTZ workers are made aware of important health issues and having access to services.	number and types of programs conducted
Assessment of degree of health burden due to intimate partner violence	Information is generated on health burden due to intimate partner violence	number of survey reports
Conducting health promotion programs that are aimed to promote intimate partner harmony though life skill building & promoting male participation	intimate partner violence reduced improved life skills of couples improved male participation in family matters	number of DDHS areas where programs conducted

Activities	Expected Results	Process Indicators
Assess special reproductive health needs of teenagers by conducting small scale surveys.	Information gathered on teenage reproductive health problems.	survey report
Preparation of IEC material to promote reproductive health among teenagers	IEC materials produced.	IEC material exists.
Conduct educational programmes for teenagers at MOH level.	Distribute adequate knowledge among teenagers about reproductive health problems.	Number of educational programmes conducted.

(1) **Project Title:**	Strengthening the Emergency Obstetric Care & Neonatal care	(2) **Project Number:**	1.1.3.c
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG./PHS II	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	FHB with provincial health authorities	(7) **Project Duration:**	5 years

Project Summary

Provision of Emergency Obstetric care and New born care aims at reduction of Maternal mortality and morbidity and New born morbidity and mortality in Sri Lanka. Improve Emergency Obstetric care and ensure a safe delivery will have impact not only on maternal health. It has a greater impact on Newborn health. Provision of EMOC services can further reduce the case fatality rates due to hemorrhage and other major obstetric complications.
Infrastructure development allocation of Human resource and other recourses is a major activity in this project.
Improvement of Quality of care is a major activity to be carried out.

Maternal death is a tragedy and also a social injustice for individual women, their families and their communities. Most maternal deaths are avoidable, and thus unacceptable. A woman dies from the complications of pregnancy and childbirth due to many factors. Availability of adequate health services to treat life saving complications is curial. However if deaths are to be avoided women must have access to these services. Maternal mortality is also closely linked with health of children. It is known that the same factors that cause maternal mortality and adversely influence child survival effecting a healthy early start for the baby.

It is now acknowledged that risk factors such as parity and age while identifying groups of women who are more likely to have complications; will not necessarily predict which individuals will have complications. While most obstetric complications can neither be predicted nor prevented, they can be successfully treated if access to quality emergency obstetric care services is available. "Interventions that reduce maternal mortality have often been confused with what improves maternal health. Emergency obstetric care is essential and life saving for complications that may arise with pregnancy and childbirth. Also needed are interventions that improve women's health and wellbeing, such as providing quality antenatal care, sharing information, treating anaemia and improving nutrition".

Evaluation of maternal programmes in most countries in South Asia show that management and leadership are the most critical issues that affect programmes. Thus the project: "Women's Right to Life and Health" will mainly address leadership and management issues related to implementation of maternal care programmes at all levels of implementation. The project is based on the epidemiological praise that:

*Maternal mortality is a result of complications that develop in pregnancy,
*That these complications cannot be reliably predicted or prevented,
*Death from complications can be averted with timely medical care.

It mainly supports the third delay of the "3 delays mode" namely the delay in the hospital. The reasons include lack of motivation, teamwork, commitment, leadership and management as well as lack of resources and technical skills.

(17) **Target Areas & Beneficiaries:**

Target areas will be selected according to the district maternal mortality rates and the availability of the EMOC facilities. Districts where there is no EMOC facility and having a high maternal mortality rates would be selected as target areas for this project. All pregnant mothers and newborns, specially the mothers with an obstetric complications and life threatening complications and premature babies who need life saving comprehensive newborn care will be the beneficiaries of this project.

(18) **Justification:**

In Sri Lanka maternal mortality rate declined appreciably during the last few decades from 1600/ 1000 live birth in 1945 to 46/ 1000 lb in the year 2001. The National Maternal death reviews revealed that 86% of maternal deaths are preventable. Deaths due to haemorrhage was the commonest cause while the next was PIH. Although the MMR at present is 46/1000 lb it has a very high inter district variation as 167/1000 LB in Nuwaraeliya and 26/1000 LB in Colombo. It is observed that all maternal deaths cold be explained according to three-delay model. This model explains the direct or indirect contribution of the services related, social and other factors related to maternal deaths. The third delay explains the maternal deaths due to non-availability of EMOC facility in the institutions. This highlights the need to pay more attention for further reduction of maternal mortality.

At present in Sri Lanka , IMMR is 15.2/1000 LB and Neo natal Mortality Rate is 12.9/1000LB.Although the IMR has declined from 263/1000 LB in 1935 to current level ,75-80% of neonatal deaths are accounted for infant deaths in Sri Lanka. Prematurely , Asphyxia neonatarum and infection has contributed for majority of deaths. Further reduction of NNMR needs well-focused interventions and could be implemented during intrapartum period.

In Sri Lanka 94% of the deliveries take place in hospitals and >70% are at specialised institutions. Inspite of this high coverage of institutional deliveries Need assessment survey done in 2001 observed that inadequate access to Emergency Obstetric care as one of the key issues that are contributing for high maternal mortality rates in underserved / under privileged areas in Sri Lanka. Therefore appropriate interventions during intrapartum period, namely Emergency Obstetric Care and Comprehensive New born Care will play a major contribution to reduce MMR and NNMR in Sri Lanka.

(19) **Important Assumption and Risk conditions:**

Human resource allocation and development for EMOC and Care-New Born care need to be addressed by Ministry of Health with considering on priority basis.

Stewardship issues are adequately addressed by MOH and provincial health authorities is fundamental important for implementation of project in the periphery.

(20) **Project Objective:**

Objective	Indicators	Means of Verification

Objective	Indicators	Means of Verification
■ To improve the health of pregnant women and newborn by providing quality Emergency Obstetric Care and comprehensive newborn care in hospitals while respecting women's rights.	1. Availability of EmOC facilities per 500,000 population	Routine MIS EMOC MIS
	2) Availability of EmOC services 24 hours 7/7 for days	Routine MIS
	3) Met need for EmOC	MIS on EmOC
	4) LSCS rate in district	
	5) CFR for all complications	EmOC MIS
	6) Proportion of MMR due to haemorrhage and PIH and complications	NMMR
	7) Percentage of hospital equipped to 24 hour blood transfusion service for 7/7 days	EmOC MIS
	9) Proportion of newborn death due to Asphyxia neo natarum and neonatal septicaemia	Perinatal data MIS CMCM
	10) NMMR institutional/hospital	RHIS
	11) MMR (institutional)	RHIS
	12) Hospital Still Birth rate	RHIS

(21) **Project Output/Product:**

Output	Indicators	Means of Verification
1) CEMOC facilities for 500,000 population (at district level) established in all districts	Percentage of districts having EMOC for 500,000 population.	Reports from the districts
2) Supportive service for EMOC facilities established.	Availability of human resource policy. Percentage of EMOC facilities having Supportive service	Report from Medical Institutions
3) Quality of care in EMOC, improved	CFR for different causes. Hospital Infection Rate	Institutional reviews
4) Hospital staff trained on EMOC service delivery, management, Information system on EMOC.	Percentage of hospital staff Trained Percentage of hospitasl using MIs on E MOC	Reviews at provincial and central level. Reproductive H. Return from institution (RHIS)
5) Progress of EMOC service delivery is monitored	Percentage of hospitals conducting progress review meetings Indicators developed	MIS on EmOC
6) . Newborn care facilities at district level established.(at least 1 per district)	`Percentage of provinces with New born units established	Reports from provincial plans
9) Sick baby unit at each	Percentage of SCBU	Reports from provincial plans

district established (SCBU)	established	
	Percentage of hospital staff Trained	MOH FHB Reports
11) Essential equipment and supplies for the new born facilities and EMOC facilities provided.	Percentage of hospital where essential list of equipment identified Percentage of hospital where essential equipment provided	MOH FHB Reports from provincial / district authorities.
7) New born service delivery monitored	1) No.of reviews done 2) Indicators identified	MOH FHB Reports Reports from Institutions, district and provincial level.
13) Periodically reviews at district and provincial level on newborn mortality & morbidity conducted.	1) – Pattern of newborn mortality, morbidity is reviewed. 2) Leading cause of death identified.	Reports of the review meetings.
8) System of accountability in obstetric and new born care units improved	1) Patient hand over/take over check lists, developed (as rubber stamp) 2) Availability and usage of check list for discharge 3)	Institutional reports Supervision reports from MOO/MCH
9). Referral system for Institutions with EMOC facilities established.	Percentage of referrals done	Reports from hospitals.

(22) Related Projects *(include ongoing projects & projects under the Health Master Plan)*:

Project No.	Project Title
1.1.3.	Strengthen the service for mother & child
1.2.1.	Medical supplies including drugs

(23) **Relevant Agencies to be Coordinated:**

Ministry o f Health, Nutrition & Welfare

Provincial Government

(24) **Monitoring & Evaluation:**

1. Who Central Level – Ministry of Health (Family Health Bureau),

Provincial, District Level – PDHS, DPDHS, Overall and detail supervision supervision by

MO.MCH

2. When Annually reports – Periodical Reports and routine District MCH Reviews (Annually/ Biannually) Routine MIS on EmOC

Periodical survey

3. What actions to be taken based on results of monitoring & evaluation?

   Relevant actions will be taken to overcome the identified deficiencies to improve the existing system and constraints will be addressed

(25) **Major Activities :**

Activities	Expected Results	Process Indicators
1) Establish EmOC facilities per 500,000 population - 1 Sick Baby Unit facility per district - 1 comprehensive newborn facility per province	Functioning units established	Identification of the priority districts and provinces
2) Provision of essential equipments & drugs	Essential equipments available at facilities	Essential list identified Procured.
3) Training of staff (competence based training) on the care of the new born completed.	Availability of Trained staff on new born care.	Percentage of completed training programs
4) Allocation of Human Resource for EmOC and New Born care facilities	Policy developed H.R .allocated	H.R. Policy and Norms developed
5) Establishment of supportive service for EmOC service delivery such as laboratory, operating theatre facilities, blood banks	Identified supportive service and allocated	Identify essential supportive service
6) Improvement of Quality of care on EmOC and New Born Care facilities	Established guideline on quality of care	Norms/Standards/Developed Indicators/Identified/ Quality assurance system developed
7) Improved Management system at EmOC and newborn facilties	Management system developed	Management at EmOC facilities is improved
8) Development of MIS for EmOC and comprehensive newborn care	MIS developed for EmOC	Indicators identified
9) Competence based training for service providers	Knowledge and competence improved	Curriculum developed, no.of training programme done
10) Development of Monitoring system on EmOC and new born care	EmOC and newborn care monitored	Indicators and process developed
11)periodically reviews at district and provincial level on new born mortality and morbidity.	pattern of new born mortality and morbidity studies leading causes of death identified	number of review meetings conducted
12) Study the morbidity and mortality pattern of new born	Morbidity, mortality pattern of newborn identified	Research published
13) Development of Accountability within EmOC, and newborn care service delivery	Accountability at hospital level improved	Hand over and take over system developed

(1) **Project Title:**	Establishment And Maintenance Of A Developed Logistic Management System For Strengthening Of Family Health Services	(2) **Project Number:**	1.1.3.d
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/ PHS II	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Family Health Bureau	(7) **Project Duration:**	5 years

(8) Target Areas & Beneficiaries:

The whole community with especial regards to Pregnant and lactating mothers, women, infants and children in general.

(9) Justification:

The Family Health Bureau (FHB) is the central organization responsible for the planning, co-ordination, direction, monitoring and evaluation of Family Health Programme in the country.

Hence, a very important activity of the Family Health Bureau is the procurement and distribution of contraceptives, micronutrients, equipment and supplies needed for the implementation and delivery of Family Health activities at the periphery.

Hence, establishment and maintenance of a proper logistic management system throughout the country, so as to have an uninterrupted supply of contraceptives, micronutrients, equipment and supplies for the Family Health Programme will enhance and strengthen the Family health Services of the country.

(10) Important Assumptions/Risks/Conditions:

The above goal would not be achieved, if the human resources, other physical resources and infrastructure facilities are not provided on time, and if the cross cutting issues related to logistics are not addressed.

Objective	Indicators	Means of Verification
■ To improve the quality of Family Health Services by establishing a proper logistic management system such as procurement, storage, and supply of equipment, micronutrients, contraceptives and supplies.	1. proportion of MOH offices	Periodical surveys.
	having a 1 month buffer stock of	Supervision reports.
	contraceptives at a given time.	Audits.
	2. proportion of RMSDD having	District review reports.
	3 month buffer stock of contrac-	MIS
	eptives at a given time.	
	3.Proportion of MOH offices who	
	had stockouts during a given	
	time period.	

(11) **Project Output/Product:**

Output	Indicators	Means of Verification
1.A proper logistic management system is established and maintained.	Proportion of RMSDD where the new logistic system is implemented.	Project report with guidelines and recommendations.
2. Logistic management system at central level and at district level (RMSD level) is computerised and a proper flow of information from the periphery to the centre is established, and maintained	No. of centres with computerised logistic system.	Supervision reports. MIS
3.Improved procurement, storage, and supply of contraceptives for the family health services.	Proportion of institutions who maintain the relevant buffer stocks at district and divisional levels during the year.	Supervision reports. MIS. Periodicl surveys.
4.Improved procurement, storage, and supply of MCH/FP equipment and micronutrients, and supplies for family health services.	Proportion of institutions at central, district and divisional levels who had stock-outs during the year.	Supervision reports. MIS Periodical surveys.

(12) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)*

N.I.L.

(13) **Relevant Agencies to be Coordinated:**

N.I.L.

(14) **Monitoring & Evaluation**

1. Who? FHB will be responsible for the monitoring and evaluation at the central, district and divisional levels.
   MO/MCH will be responsible for the monitoring at the district and divisional level
2. When? Monitoring, Ad-hoc surveys, regular verifications, quarterly evaluations.
3. What actions to be taken based on results of monitoring & evaluation?

   Re-planning, Take action to minimize deficiencies identified.

(15) **Major Activities:**

Activities	Expected Results	Process Indicators
1.Situation analysis of the existing logistic management system.	Information on the existing logistic system is collected.	Enumeration and coverage of the information items

Activities	Expected Results	Process Indicators
		identified.
2.Designing a proper logistic management system.	A proper logistic management system is designed.	Designed logistic management system document.
3.Implementatin of the newly designed logistic management system.	The newly designed logistic management system is implemented.	Implemented system at various levels.
4.Monitoring, supervision, and evaluation of the implemented logistic management system.	Logistic management system is maintained.	Review reports MIS
5. Human resource development at different levels to improve the logistic management system.	Capacity building of the service providers of the logistic management system is implemented at central and at district levels.	No. of trainings given and training programmes organised.
6. To ensure availability of the required staff to improve the logistic management system at different levels.	Recruitment of staff done.	No. of staff recruited .
7.Establishment of a computerised system of data management at central and district level.	A computerised information management system is established at central and district level.	A computerised information management system at central and district levels.
8. Establishment of a proper system of procurement of contraceptives.	A proper system of procurement of contraceptives established.	
9. Improvement of storage facilities at central and district level to accommodate a larger consignment of supplies.	Storage facilities at central and district levels improved.	No. of stores improved.
10. To improve transport facilities at central and district level to transport supplies.	Transport facilities at central and district levels improved.	No. of vehicles purchased.

(1) **Project Title:**	Child Health Programme	(2) **Project Number:**	1.1.3 e
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG PHS 2	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	D MCH	(7) **Project Duration:**	10 yr

Project Summary :

Provision of service delivery for children aged five and under focuses on improving the quality and coverage of service delivery with special emphasis on vulnerable groups such as those living in urban slums, conflict areas, institutions, rural remote areas, street children and those in the estate sector. It aims at strengthening the existing services while identifying and implementing new strategies to address the unmet needs of children. The following major activities would be implemented by the Central and Provincial Health Ministries in co-operation with local and foreign consultants.

- review and revise existing Child Health Policies, Child Health programmes and guidelines.
- Implement the Early Child Care and Development programme in all Provinces.
- Provide services for differently abled children.
- Provide sustained services to those living in vulnerable areas and belonging to vulnerable groups.
- Establish a system to investigate all deaths occurring in infants and children aged 1-4 years.
- Establish a surveillance system to identify the morbidity patterns of under 5 children.
- Enhance coverage and quality of EPI programme to improve child survival.

(8) **Target Areas & Beneficiaries:**

In the first phase (upto 2007) target areas will be 6 pilot zones representative of different types of vulnerable and normal populations, each covering one division at least. In the second phase this will be expanded to reach all the vulnerable populations and normal population.

(9) **Justification:** Family Health Bureau co-ordinates the implementations of preventive and promotive health care for mothers and children in the country. There is a need to improve equity of services in order to improve national indicators and thus reach millennium goals, taking into consideration the changing demographics, changing fertility, changing role of women in society which require changes in the methods of delivery and addition of new service. To do this there is a need to review the existing policies with a view of formulating new policies to accommodate the current needs. FHB has a monitoring system that shows some deficiencies in ANC and delivery care, in growth surveillance and nutrition education as well as in coverage of working in the poor, language minorities and remote communities. The Medical Officers of health need to reorient their role to provide community care and community dialogue through community mobilisation. The Public Health Midwives need to be trained to be able to deliver more intensive nutrition education, new services in ANC and children focusing on the needs of the individual families.

Primary prevention in the community will have to be organized with local government and community groups with involvement of NGO.

The PHM need to have newly designed populations to be able to carry out the new tasks. Field Logistics need to be improved for MOH and PHM especially in rural and remote areas to assure adequate population coverage and working schedules need to be adapted to assure access to working mothers.

Monitoring and Evaluation has to be identified as a major responsibility of the Medical Officer of Health. Reports based on supervisions of all levels need to be used for quality assurance.

(10) **Important Assumptions/Risks/Conditions:**

First three years can be reserved to pilot, monitor and evaluate and cost effective delivery methods in 6 pilot zones covering each one division of average 60.000 people (20 to 100.000 population) in different areas : urban slum, Estate, NE, remote rural, normal rural and one normal urban. The fourth year will be transitional.

The need to revise the populations served by each Public Health Midwife will have to be decided. The job functions of the PHM will have to be identified clearly enabling her to expand her services to incorporate the total family.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To improve the service delivery for children aged five years and under aimed at improving their health and well being by providing quality services at an affordable cost, focussing on all with special attention to the least privileged.	Perinatal mortality rate	Vital registration Hospital ward data Medical Information System (MIS)
	Neonatal mortality rate	
	Post neonatal mortality rate	
	1-4y mortality rate	
	% of children with low Wt/age, % of children with low wt/ht, % of children with low ht/age	Growth surveillance
	Immunization coverage	EPI records
	Anemia of children under 5	Periodic surveys
	% of caregivers providing homebased psychosocial stimulation to children under five	Periodic surveys
	Proportion of MOH areas implementing the Early Childhood Care and Development (ECCD) programme	MIS
	Proportion of mothers who are aware about home based ECCD.	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Policies and guidelines on Child Health developed.	Child Health policies and guidelines available.	Policy document at Ministry of Health Guidelines available at FHB
Growth Monitoring and Promotion and Complementary Feeding programmes strengthened.	% of children under five with low Wt/Ht, % of children under five with low Ht/Age, % of children under five with low Wtt/Age Prevalence of anemia among under 5. Prevalence of Vitamin A deficiency among preschool children.	Medical Information System Data from periodic surveys DHS data
Home based Early Childhood Care and Development (ECCD) established in all MOH areas.	Proportion of under five children receiving home based Psychosocial stimulation /Proportion of MOH areas implementing the ECCD programme Proportion of mothers who are aware about home based ECCD.	MIS Special surveys
A referral system linked to the ECCD programme established for identification and referral of children with problems.	% of MOH areas with a functioning referral system	Special formats/MIS
Services to children with disabilities provided.	Proportion of districts with a system to identify children with developmental delays No. of trained personnel available per district	Information from DPDHS office
All reported infant and Child (1-4) deaths investigated.	Proportion of Infant and Child Deaths investigated.	Evaluation formats used MIS
Surveillance system established to report morbidity conditions of under five children.	No. of surveillance sites established. Proportion of sites reporting data	Special information systems
Communities empowered to identify their health needs and communicate their needs to Medical Officer of Health.	No. of community groups formed per PHM per districts Proportion of community groups involved in identifying their health needs % of MOHs with satisfactory communication with community groups	Information using special formats

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1.4.2	Communicable Diseases Control
1.6.1	Nutrition
1.6.2.	Nutrition

(14) **Relevant Agencies to be Coordinated:**

Health Education Bureau, Division of Mental Health of MInistry of Health, Nutrition division of Ministry of Health, Nutrition Co-ordination division of Ministry of Health, Epid. Unit, Provincial Health authorities, Community Organisations, Relevant NGOs working with children

(15) **Monitoring & Evaluation:**

1. What?Who?When? Monitoring of Services will be done by each Medical Officer of Health supported by the Provincial Health Officers and FHB. Data will have to be handled electronically. Data input should be done daily, analysis of data should be done every month using agreed upon indicators, field follow-up of deaths should be instantaneous (verbal autopsy by MOH). Data should be regrouped by 3 months for more definitive analysis and transmission to PHO and central FHB. Verbal autopsies should be discussed with everyone and decisions taken on how to reduce such events in the future. Monitoring should also lead to collective feedback to the whole team involving even community members on a regular basis.
2. Evaluation of Services Finally monitoring on an annual basis will lead into evaluation based on routine data. When information is not available through the routine system special studies need to be organized to evaluate the services.
3. Monitoring of the progress towards planning and training output This task should be shared by Provincial Health Officers and FHB with technical assistance from MDPU of the Ministry of Health.
4. Evaluation of the output towards planning and training for expansion

   All Monitoring &Evaluation data and reports will be shared freely with all concerned agencies in and outside MOH, provinces and interested divisions.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Doing a study to evaluate the existing Child Health programme in Sri Lanka.	The strengths and deficiencies in the existing services including the unmet needs identified.	Doing a survey on a nationally representative sample.
2. Revise and develop new policies for the National Child Health programme.	Policy on Child Health developed.	Draft policy developed.
3. Develop guidelines for the Child Health programme in Sri Lanka.	Guidelines developed and distributed to the Districts and divisions on the Child Health programmes.	Draft of guidelines developed at several consultative workshops.

Activities	Expected Results	Process Indicators
4. Strengthen the GMP/CF programme.	Prevalence of malnutrition among under 5 reduced.	No. of training programmes conducted Composition of a low cost CF decided.
5. Implement the integrated ECCD programme in all MOH areas on a phased out basis in a sustainable manner.	Knowledge and skills of parents on home based psycho-social care improved.	Percent of parents aware on the importance of psycho-social development of children. Proportion of parents receiving services.
6. Establish and strengthen services for Differently abled children at District and divisional levels.	Child Development centres established. Home based services provided for families	No. of centres established per district. No. of divisions with home based services for Differently abled children.
7. Conduct infant and child death reviews at District level annually.	To identify the causes of death and take steps to minimise further deaths due to preventable causes thereby reducing mortality rates.	No. of reviews conducted
8. Establishing a surveillance system to monitor the morbidity conditions affecting the infants and children aged 1-4 years.	Morbidity conditions affecting infants and children aged 1-4 years identified and trends observed.	No. of surveillance centres established. Proportion of centres reporting data.
9. Revise, Print and distribute Child Health Development Records to all Districts.	350,000 CHDR printed and distributed annually.	Number of CHDR printed annually.
10. Procure supplementary equipment, vitamins and needed supplies for project areas.	Essential supplies including equipments and Vitamins provided for the smooth implementation of programmes.	
11. Support the mobilization of field health workers specially the PHM by providing bicycles thereby improving the coverage and quality of services at community level.	Bicycles provided to all PHMs willing and able to ride a bicycle.	Proportion of PHMs having a bicycle.
12. Provide basic services for children living in vulnerable groups like those living in institutions/ Children's homes/Street children/urban slums/ estates/conflict areas etc.	Children under five years in institutions have access to basic care.	
13. Coverage and quality of EPI services	1. % of EPI review	1. Availability of

Activities	Expected Results	Process Indicators
improved.	meetings conducted. 2. % of relevant Health Staff trained on EPI activities. 3. Provide guidelines doe Health staff on monitoring and evaluation.	minutes of the meetings. 2. Report from MO/MCH and RE> 3. Availability of guidelines.

(1) **Project Title:**	Family Planning Programme	(2) **Project Number:**	1.1.3.f
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG PHS II	(6) **Starting Fiscal Year: 2004**	
(5) **Implementing Agencies:**	Family Health Bureau	(7) **Project Duration:**	5

Project Summary

Even though Sri Lanka has already achieved a replacement level fertility, it was estimated it would take at least next 30 years to reach zero growth rate due to the presence of a larger number of females in reproductive age groups. There fore it is very important to sustain the effective family planning program through out near future.

The success of the family planning program has been the main factor behind the current fertility pattern. Providing family planning counselling to the women in reproductive ages at their homes by PHMs and providing continuous supplies of contraceptive commodities free of charge to the fertile couples has been the main fillers of the success. The training of PHC workers in family planning methods and counselling has been proven to be effective interventions. These activities have to be continued to sustain effective family planning program. Further it is very important to ensure the continuous supply of contraceptive commodities to this large number of fertile couples in near future.
Apart from that about 10 % of couples are sub fertile and there is no standard health management systems in place for them. Therefore the project also will look in to this problem as well

(8) Target Areas & Beneficiaries:

Fertile couples in Sri Lanka

(9) Justification:

Sri Lanka has a 18.4 million population and 52% in the reproductive ages. Therefore it is very important ensure that they receive adequate information to help them to make decisions on when, how often to reproduce and provide them with contraceptive services.

(10) Important Assumptions/Risks/Conditions:

Continuous Government and Community commitment / other INGO towards family planning programme as the UNFPA is withdrawing

(11) Project Objective:

Objective	Indicators	Means of Verification
■ to maintain the TFR level of 2.1 by ensuring, at least 72% of fertile couples are practicing an effective contraceptive method based on free and informed decision	Increase of current level of CPR for modern methods of contraception from 49 % to 70 % by 2008 TFR will be maintained at replacement level	DHS survey FHB MIS

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Adequate amounts of all categories of contraceptive commodities are available at all service outlets	% of FP clinics with all types of contraceptive methods(Pills , condoms, depo provera , IUD) available throughout the year Number of FP clinics & institutions offering sterilization services on regular basis.	Monthly stock returns H1200 Special surveys
2. All categories of family planning service providers are trained in family planning & counselling	% of MOH/PHNS/AMO/RMO trained in service programmes on family planning methods / counselling at FHB # of training programs carried out for PHMS at district levels on family planning and counselling KAP of PHC workers	Project reports Surveys
3. Availability of guidelines for the use of contraceptive methods with service providers	% of PHMS who possess written guidelines on contraceptive usage in Sinhala /Tamil languages	Surveys IEC Facility audit
4.Capacity building of consultants at central level on FP methods, counselling, and sub fertility	# of Consultants trained at the overseas centres of excellence on these subjects	project reports
5. Availability of IEC material necessary for family planning related community motivation and training of service providers	number of /types of available IEC materials	Audit
6. Scientifically sound and standard protocols are in operation for the management of sub fertility at community & curative levels	Existence of protocols % of VOGs / PHC MO in government sector , who are aware of such guidelines number of clients successfully treated	Surveys
7. Action research focussed to improver family planning programme are carried out	Number and types of research number of times when FP programme based on objective evidence	Research

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1.7	Health promotion programme

(14) **Relevant Agencies to be Coordinated:**

provincial governments, NGO involved in FP programme

(15) **Monitoring & Evaluation:**

1. Who? FHB
2. When? Quarterly
3. What actions to be taken based on results of monitoring & evaluation?,

   correcting logistical problems

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Obtaining & distribution of contraceptive commodities & equipments to the local clinics	Required amount of contraceptive commodities are available at the FHB FP clinics in districts are supplied with all types of contraceptive commodities available through out a given year	% balance of the required amount of contraceptive commodities at the FHB % of FP clinics in a district with all types of contraceptive commodities available through out a given year stock balance at the FHB
2. Training of PHC workers in contraceptive methods, FP counselling	FP service providers are having satisfactory knowledge & sk ills in FP counselling & contraceptive commodities	% of MOH/PHNS/PHM trained in in-service programs at FHB & Districts # of training programs carried out in the districts
3. Development of standard guidelines for FP service providers	Updated Instruction manuals are formulated and distributed among service providers	number/types of instruction manuals prepared
4. Training of consultants at central level on FP methods, counselling & sub fertility at overseas centres of excellence	FP service provision, counselling and sub fertility skills of consultants at the FHB is improved	# /types of train programs conducted changes are made to the programs base don training
5. Production of IEC material relate FP activities	IEC materials on FP methods, prevention of abortion are prepared	Number & types of available IEC materials
6. Develop / update the guidelines for the management of sub fertility & train PHC staff	Working manuals are prepared	Existence of the manuals % of PHC workers and specialists who are aware of such guidelines

on sub fertility	PHC staff are trained in sub fertility management	
7. Designing and conducting action research on FP programme	programme activities are evaluated and revised based on the scientific evidence	number & types of research projects conducted number of changes to the programme

(1) **Project Title:**	Information, Education and Communication Support to Reproductive Health Services (IEC support for RH)	(2) **Project Number:**	1.1.3.g
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	**Health Education Bureau**	(6) **Starting Fiscal Year:**	2002
(5) **Implementing Agencies:**	Health Education Bureau Provincial Director of Health Services, Deputy Provincial Directors of Health Services from Ministry of Health. Over implementing agencies are Department of Labour, National youth Services Council, University Grants Commission and Sri Lanka Army.	(7) **Project Duration:**	Five years (already commenced and continues till 2006)

Project Summary

Sri Lanka has performed better than most developing countries with regard to population reproductive health and women empowerment.

Despite the favourable overall national demographic and social indicators of Sri Lanka, there are vulnerable groups of population and underserved geographic areas where the indicators are much less favourable than the national averages.

Under the 5th country programme cycle of support to Sri Lanka which implemented in 1997 – 1998 IEC activities were aimed at general public, health workers as out of school adolescents and youth. The 6th country programme cycle has build upon the experiences and lessons learned of the previous project and further focus on undersweved areas and vulnerable groups.

The objective of the project is to have increased awareness of sexual and reproductive issues, including responsible and gender sensitive behaviour among adolescents and youth.

In order to achieve this five IEC implementing agencies which are dealing with youth and adolescents have been identified and a series of IEC activities have been scheduled..

Among these IEC implementing agencies HEB plays a leading role in providing technical guidance and support and as a monitoring body too.

HEB activities mainly focus on increase awareness among youth and adolescents through capacity building in health staff and media personnel production of IEC materials both print and electronic media.

Project activities are evaluated at periodical intervals as annual, mid term and final..

(8) Target Areas & Beneficiaries:

Adolescents and Youths, Parents of adolescents and youth.

Primary Health Care Staff/ Medical Institutional Staff.

Provincial /Regional Health Planners/Health Staff

Central and Provincial media Personnel.

(9) Justification:

Sri Lanka has performed better than most developing countries with regard to population, reproductive health and women empowerment. The total population for Sri Lanka is 18.73 million according to the census done is 2001. The rate of population growth has reduced from 1.4 percent during the early part of 1990s to 1.1 in 2001. The total fertility rate decline to 2.1 by 2002.

However the country still has certain specific issues which are in urgent need of intensified attention Despite the favourable overall national demographic and social indicators of Sri Lanka. There are vulnerable groups of population and underserved geographic areas where the indicators are much less favourable than the national averages. These include the districts affected by the ongoing conflict, marginalised rural areas, the plantain sector, urban slum dwellers etc.

High amount of induced abortion,, STDs/RTIs including HIV/AIDS, high reliance on traditional methods of family planning, low male involvement and ageing have been identified as issues needs urgent and more attention.

The UNFPA's 6TH country programme of support to Sri Lanka, which covers the five years 2002 to 2006 has been designed to address these and other identified priority issues. Under the fifth UNFPA country programme. IEC activities were aimed at the general public, health workers out of school adolescents and youth. The new IEC project has been build upon the experience and lessons learned of the previous project and further focus on underserved and vulnerable groups. The vulnerable groups include adolescents and youth in urban, semi urban rural and plantation settings, free trade zone workers, university students and youth working in armed forces etc.

Influential groups such as primary health care workers, hospital health workers and media personnel will be used as communicators and educators for high effect. Total IEC project is implemented through 5 IEC implementing agencies of which HEB has to act as the main agency. The other agencies are Worker Education Division of Department of Labour, National Youth Services Council, Sri Lanka Army Medical Directorate and University Grants Commission.

Activities implementing under HEB will support to attain the objective of national IEC programme with greater focus on IEC support in underserved districts, vulnerable groups etc by training of central, provincial, regional and divisional health staff and media personnels. The provision of OIEC materials with print and electronic media will improve awareness creation.

In addition to HEB main focus, it also provides technical support to other IEC implementing agencies establishes coordinating mechanisms for quality output.

(10) Important Assumptions/Risks/Conditions:

Assumptions

Trained health personnel (both PHC and institutional)continue to impart knowledge, practices to inculcate favourable attitudes, promote and practices on sexual and reproductive issues including responsible and gender sensitive behaviour among adolescents and youth.

Funding and support from UNFPA will continue till 2006 as at present and as promised.

Provincial , Regional and Divisional health authorities support and joint with the planning, implementation, monitoring and evaluation with central organization.

Trained media personnel continue to disseminate knowledge inculcate favourable attitudes and promote good practices on sexual and reproductive issues among adolescents and youth.

Risks

Social cultural factors creating problems or obstruction to implementing the awareness programmes.

Conditions.

Youth and adolescents will perceive knowledge, correctly inculcate favourable attitudes and practice gender sensitive responsible sexual behaviour.

Supportive socio-cultural environment for awareness creating programmes.

(11) **Project Objective:**

Objective	Indicators	Means of Verification	Relevant Agencies
■ To have increased awareness of sexual and reproductive issues including responsible and gender sensitive behaviour among adolescents and youth.	Improved knowledge , attitudes practices and behaviour of target Population.	Periodic Survey.,	HEB, Ministry of Health,
	% of health workers trained.	Evaluation reports.	
	% of media personnel trained.	Evaluation reports.	
	Number of IEC materials produced in each.	Evaluation reports.	
	Numb of training material produces in each issue.	Evaluation reports.	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification	Relevant authority
Trainer team trained on priority issues of RH.	Numbers of trainers trained.	Reports.	D/HEB PDHS DPDHS
Field and Institutional health staff trained on priority issues of RH.	Number of health staff in each district/institution	Reports	D/HEB PDHS DPDHS Hospital Directors MOH
Media personnel trained on priority issues of RH.	Number of media personnel trained of provincial and central levels.	Evaluation reports.	D/HEB PDHS
IEC materials (both electronic and print)	Type and number of IEC materials developed	Evaluation report.	D/HEB

developed on priority issues of RH.			
Training materials developed on priority/issues of RH.	Type and number of IEC materials developed.	Reports.	D/HEB

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	HIV/AIDS prevention, Health Education Programmes Health Education programmes in Cancer prevention.

(14) **Relevant Agencies to be Coordinated:**

Relevant Directors of Ministry of Health, Provincial Regional and Divisional Halth Authorities, Institutional Health authorities.

(15) **Monitoring & Evaluation:**

1. Who? HEB
2. When? Quarterly reviews : Annual evaluation, mid term evaluation, final evaluation.
3. What actions to be taken based on results of monitoring & evaluation?

   Further improvement and building upon the experience and lessons in the sixth cycle in further programme planning, implementation, monitoring and evaluation.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Workshops to develop national IEC strategy on RH.	Use of national IEC strategy by all IEC implementing agencies.	National IEC strategy developed.
Workshops to develop HEB training curricular for health staff and media personnel.	Use of training curricular in training.	Training curricular developed.
Seminars to build capacity at central level staff/trainers.	Improved knowledge and skills in IEC on RH at Central level staff .	Seminar reports prepared
Capacity building training programme for provincial and regional level health staff.	Improved knowledge and skills in IEC on RH at provincial and regional level staff.	Training programmes evaluation reports prepared.
Communication and counselling training programme for PHC and institutional staff.	Improved knowledge and skills in Communication and counselling in RH.	Training programmes evaluation reports prepared.
Seminars/training programmes for media personnel.	Improved knowledge and skills of media personnel on	Training programmes evaluation reports prepared.

Activities	Expected Results	Process Indicators
	RH.	
National and Provincial Media forum.	Improved implementation of activities in media organizations at different levels.	Evaluation reports prepared.
In country visits for journalists.	Increased awareness and inculcate favourable attitudes among journalists	Field visits, evaluation reports prepared.
Annual multi media campaign.	Increased awareness among youth and adolescents.	Multi media campaign conducted. & evaluation report prepared.
Production of Audio-visual programme.	Increased awareness among youth and adolescents.	Audio visual programmes produced & Evaluation reports prepared.
Printed IEC materials, Production of exhibition panels, and newsletters etc.		IEC materials printed exhibition panels and newsletter produced.
Monitoring and supervision visits to MOH offices/Medical Institutions to observe monitor and supervise IEC activities.	Improved implementation of IEC activities.	Observation and supervision report prepared.
Project Steering Committee meetings	Improved implementation of IEC activities	Progress reports prepared.

(1) **Project Title:**	Re-organizing and Strengthening of Laboratory and Diagnostic Services in State Hospitals, Field & Private Sector Laboratories	(2) **Project Number:**	1.1.4
		(3) **Project Priority:**	
(4) **Focal Point:**	Deputy Director General / Laboratory-Services (DDG/LS)	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	▪ D/MSD, D/LS ▪ Provincial Authorities ▪ Directors of Teaching Hospitals & Directors of Specialized Campaigns	(7) **Project Duration:**	5 years for initial implementation; 10 years to achieve full potential

Project Summary :

To practice the science of medicine either in the hospitals or field, one needs a consistent support from laboratory services.
The Project is aimed at providing quality laboratory services by ensuring efficiency in the functioning and equity in the clustering of laboratories in public hospitals and field as well as in the private sector.
To achieve its objective, the Project will formulate clear, coherent and practical policies, standards/norms and regulations based on lessons learned from local and international experiences in improving laboratory services. The following will be pilot-testing to assist the formulation or amendment of existing policies, standards and regulations: clustering of government laboratories; public-private partnerships; and Laboratory Investigation Data System. Once approved, the policy, standards and regulations will be used for the nationwide implementation of mechanisms to improve intra- and inter-sectoral partnerships, strengthening the human, financial, equipment and logistic resources to the maximum capacity for the needs of the patients. Furthermore, an accreditation system will be established that will encourage and not police laboratories so that they will consistently strive for quality and excellence. Considering the cost of maintaining and replacing equipment, an improved equipment accountability system will be adopted.

(8) Target Areas & Beneficiaries:

The target area for the Project is limited initially to two districts during the pilot-testing phase. Once formulated, though, the Policy on Enhancing Efficiency, Equity and Sustainability of Laboratories will address issues in all laboratories of the government and private sector. After the pilot-tests, the Project will support the strengthening of institutional capacities throughout the country in a phased approach.

The following areas are intended to be addressed in the Policy, Standards or Regulations on Laboratories:

1. Pilot-testing and nationwide implementation of clustering of laboratories to achieve efficiency in conducting and reporting the results of investigations;
2. Mechanisms to optimise inter-sectoral partnerships with other government agencies, for-profit and not-for-profit private sectors; and
3. Procurement of laboratory equipment and supplies to be based on the results of a Technology Assessment process and National Policy on Equipment, Policy on Donations of Equipment.

The Project beneficiaries will be the following:

- Laboratories in all categories of public and private hospitals;
- Key managers or consultants of laboratories will be provided with a clearly defined policies, standards and regulations as well as receive management training;
- Key laboratory staff will participate in Total Quality Management training as well as take active part in assuring quality of laboratory services and institutionalising mechanisms to foster sustainability; and
- Patients and other clients of laboratories will be the ultimate recipients.

(9) **Justification:**

It is observed that due to poor supervision and supply of inadequate human, financial and logistic resources to the laboratories in hospitals, quality of most of the laboratories have deteriorated. Statistics indicate that very few hospital directors, medical superintendents and DMOO inspect the laboratories during their routine ward rounds and others try to avoid visiting the laboratories due to many problems encountered as a result of complaints made by the Consultants, patients and the laboratory staff. The situation is being aggravated further due to non-availability of Consultants in most of the laboratories to administer the routine activities and as a result the MLTT taking over the full administrative control according to their own whims and fancies. This is very clearly seen when comparison is made between two similar grade hospital laboratories with the availability of similar facilities the services provided would be of two different standards. Posting of staff, supply of equipment and chemicals do not take place according to a laid down guidelines or norms. Most of the Consultants do not have confidence on the reliability of the laboratory investigation reports and as such tend to order second investigation to be performed by a private sector laboratory. It is also observed that most of the private sector laboratories do not have qualified staff as well as calibrated equipment. Quality Control and monitoring of the routine activities of the laboratories (state as well as private) are not being performed and as such there is a doubt on the reliability of the reports issued by the laboratories. As there is no price control various laboratories in the private sector tend to charge as such re-organisation and strengthening of laboratories in the country has been identified as a project to be conducted on a priority basis.

(10) **Important Assumptions/Risks/Conditions:**

The important assumptions include the following:

- Firm policy decisions to be taken in spite of the resistance from trade unions;
- Adequate funds to be made available so that the project proposal could be carried out in stages;
- Required numbers of various categories of staff to be trained and provided periodically as identified in the project;
- High technology, costly equipment with the consumables to be provided periodically according to the laid down norms for implementation; and

- All categories of staff involved in the laboratory sector to be made aware of the Project so that continuous support, co-ordination, supervision and monitoring would be voluntarily extended.

The risks include the following:

- Initial protest from trade unions;
- Sabotage of equipment by the staff in laboratories;
- Inadequate funds; and
- Posting of staff strictly according to the needs of the country maintaining equity.

(11) Project Objective:

The overall goal of the Project is to improve comprehensive health services delivery and health actions, which reduce the disease burden and promote health. The specific objective is limited to improving laboratory services.

Objective	Indicators	Means of Verification
To provide quality laboratory services by ensuring efficiency in the functioning and equity in the clustering of laboratories in hospitals, field and private sector	% of government laboratories that are accredited	▪ Mid-term evaluation ▪ End-of-project evaluation
	% of private laboratories that are accredited	▪ Mid-term evaluation ▪ End-of-project evaluation
	% of randomly selected consultants who are satisfied with laboratory services and results	▪ Mid-term evaluation ▪ End-of-project evaluation
	% of randomly selected patients who are at least satisfied with the improved system of delivering laboratory services	▪ Mid-term evaluation ▪ End-of-project evaluation
	Number and % of repeat investigations due to suspicious or spurious results	▪ Mid-term evaluation ▪ End-of-project evaluation

(12) Project Output/Product:

Output	Indicators	Means of Verification
Detailed Project Implementation Plan (PIP) that is used for Project Management, Monitoring & Evaluation	▪ % of PIP indicators that were used, analysed and discussed in project management, monitoring & evaluation reports	▪ Mid-term evaluation ▪ End-of-project evaluation
Clear, coherent and practical policy, standards or norms and regulations that are used for formulation of plans for improving and accreditation of various levels of laboratories	▪ % of major items in the policy, standards/norms and regulations that are being implemented	▪ Mid-term evaluation ▪ End-of-project evaluation
Motivated, skilled and competent laboratory staff	▪ % of laboratories with staff according to the approved standards ▪ % of laboratories with staff who perform well based on an approved competency checklist	▪ Mid-term evaluation ▪ End-of-project evaluation

	▪ % of laboratories with Total Quality Circles	
Adequate and appropriate equipment and consumables	▪ % of randomly selected laboratories whose staff assess the equipment and consumables to be adequate and appropriate	▪ Mid-term evaluation ▪ End-of-project evaluation
Investigations performed according to approved policy, standards and regulations	▪ % of randomly selected laboratories that has the capacity to perform all the investigations according to approved policy, standards and regulations	▪ Mid-term evaluation ▪ End-of-project evaluation
More reliable laboratory reports	▪ % of randomly selected laboratory reports that meet the standards of quality	▪ Mid-term evaluation ▪ End-of-project evaluation
Clustered system of delivering laboratory services	▪ % of randomly selected laboratories strategically displaying information on the clustering system	▪ Mid-term evaluation ▪ End-of-project evaluation
Public-private partnerships in the delivery and/or financing of laboratory services	▪ % of approved mechanisms for public-private partnerships that have achieved their objectives	▪ Mid-term evaluation ▪ End-of-project evaluation

(13) **Related Projects:**

Project No.	Project Title
1.1.1	Functional Rationalisation
1.1.2	Facility Development
1.1.5	Blood Safety
1.1.6	Technology Assessment
1.2.1	Medical Supplies (including drugs)
1.2.2	Medical Equipment
1.3.4	Total Quality Control/Management of Hospital Services
1.3.5	Total Quality Control/Management of Promotive and Preventive Services
1.4.1a-h	Non-Communicable Diseases Control Programme
1.4.2a-j	Communicable Diseases Control Programme

(14) **Relevant Agencies to be Coordinated:**

- Provincial Councils and other local authorities responsible for the pilot districts and later for all other districts
- Stakeholders coming from the for-profit and not-for-profit private sectors
- Stakeholders representing the General Practitioners and trade unions
- Development partners that are interested in improving laboratory services

(15) **Monitoring & Evaluation:**

Who?	When?	Actions?
▪ Focal Point ▪ Implementing Agency	Monthly	Report to the Committee for Enhancing Efficiency, Equity and Sustainability of Laboratories on the progress of Project

▪ CEEESL (focal point is a member)	Quarterly	▪ Assess achievement of Expected Results and Process Indicators of appropriate Activities ▪ Make decisions to ensure success of Project Activities
▪ CEEESL (focal point is a member) ▪ Implementing Agency	Annually	▪ Recommend to DG, Secretary and Minister (on minor adjustment in the Project Implementation Plan on an annual bases and the major adjustment based on the result of the mid-term evaluation)
▪ Team of evaluators to include the Project Focal Point, representative of the CEEESL, and an external evaluator	Midterm Evaluation	▪ Assess the achievement of Project Output/Product ▪ Recommend to DG, Secretary and Minister (on major adjustment in the Project Implementation Plan)
▪ CEEESL (focal point is a member) ▪ Implementing Agency	End-of-Project Evaluation	▪ Assess the achievement of Project Output & Objective ▪ Recommend amendment to the Policy, Standards and Regulation

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Preparatory Phase	▪ Project Implementation Plan is formulated and approved	▪ Number of weeks required for the Project Implementation Plan to be approved
	▪ Committee for Enhancing Efficiency, Equity and Sustainability of Laboratories (CEEESL) is organised	▪ % of meetings of CEEESL with approved minutes/record ▪ % of members of the CEEESL who attend the meetings
2. Learning from Local and International Experiences in Improving Laboratory Services	▪ Specific new or amendments to existing policies, standards and regulations are recommended based on the findings of studies ▪ Specific strategies or lessons related to pilot-tests are recommended	▪ % of studies that were completed within targeted period and having achieved all their objectives
3. Pilot-testing to Assist the Formulation of Policies, Standards and Regulations	▪ Specific new or amendments to existing policies, standards and regulations are recommended based on the results of pilot-tests	▪ % of laboratories within the 2 pilot districts that participated in the Planning Workshop ▪ % of government laboratories within the 2 pilot districts that participated in the clustering system ▪ % of private laboratories within the 2 pilot districts that participated in the any partnership mechanism ▪ % of randomly selected clients of pilot laboratories who are at least satisfied with Laboratory Investigation Data System

Activities	Expected Results	Process Indicators
		▪ % of activities to monitor and evaluate the pilot-tests that were completed and have achieved all their objectives
4. Formulation of Policy, Standards and Regulations	▪ Policies, standards and regulations are introduced or existing ones are amended, printed, disseminated, and reviewed	▪ % of studies completed within targeted period and have achieved all their objectives ▪ % of priority stakeholders who participated in the consultation process ▪ % of priority stakeholders who received the approved policy, standards and regulations ▪ % of priority stakeholders who participated in the process to review and recommend amendments to the approved policy, standards and regulations
5. Nationwide Implementation of Mechanisms to Optimise Intra- and Inter-Sectoral Partnerships	▪ Mechanisms to optimise intra- and inter-sectoral partnerships are implemented in all districts	▪ % of districts where mechanisms to optimise intra-sectoral partnerships are in place ▪ % of districts where mechanisms to optimise inter-sectoral partnerships are in place
6. Reinforcing Capacities of Human Resources for Laboratories	▪ Adequate number of qualified human resources to supervise, manage and operate laboratories are appointed, trained and the good performers are recognised	▪ % of workshops and other training programmes completed and have achieved all their objectives ▪ % of targeted trainees who participated in the training programmes ▪ % of trainees who evaluated the training programmes with a rating of at least a satisfactory or its equivalent ▪ % of trainees who participated in the refresher course ▪ % of laboratories or their staff that received recognition for good performance
7. Hardware Acquisition, Installation and Maintenance	▪ Hardware installed and maintained according to standards	▪ % of provinces with an approved Equipment Acquisition and Maintenance Plan ▪ % of laboratories that have the functional hardware according to the approved policy, standards and regulations ▪ % of laboratories with at least one staff trained on preventive maintenance ▪ % of laboratories whose equipment are recalibrated periodically ▪ % of laboratories whose equipment downtime are being monitored periodically
8. Enhancement of Laboratory Supplies Management	▪ Management of laboratory chemicals and other supplies is improved	▪ % of government laboratories with the improved Laboratory Supplies Management System ▪ % of government laboratories with mechanisms to foster financial sustainability
9. Accreditation of	▪ Accreditation system is	▪ % of randomly selected stakeholders

Activities	Expected Results	Process Indicators
Laboratories and Assessment of Results	established and valued ▪ Randomly selected laboratory results are assessed	who are at least satisfied with the accreditation system ▪ % of laboratories that are included in the monitoring of quality of laboratory results ▪ % of laboratories that were identified to have problems with the quality of laboratory results and took remedial measures ▪ % of laboratories that have at least once a year discussion with their consultants and the meeting was held in the laboratory itself
10. Fostering Accountability in the System	▪ Equipment Accountability system is improved ▪ Impact of private practice during off-hours is assessed ▪ Mechanisms to systematically solicit feedback from consultants, patients and clients of the laboratories are being implemented	▪ % of laboratories with the Laboratory Investigation Data System ▪ % of randomly selected laboratories with inventory reports for the immediately preceding year ▪ % of problems in the inventory of randomly selected laboratories that were acted upon ▪ % of laboratories that are included in the monitoring of impact of private practice during off hours ▪ % of laboratories with mechanisms to receive feedback and act on them ▪ % of randomly selected laboratories that act on all the feedback they received from their clients
11. Project Monitoring and Evaluation	▪ All monitoring and evaluation activities are completed and result to improvement in the Project Implementation	▪ % of monitoring and evaluation activities having been conducted on time ▪ % of monitoring and evaluation recommendations that have been acted upon
12. Documentation, Recognition and Reports	▪ Audio-visual documentaries are produced, used and disseminated ▪ Recognition system is established ▪ Annual and Final Reports printed, disseminated and discussed	▪ Number of documentary audio-visual materials developed and used for promotional activities ▪ % of achievers who continue to be so ▪ % of under-achievers who become achievers ▪ % of priority stakeholders that received the Annual Reports ▪ % of priority stakeholders that received the Final Report ▪ % of randomly selected laboratories that discussed the Annual Reports

(1) **Project Title:**	Blood Safety	(2) **Project Number:**	1.1.5
		(3) **Project Priority:**	Very High
(4) **Focal Point:**	DDG/LS assisted by D/NBTS	(6) **Starting Fiscal Year:**	1st Year (FY 2004)
(5) **Implementing Agencies:**	D/NBTS	(7) **Project Duration:**	05 Years

Project Summary :

The Blood Safety projects aims to increase blood safety through provision of adequate amounts of safe blood and blood products and better utilization of blood through use of blood components and plasma fractions as well as appropriate clinical use. The following activities will be implemented by the National Blood Transfusion Service with help from Ministry of Health and local and international consultants.

1. Implementation of Blood Policy in both state and private sectors
2. Improvement of testing, processing, storage and transportation of blood and blood products
3. Introduction of plasma fractionation with help from international partners
4. Establishment of an IEC unit on Blood safety
5. Improvement of Quality Assurance through introduction of Quality systems and bio safety techniques
6. Improvement of Human Resource Development with introduction of training programmes

(8) Target Areas & Beneficiaries:

Teaching ,Provincial , Base & Private Hospitals

Hospital system in general and National Blood Transfusion Service in particular to the benefit of the patients

Blood donors and patients requiring blood

(9) Justification:

Although the National Blood Transfusion Service – Sri Lanka has improved considerably during the last few years and some more development projects are under way at the moment, some areas lag far behin. The major problem areas are;

- Implementation of blood Policy in both state & private sectors
- Inadequate facilities for storage & transportation with cold chain maintenance
- Non availability of adequate amounts of components and plasma fractions
- Inadequate facilities for Publicity & awareness campaigns
- Inadequate facilities for Bio-safety

Improving these areas are critical to make the best use of ongoing projects such as JBIC funded Blood Bank Development Project and World Bank funded Blood Donor Recruitment & Improvement of clinical use of blood and blood products projects.

(10) Important Assumptions/Risks/Conditions:

Assumptions

- Availability of adequate funds to meet the needs of the Blood Transfusion Service
- Sustainability of Volunteer Donor System to meet the demand
- Availability of adequate human resources

Risks

- Private Sector resistance to the Blood Policy
- Trade Union action affecting system
- Lack of resources for sustaining the programmes

(11) Project Objective:

Objective	Indicators	Means of Verification
■ To have a safe and adequate supply of blood products for the entire population of Sri Lanka	1. % of voluntary donors	Donor Register
	2. Percentage of replacement donors remaining	Relevant registers
	3. Request/Cross match ratio	Relevant registers
	4. No. of samples tested (+)ve for transfusion	Relevant registers
	5. No. of transfusion transmitted infections	Relevant registers
	6. No. of unfulfilled requests for blood & blood products	Relevant registers
	7. Percentage of regular donors enrolled	Relevant registers

(12) Project Output/Product:

Output	Indicators	Means of Verification
1. Implementation of National Blood policy	- NBTS as the sole organization for collection and supply of blood	
2. Maintenance of Cold Chain	- Decreasing outdating - Increased efficacy of products	
3. Introduction of contract fractionation	- Availability of plasma fractions - Improved Haemophilia therapy	
4. Establishment of an IEC unit	- Increase in volunteer donors - Increase in regular donors	
5. Introduction of Bio Safety	- Hospital infection control procedures in place	

	- Staff awareness increased	
6. Implementation of quality system	- GMP/ISO certification	
7. Human Resource Development	- Trained staff available - Academic programmes in transfusion medicine introduced	

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Blood Bank Development Project – JBIC
	World Bank Project for the Improvement of Blood Donor Recruitment & for the improvement of clinical use of blood & blood products

(14) **Relevant Agencies to be Coordinated:**

MoH, NBTS

(15) **Monitoring & Evaluation:**

1. Who? MoH & National Blood Transfusion Service
2. When? Annual & periodic surveys
3. What actions to be taken based on results of monitoring & evaluation?

   Positive Results – Continue Improvements

   Negative Results – Increase efforts

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1.Formulation of National Committee	Implementation of National Blood policy	
2. Phenotyping of group O donors	Screening an identification panel production	
3. Providing automated cell washing centrifuges to all Hospital Based Blood Banks	Improved sensitivity in Antiglobulin x-match	
4. Providing automated grouping to all 06 testing centres	Reliability of results & centralization of grouping	
5. Development of barcode system	Barcode printers & scanners installed s required	
6. Introduction of automated documentation	Interfacing software available	
7. Making laptop computers available to all	Compilation of donor database	

mobile teams	made easy	
8. Signing contract for fractionation	Plasma derivatives available for patients	
9. Conducting workshops for all categories of staff	Human Resource Development	
10. Making provisions for accommodation of trainees from all over the country	Human Resource Development	

(1) **Project Title:**	Technology Assessment	(2) **Project Number:**	1.1.6
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/BES	(6) **Starting Fiscal Year:**	
(5) **Implementing Agencies:**	MoH	(7) **Project Duration:**	

(1) **Project Title:**	Emergency Preparedness & Response	(2) **Project Number:**	1.1.7
		(3) **Project Priority:**	High
(4) **Focal Point:**	DDG/MS	(6) **Starting Fiscal Year:**	
(5) **Implementing Agencies:**	MoH	(7) **Project Duration:**	

Project Summary:

Emergency Preparedness and response project aims at the provision of standard and quality emergency management service specially to people affected by a disaster, man made or natural and also to provide immediate care to the patients brought hospitals in moribund stages. At present, there is no proper system or national policy in this regard. With the implementation of this project, a system of emergency care will be available which is nationally accepted. EPR once implemented would be supported, controlled, and regulated by frequent monitoring at the central and provincial levels. This regulation would be to maintain the standard of the quality of services. Following will be the main activities.

1) Based line need assessment in all health institutions including District Hospitals and above in respect of EPR facilities.
2) Actions will be taken to establish EPR units in all DHH and above.
3) Existing EPR units/ facilities will be improved according to the level of institution.
4) All the units will be provided with appropriate basic equipment, skilled personnel and other basic infra -structure required for EPR management (Provision of equipment will be planned by the respective group)
5) Equipment will vary according to the level of institution.
6) National policy/Plan will be formulated in order to ensure quality and the uniformity of EPR services.
7) Curative health care will be integrated with primary health care services in respect of EPR to form an emergency primary health care complex.
8) EPR services will be directed towards the provision of immediate care and the aspects of rehabilitation and restoring of the health of the people of a conflict/disaster affected areas.
9) Provision of safe drinking water, foods and nutritional support, latrine facilities control of possible out break of communicable diseases among the refugees will be ensured.
10) Routine medical /surgical emergency services will be in all health institutions.
11) Disaster management plan will be prepared to ensure the uniformity of service in each level

(8) **Target Areas & Beneficiaries:**

All the health care service personnel and patients.

(9) **Justification:**

Currently there are no facilities to cater to natural or man-made disasters in most of our District Hospitals or primary health care complexes. These units are either absolutely not prepared to face situations or poorly response to disaster situations or acute epidemic of infectious diseases such as cholera, though rare. There fore it would be beneficial to all DHH and institutions above to have EPR units.

(10) Important Assumptions/Risks/Conditions:

Government is committed to establish EPR activities.

High Commitment of health staff towards the delivery of EPR service

Adequate human resources allocated to health institutions

Freedom of transport in conflict affected areas

Preventive mechanism would be strengthened

(11) Project Objective:

Objective	Indicators	Means of Verification
■ Institutionalize the health emergency preparedness and response activities in all health institutions at the level of DHH and above. This will be supported by the primary health care facilities to co-op with sudden disaster either natural or man-made to maintain the health of the people.	Number of institutions provided with EPR Facility	Special survey
	Number of displaced people, refugees / critical patients provided with EPR services	Special survey, reports and records (MOH, Hospital and other)
	Number & % of health facilities provided in affected areas/Institutions	MOH reports/Provincial health reports
	Differences between the health states of the people in affected areas and the and the rest of the country	Epidemiological reports & records Hospital reports/records Clinic data
	Responsive difference between the affected areas and the rest of the country	Special survey
	% Of reduction of deaths with in 24 hours of admission	Hospital records/reports

(12) Project Output/Product:

Out put/product	Indicators	Means of verification
Establishment of EPR units at appropriate levels	- No. Of EPR units established	- MOH/PHA records/reports - Hospital reports
Development of a standard EPR management protocol	- Availability of a EPR management protocol	- No.& % of EPR staff trained
Emergency health system developed and managed in the appropriate levels	- Availability of EPR in operation - EPR surveillance report issued	- Surveillance reports - PHA records
Health emergency actions operationalized by EPR units in institutions / affected areas	- No. Of activities carried out and amount of funds utilized	- Monitoring records - Official reports of MOH, PHA - Records/ Minutes MOH/PHA
Resources for EPR mobilized	- Amount of EPR assistance	- MOH, PHA records

	mobilized annually - No. Of EPR assistance taken by units	- Monitoring reports

(13) **Related Projects**

Project No.	Project Title
1.2.1	Medical Supplies (including drugs)
1.2.2	Medical equipment
1.3.2	Development of emergency services, net work for injuries, accidents, poisonings and disasters
1.5.3	Disabled Health
1.5.4	Health of people in conflict affected areas and disabled population
5.2.1.	Establishing an improved management system and building capacities of management teams

(14) **Relevant Agencies to be Coordinated:**

MOH, Provincial Governments, Social Services Department, forces, NGOs and Volunteers

(15) **Monitoring & Evaluation:**

1. Who? : MOH, Provincial MOH, and appropriate Hospitals
2. When? : Quarterly reports, Annual reports, other periodic Surveys
3. What actions to be taken based on results of monitoring & evaluation?

: - Take measures to improve Quality of services

- Revision of regulations/Establishments/Circulars
- Change of Training curriculum according to the need

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Base line survey of Health Institutions at the level of DHH & above in respect of availability of EPR facilities	- No. Of Institutions with/without EPR facility identified. - Availability of resources identified - Requirements in respect of EPR identified	- No. Of institutions surveyed.
Formulate a National policy/ Plan on EPR	- Frame work available for the provision of EPR and smooth management disaster victims	- Production of Guide lines for EPR - Efficient & / improved EPR

		management
Establishment of Fully fledged EPR units in Hospitals	- Availability standard quality EPR services to the public.	- No. Of EPR units established - No. Of patients / refugees/displaced received the EPR services
Provision of Resources, manpower Equipment to EPR units	- Proper EPR management appropriate technology would be available	- % Cadre vacancy filled - % of equipment requirement supplied.
Training of staff in EPR management	- Service of skilled staff ensured	- No. of staff trained in EPR
Enhance management capacity through team work	- Motivation and Shared responsibility in the management of EPR.	- Formation of management team.
Integration of primary care field staff with the curative care services	- Enhance coordination between different categories of staff	- No. Meetings held with two sectors

1.2 MEDICAL SUPPLIES (INCLUDING DRUGS) & EQUIPMENT PROGRAMME

(1) **Project Title:**	Medical Supplies (Including Drugs)	(2) **Project Number:**	1.2.1
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	Director Medical Supplies Division	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Medical Supplies Division, RMSDD, Hospital Medical Supplies Divisions	(7) **Project Duration:**	10 years

Project Summary Ministry of Health is committed to ensure the availability of good quality, safe and effective essential drugs to the people. The aim is to make sure efficient supply with continuous availability of life saving, essential drugs and vaccines in all health institutions.

This project covers supply and distribution of all essential drugs and all other medical supplies except medical equipments to all govt and semi govt health institutions by the Medical Supplies Division. Also the latter is responsible to the supply of narcotic drugs to both public and privet sector. Prime problems at present the project is facing are incompatibility of physical drug estimates with the financial allocations. Increased receipt of poor quality drugs, delay of supply as per agreed schedules leading to extra expenditure on local purchases and absence of good guidelines for re-imbursement for quality failed drugs.

The "First in First out" principle is hardly practiced due to failure in quick identification of batch numbers & expiry dates on outer packages because of labels containing small illegible letters & figures. As a result ledger entries cannot be made as per batch amounts & no cross sectional age analysis of stocks can be made.

Reliable most recent information should be collected regularly on drugs & use of drugs from planers & consumers to improve the rational use of drugs to make the project efficient & effective.

Planning for future developments should take into consideration the adequate additional requirements of medical supplies in estimates in advance to avoid delays & problem of exceeding allocations.

(8) **Target Areas & Beneficiaries:**

All Districts in the country.

Beneficiaries are Sri Lankans as a whole & staff of the project.

(9) **Justification**:

Problems stated above in the supplies should be rectified immediately. Quality of drugs received should be ensured. Better storage conditions should be developed island wide. Rational use of drugs should be emphasized to improve the impact on health & finance.

(10) **Important Assumptions/Risks/Conditions:**

Assumption-Proper estimations of medical supplies by end users tallying with financial allocations.

Rational use of drugs will be practised by prescribes, Pharmacists & Patients.

Risk - Impact of Tuu activities on the project.

Supplies not being made according to schedules.

More quality failed drugs can create out of stock situation.

Conditions- Suppliers should compensate for the extra expenditure incurred by delaying the schedules.

STG should be developed &adopted where they are not available,

Provincial authorities & line ministry should work out a common system for procurement of equipments which requires consumables &disposables for functioning

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To improve medical supplies management through effective information management , good procurement & supply system and improved rational use of drugs	Correct national forecast for the coming year at the end January of current year.	Sum total of estimates of provincial institutions & campaigns.
	% of essential drugs being out of stock at any dispensing outlet (OPD-pharmacy, ward etc)	Reports of surprised checks.
	No of drugs/consumables being out of stock at any store each month.	Monthly returns
	Cost of local purchases by institutions/by drugs	Monthly returns of DTCC
	No & % of items failed in quality per year.	Quality failed drug register.
	Drug use indicators such as mean number of drugs per encounter,% of prescriptions with antibiotics, % of prescriptions with generics etc.	DTCC reports

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Policies, implementing guidelines, national pharmaceuticals plan & that for	■ The following policies formulated within 6 months after adoption of the Health	■ Approved National Drug Policy and Policy on Donations of Drugs &

Output	Indicators	Means of Verification
donations of drugs formulated	Master Plan and approved by the Cabinet within 3 months thereafter 1) National Drug Policy 2) National Policy on Medical Supplies Other than Drugs 3) National Policy on Donations of Drugs & Medical Equipment ■ Implementing Guidelines and Plan formulated within 6 months after formulation of the abovementioned policies ■ Formulation of Provincial Implementation Plans for the abovementioned policies ■ Periodic review of Policy, Implementing Guidelines and Plans by Medical Supplies Coordination Committee	Bio-medical Equipment ■ Approved Implementing Guidelines and Plan ■ Approved Provincial Implementation Plans ■ Minutes of meeting of Medical Supplies Coordination Committee
2. Strengthening drug regulation procedure including good manufacturing practices & low enforcement through strengthening of drug regulatory authority	■	■
3. To ensure the availability of safe effective and quality Pharmaceuticals in the country by strengthening the quality of performance of the laboratory	■ Accredited National Drug Quality Assurance Laboratory.	■ Mid - term evaluation End of project Evaluation
	■ Assessment of 80% of the products available in the Sri Lankan market at least once every three years.	■ NDQAL Reports & Records
	■ Detection of any substandard and counterfeit western pharmaceutical suspected to be present in the Sri Lankan market at any time.	■ NDQAL Reports & Records
4. Well coordinated supply system and good pharmaceuticals procurement system established.	■	■
5. Comprehensive information system including network established	■ % of Teaching Hospitals , Regional Medical Supplies Division with network facilities	■ Survey
6. Adequate human, financial	■ Total personnel required	■ Monitoring Report

Output	Indicators	Means of Verification
& physical (space & transport) resources provided for acquisition and better management of medical supplies	for Medical Supplies units as a % of total approved cadre, % of total cadres filled up and % of total staff trained as much as possible to adhere to norms ■ Expenditure on medical supplies in line ministry & Decentralised units/ institutions as a % of total expenditure respectively. (capital and recurrent costs) ■ Space available for medical supplies (specific & total) in stores & institutions as a % of space required for storing a quarterly requirement	
7. Availability of essential medicines, devices & other medical supplies optimized in all government health facilities	■ % stock-outs and overstocking compared to annual consumption of essential medicine and devices	■ Random monitoring DTCC reports and monthly reports of RMSDD
8. Availability of essential medicines, devices & other medical supplies optimized in private health facilities	■ % stock-outs and overstocking of essential medicine and devices	■ through the private sector Executive Council
9. Scientifically rational prescribing, dispensing & use of medicines continually promoted in the public & private sectors	■ % of randomly selected prescriptions that comply with good practices ■ % of encounters with good dispensing practices from a randomly selected patients population. ■ % of public with knowledge, attitudes and practices to reflect rational use of medicines	■ Prescription review ■ Observation ■ Public perception survey ■ DTCC reports.
10. Confidence of the public, dispensers & prescribers on the quality of drugs in all drug outlets as well as laboratories	■ % of randomly selected public, dispensers and prescribers that are satisfied with the medicines acquired from drug outlets and laboratories	■ Survey
11. Reduced waiting time in queues to obtain medicine from	■ Facility indicators such as mean consultation time, mean	■ Observation survey

Output	Indicators	Means of Verification
govt. health facilities	dispensing time etc.	■ DTCC reports

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Medical supplies & technology National Drug Quality Assurance Laboratory

(14) **Relevant Agencies to be Coordinated:**

N.I.L

(15) **Monitoring & Evaluation:**

N.I.L

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
National forecast of medical supplies annually.	Forecasting coming years requirement by January current year.	List of drugs approved by DGHS available. Estimate & forecast formats sent to end users by October. RMSDD/institutions timate with latest consumption information received by January
Indenting of medical supplies	Orders placed for coming year in advance.	indents updated in the main computer programme.
Receiving medical supplies as per schedule and storage	Receiving, storing & accounting as per batches and expiry date	A ledger / bin card / lot card maintained giving batch details
Quarterly distribution of medical supplies	All medical supplies available in divisional & institutional stores as per estimates	All supplies despatch ed as per quarterly programme
Disposal of quality failed & expired drugs	All unsuitable drugs removed & space made available for new stock	Quarterly return of quality failed and expired drugs
Establishing an accredited Laboratory (Accredited by an International body)	Precence of accredited Laboratory (Accredited by an International body)	
Making available adequate and appropriate laboratory equipment, glassware, Primary & Secondary Reference standards	Availability of adequate and appropriate laboratory equipment, glassware, Primary & Secondary Reference standards	
Intra & Inter-Net Facilities		

Provision of current editions of Pharmacopoeias, relevant books, journals & Research Papers	Availability of current editions of Pharmacopoeias, relevant books, journals & Research Papers	
Training/skill development of and competent Technical/ non Technical Laboratory staff	Motivated, skilled and competent Technical/ non Technical Laboratory staff	
Establishment of Research & Development section	Availability of Research & Development section	
Building capability for analysing any western pharmaceutical product or essential medical devices used in the country.		

1) **Project Title:**	Medical Equipment Management Improvement	(2) **Project Number:**	1.2.2
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG(BES), Provincial Directors of Health Services.	(6) **Starting Fiscal Year:**	1st Year
(5) **Implementing Agencies:**	DDG(BES), Central BES, PDHS, Provincial BES, Respective Hospitals.	(7) **Project Duration:**	05 years

Project Summary

The Medical Equipment Management Improvement project aims to increase efficiency, efficacy and cost-effectiveness of medical equipment in procurement and utilization in the country, by further enhancing capacities of management in responding to the needs and expectations of patients and the other clients.

This project basically aims at following major areas in order to improve the performances of medical equipment in the country.

1. Establishment of efficient and cost-effective medical equipment maintenance system for public health sector.
2. Establishment of evidence based medical equipment procurement planning system.
3. Establishment of medical equipment management system including a computer based medical equipment information system.
4. Establishment of a training center for continuous training on healthcare technologies and clinical engineering for end-users, maintenance staff and decision makers.
5. Establishment of public-private partnerships.

Successful implementation of this project will be expected to deliver following benefits to the healthcare delivery system in the public sector.

1. More than 90% of the available equipment are in proper working condition at any time.
2. Only required equipment are purchased and all the equipment are utilized in their optimum capacity.
3. End-users and maintenance staff are well-trained on their jobs and decision makers know on what they make decisions and their impacts to the health sector.

(8) Target Areas & Beneficiaries:

Central BES, Provincial BES, Teaching H, Provincial H, Base H, District H.

(9) Justification:

Medical equipment management in the country is still performed centrally by the Division of Biomedical Engineering service, and this division is responsible for all the procurement, maintenance and management activities related to medical equipment, in most of the government hospitals in the country. Provincial councils also procure equipment but their maintenance capabilities are not in par with the required level.

The total assets maintained by the central BES is estimated to be Rs.12, 000 million. These assets are distributed among several levels of government hospitals scattered all over the country. Due to ever increasing sophistication and the ever-increasing quantities of equipment, this central equipment management system has become no more effective and sustainable. Therefore in order to increase the efficiency and cost-effectiveness, decentralised units need to be established at provincial level and at teaching hospital level. It is also required to strengthen the central BES as medical equipment technology is steadily growing in sophistication at a rapid pace. At present one technician is responsible for 750 hospital beds, and there is no mechanism / budget to upgrade their knowledge and skills resulting most of them are not in par with the current technological advancements.

It is also observed that more emphasis is given to procure sophisticated capital equipment and establishing new units, neglecting the maintenance of commonly used equipment. The present maintenance system has further deteriorated due to inadequate maintenance budget, skilled manpower, lack of a maintenance policy and lack of basic facilities required for the successful functioning etc. The available resources are hardly sufficient to implement periodic inspection and preventive maintenance system, though it is essential to perform for the long lifetime of equipment. At present equipment calibration is also not done periodically due to lack of man power and calibration tools and equipment though it is essential for safe and reliable operation of medical equipment. It is noteworthy that providing more budget on maintenance can definitely reduce the budget on new procurement and the net result would be a big saving to the health sector.

At present, approximately 50% of the medical equipment at government hospitals in the country is not in proper working condition due to lack of maintenance and non-availability of consumables, trained operators etc. Especially at provincial level, there are large number of sub-standard equipment and there is no uniformity in availability of equipment at similar institutions due to non-availability of standard equipment list and generic specifications. Still enough attention is not given for the decommissioning obsolete equipment out of the system. Lack of information required for decision-making and lack of coordination between BES and hospitals has also contributed adversely to this situation. Therefore it is paramount to have a computerised medical equipment information system including equipment inventories, equipment related policies, maintenance records, equipment planning methodologies and cost involved etc. Non-availability of this information has affected to the system by making it difficult to arrive at informed and evidence based decisions on medical equipment management. In addition, there shall be a methodology to monitor and evaluate the performances of equipment, to make decisions more precisely in the future.

In order to ensure good management and engineering practices, it is mandatory to train engineers at central BES and provincial BES on healthcare technology management and clinical engineering. There shall be a mechanism and a budget line for continuous training of technical personnel, end-users, supporting staff, and decision-makers in both public and private sector. The central BES facility could be utilised to train technical staff from developing countries. There had been some successful programmes conducted by central BES for Biomedical engineers / Technicians from developing countries in collaboration with Japan International Cooperation Agency (JICA).

(10) **Important Assumptions/Risks/Conditions:**

Risks:

1. Government policies may be changed.
2. Sufficient budget may not be allocated.
3. Sufficient human resources and facilities may not be provided.
4. Equipment policy may be changed time to time.
5. Medical equipment has not been given a correct priority as being an important component in functioning of health sector.
6. Difficulty in coordinating with other agencies who are responsible for the project implementation.
7. Delays in implementing related projects.
8. Accepting used / discarded equipment as donations which could not be serviced in Sri Lanka.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To increase efficiency and cost-effectiveness of medical equipment in utilisation and management in the public health sector.	Equipment up time	Equipment maintenance records
	Mean time before equipment failure (MTBF)	Equipment maintenance records
	Response time to attend repairs	Equipment maintenance records
	Number of functional maintenance units at provincial level	Surveys
	Number of functional maintenance units at teaching hospital level	Surveys
	Number of hospital beds per technician	Equipment records and staff records.
	Number of training courses conducted for end-users, technical and other staff	Training records.
	Number of hospitals covered by the medical equipment information system	Surveys
	Number of IPM programmes conducted	Inspection and preventive maintenance records
	Percentage maintenance cost	Budgetary records

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Establishment of efficient and		

Output	Indicators	Means of Verification
effective medical equipment maintenance system in public health sector.		
1.1 Establishment of provincial maintenance units has been decided for Provincial set up.	Number of functional maintenance units established	Number of staff recruited compared to the approved carder, Number of trained staff, availability of adequate facilities such as buildings, vehicles, tools and spares, number of repairs carried out etc. Number of units established
1.2 Establishment of Hospital based maintenance units for District Base/ District General/ Teaching Hospitals	Number of functional maintenance units established	Number of staff recruited, Number of trained staff, availability of adequate facilities such as buildings, vehicles, tools and spares, number of repairs (preventive & corrective) maintenance carried out etc.
1.3 Strengthening the capacity at central BES	Number of staff recruited and trained Number of tools / test equipment provided. Number of new vehicles provided. Budgetary allocation for maintenance compared with the total value of assets maintained.	Number of preventive & corrective maintenance activities carried out. Number of training courses conducted for BES staff / end users Reduction in response time to breakdowns Availability of spares / tools and consumables etc.
1.4 Establishment of Maintenance performance monitoring and evaluation system	Number of surveys conducted to monitor the performance of maintenance in different types of equipment.	Average equipment down time at each hospital / equipment availability for use.
1.5 Establishment of Regulations	Number of Preventive maintenance carried out in selected equipment.	Administrative documentation
1.6 Establishment of Preventive maintenance, periodic testing and calibration system.	Number of calibrations carried out. Average mean time before equipment failure (MTBF)	Preventive maintenance, calibration and periodic testing records maintained by central BES and provincial BES units.
1.7 Formulation of a equipment maintenance policy	Number of training	Administrative

Output	Indicators	Means of Verification
	courses conducted.	documentation
1.8 Establishment of training facilities for private sector personnel in technology management and equipment maintenance.	Number of personnel trained.	Training records at central BES
2. Establishment of evidence based equipment procurement planning system		
2.1 Establishment of Standard list of equipment for each category of Health Institutions.	Numbers & types of equipment lists prepared for different levels of health activities.	Equipment purchasing records
2.2 Formulation of equipment purchasing policy.		Availability of Policy document
2.3 Formulation of equipment replacement policy	Number of specifications formulated for all types of equipment	Availability of Policy document
2.4 Formulation of generic specification for all equipment and issue guidelines to provincial set up.	Percentage of spare parts utilised	Availability of standard specifications.
2.5 Establishment of evidence based spare parts procurement.	Equipment down time due to lack of spare parts Equipment up time.	Stores records on spare parts utilisation. Hospital records on equipment down time
2.6 Establishment of better coordination between hospitals & MSD to assist procurement of reagents, consumables etc.		Hospital records on equipment utilisation.
3. Establishment of medical equipment management system		
3.1 Establishment of a computer based medical equipment information system at centre/ district base/ district general/ teaching hospitals, including equipment inventory, maintenance information, stores management etc.	Number of institutions in which hardware, software and system operators available Number of institutions in which equipment inventories are available.	Hospital records and surveys.
3.2 Arrangements of opportunities for training/ postgraduate studies in medical equipment management / clinical engineering for BES engineers and provincial engineers.	Number of engineers trained / Budgetary allocation on training	Training records / expenditure records on training.
3.3 Provide training for clerical	Number of clerical and	

Output	Indicators	Means of Verification
and stores staff on general management & stores management.	stores staff trained annually.	Training records / expenditure records on training.
3.4 Establishment of a methodology to forecast a realistic budget for equipment replacement/ new additions/ spares/ maintenance/ etc.	Number of hospitals following the methodology	Hospital records on equipment replacement, new addition and maintenance.
3.5 Establishment of Safety and risk management programmes	Number of programmes conducted annually.	Records on safety and risk management programmes.
3.6 Establishment of equipment utilisation monitoring criteria.	Number of surveys done. Number of hospitals covered. Number of equipment covered.	Utilisation records of equipment at each hospital.
4.Establishment of a Training centre for continuous training on healthcare technologies and clinical engineering		
4.1 Establishment of training unit to provide continuous training for BES staff, end users, provincial BES staff, private sector personnel & other foreign participants. (Training Centre can be constructed in the present premises)	Number of training programmes conducted Number of personnel trained. Income generated by training out siders.	Availability of a fully equipped training centre. Training records.
5. Establishment of Public – Private Partnerships		
5.1 Establishment of a mechanism to assist private sector in their capacity building in maintenance.	Number of personnel trained. Number of training courses conducted.	Training records.
5.2 Obtaining private sector participation in maintenance and training.	Number of equipment maintained by private sector. Percentage of the value of assets maintained by private sector.	Equipment inventory and Maintenance records.
5.3 Assisting private sector in calibration/ testing their equipment.	Number of equipment calibrated. Income generated by BES from calibration & testing.	Equipment calibration records .

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1.1.2	Facility Development According to the Rationalised Health Services Delivery Plan.
1.1.4	Strengthening of Laboratory and Diagnostic Services.
1.1.6	Technology Assessment.
1.2.1	Medical Supplies (Including Drugs)

(14) **Relevant Agencies to be Coordinated:**

MoH, Provincial Governments, Central BES, Respective hospitals.

(15) **Monitoring & Evaluation:**

1. Who? Central MoH, Central BES, Respective hospitals, Provincial Health authorities, Provincial BES.
2. When? Annual report, Annual survey, Periodic survey, Ad-hoc survey
5. What actions to be taken based on results of monitoring & evaluation?

   Revision of procedures

   Identification of performance gap and find solutions in order to fill the gap.

1.3 NATIONAL QUALITY ASSURANCE PROGRAMME

(1) **Project Title:**	Improved Quality of OPD & IPD Services	(2) **Project Number:**	1.3.1
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/MS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Ministry of Health	(7) **Project Duration:**	

The project of improving quality of Out Patient Department Services & In Patient Department Service is designed in a objective of developing standards, protocols on best practices & also upgrading facilities at OPD & IPD to improve structure & process care including diagnostic services & establishments of a medical audit system through which ensure high quality of care. In view of achieving this objective various activities such as developing policies, treatment protocols & standards regulatory frame work for medical audit, logistical plan for each institution as an establishment of an information network.

(8) **Target Areas & Beneficiaries:**

The whole population of the country.

(9) **Justification:**

The quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with the best, current professional knowledge in order to deliver high quality health care. Certain inputs such as facilities and environment for such delivery should be in place and the necessary resources should be available. In provision of quality of care it is necessary to focus attention on structure process and out put /out come in terms of efficiency and effectiveness. New studies have shown the important of identify problems related to consumer need and satisfaction in providing quality of care. Instructions are already in place to the effect that medical & health care professionals should give up the paternalistic approach that most of them adopt "we know what is the best for you." Further it had been shown in many studies that good quality patient care would reduce mortality rates, the average length of stay, over crowding which is the bug – bear of our secondary & tertiary care system and also conserve service resources. Good quality care would also by its emphasis on prevention reduce the preventable morbidity & mortality in the community that improving the quality of the work force leads to socio economic development of the nation.

(10) **Important Assumptions/Risks/Conditions:**

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To development of standards,	% of hospitals, protocols & Procedures implemented	Hospital reports & records

protocols on best practices and upgrading facilities at OPD and IPD to improve structure & process of care including diagnostic services & establishments of a medical audit system through which ensure high quality of care.	% of institutional facilities are upgraded	
	% of hospitals with appropriate diagnostic facilities	
	% of hospitals medical audit system is in place	
	% of hospitals, standards are implemented.	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Clear comprehensive policies for OPD & IPD quality care.	.	
Detail procedures for development of standards and protocols		
Human resource development plan aims at adoption of best process & attitudes change		
Comprehensive health information net work within the institution.		
Regulatory frame work for medical audit system.		
Detailed logistical plan for each institution for structural improvement		
Detail plan for project awareness to facilitate access to services.		

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	N.I.L.

(14) **Relevant Agencies to be Coordinated:**

N.I.L.

(15) **Monitoring & Evaluation:**

N.I.L.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators

Develop policies for high quality OPD & IPD services.		
Develop details treatment protocols & standards		
Develop regulatory frame work for medical audit.		
Identify medical audit teams nationally & provincial levels. .		
Develop logistical plan for each institution in view of improving the Structure		
Developing a minimum & maximum equipment & supplies list by levels (Primary, Secondary, & Tertiary)		
Establishment of comprehensive. Information net work within the institutions.		
Developing plans for human resource training & development.		

(1) **Project Title:**	Development of Emergency services network for Injuries, Accidents, Poisoning & Disasters.	(2) **Project Number:**	1.3.2
		(3) **Project Priority:**	
(4) **Focal Point:**	Director Tertiary Care Services	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Ministry of Health Provincial Health Ministry	(7) **Project Duration:**	

Project Summary :

Analysis of mortality patterns due to injuries, accidents, poisoning & disasters over the years have clearly shown that the delays of attending to these emergencies have been the route cause of mortality in this country. Hence with the objective of organizing an emergency services network an improving intensive care services in secondary & tertiary care services and also strengthen ambulance services with the communication network following activities such as developing rules and procedures for emergency services network, guideline for prioritization man power development etc. have been developed. This project will be implemented through out the country on priority basis by the Ministry of Health.

(8) Target Areas & Beneficiaries:

The whole population of the country

(9) Justification:

The network of curative care institutions ranges from sophisticated teaching hospitals with specialized consultative services to small central dispensaries which provide only out patients services. There are three levels of curative care institutions namely primary, secondary & tertiary. How ever patients can seek care in the medical institutions of their choice.

Analysis of mortality pattern due to injuries, accidents, poisoning & Disasters over the last decade clearly shown that the delays of attending to these emergencies have been the main route cause for mortality. The important factors contribute to there delays are

1. Lack of adequate first aid knowledge and skills among the care provider s.
2. Transportation problem.
3. Problems with the communication & lack of awareness about the facilities available by the public.
4. Lack of adequate ICU care facilities

Hence a network of emergency services & ICU care needs to be developed in view of addressing above issues, with the aim of reducing mortality rates due to injuries, poisoning & Disasters.

(10) Important Assumptions/Risks/Conditions:

(11) Project Objective:

Objective	Indicators	Means of Verification
■ To develop comprehensive first	% of primary care trained workers in first aid.	Hospital records & obstacles.

aid coverage of primary care level and organizing & strengthening of emergency services and intensive care service of secondary & tertiary hospitals with a strengthen ambulance services couple with a communication system functioning round the clock.	% of secondary & tertiary care hospitals with intensive care facilities.	
	% of availability of communication systems among primary, secondary, tertiary care institutions..	
	% of ambulance services available of institutional level.	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Clear procedures for developing comprehensive plan for emergency service net work..	.	
Priority list of which districts should be developed first.		
Comprehensive Human resource development plan which include recruitment training etc.		
Detail architectural plan for each institutions for intensive care facility improvement.		
Detail logistical plan for each in collaboration with fire brigade, police provide ambulance services or other men of transport.		
Detailed plan for communication network development.		
Detail plan with identified priority are a for provision of ambulance on other transport names.		
Regular monitory of activities by a technical team. With a feed back in place.		

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	N.I.L.

(14) **Relevant Agencies to be Coordinated:**

N.I.L.

(15) **Monitoring & Evaluation:**

N.I.L.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Develop rules & procedure for emergency service network planning.		

Develop guide line for prioritisation of network district & are wise.		
Develop man power plan & necessary training manuals for list & training.		
Develop logistic plans for each institution.		
Organizing constructions of distance & primary level's.		
Organize purchasing of necessary equipment, vehicles hard wares & soft ware.		
Monitory building progress & purchasing of necessary item by a term of emergency & .		
Develop awareness programs for the public about availability of the emergency service & how to utilize once the protect implemented Develop mechanisms for monitory evaluation..		

(1) **Project Title:**	Total Quality Control/Management of Hospital Services	(2) **Project Number:**	1.3.3
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/MS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	MOH Provincial MOH (3)of target Hospitals Target Hospitals	(7) **Project Duration:**	02 years

Project Summary

The project aims to improve the performance of the hospitals through improving the overall management. All aspects of performance including quality of care, financial management, employee satisfaction and productivity and innovation are targeted.
Six hospitals representing distinct facilities will be selected TQM activities will be initiated at these organizations. Project duration is two years. Five-S is planned as the first step of the implementation process. Based on the project experience implementation guidelines will be developed for all public hospitals.
MOH is expected to act as the facilitator and the personnel of respective hospitals are expected to be given significant autonomy to practice TQM.

(8) **Target Areas & Beneficiaries:**

Target areas:

Hospital Management at General Hospitals, Base Hospitals and District Hospitals Two from each category will be chosen.

Beneficiaries:

a. Clients
b. Hospital staff

(9) **Justification:**

Public demand for improvement of quality of service of public hospitals is increasing. Inadequacy and inefficiency of resource allocation and utilisation are identified as reasons. In addition staff motivation towards quality, customer focus and improvement of performance, is lacking. The leadership and information management skills of the senior and middle management staff are not satisfactory. Hospital management is yet to follow a system approach and team work is not emphasised. The project aims to rectify these issues by introducing Five-S and TQM to hospitals.

(10) **Important Assumptions/Risks/Conditions:**

a. Human resource inadequacy will not worsen.

b. Trade unions will not oppose the project.

c. PDHSs will not oppose the project.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ TQM is incorporated into the regular hospital management processes	% of annual budget utilised	MIS
	% of finances used for patient welfare has increased	MIS and Periodic surveys
	Level/index of employee satisfaction	Periodic surveys
	Absenteeism	MIS and Periodic surveys
	% of unserviced/ broken equipment	MIS and Periodic surveys
	% of ESR investigations done at overtime rate	MIS and Periodic surveys
	Customer satisfaction indicator	Periodic surveys
	Average hospital stay	MIS and Periodic surveys
	% of diabetics properly followed up at the clinic	Periodic surveys
	Survival rate of first time MI patients seeking treatment	Periodic surveys
	Maternal mortality rate	MIS
	Stillbirth rate	MIS
	Neonatal mortality rate	MIS
	Case fatality rate diarrhoea in the age group of under 5 years old	MIS and Periodic surveys
	% of elective surgeries done at first given date	Periodic surveys
	Post surgical infection rate	MIS and Periodic surveys
	Average waiting time at the OPD	Periodic surveys
	Average consultation time at the OPD	Periodic surveys
	Average time from ETU to Ward	MIS and Periodic surveys
	Number of innovations initiated	Periodic surveys

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Five-S principles are initiated are practiced by each hospital	Unwanted items are removed	observation of internal documents and physical environment
	Procedures for regular disposal are established	observation of internal documents
	Grid system is introduced to the hospital	observation of internal documents and physical environment

	Colour coding is practiced	observation of internal documents and physical environment
	Central storage for unserviceable items is established	Observation of physical environment
	Procedures are in place and are practiced for proper disposal of waste	observation of internal documents, physical environment and work practices
	Procedures are in place and are practiced for proper preparation and distribution of food items to the patients	observation of internal documents and work practices
	Premises are clean.	Observation of physical environment
Capacities of middle management is developed to function as TQM team leaders	Number of training programmes/ workshops held	Periodic surveys
Hospital services and activities are standardised	Services, procedures and activities are standardised and documented.	observation of internal documents
	Staff practices according to standards.	observation work practices
Motivation of the staff is improved	Level of absenteeism	Periodic surveys
Monitoring and evaluation system is improved	Improvements and adjustments to the MIS in terms of content and resource allocation are implemented.	Periodic review of the MIS and MIS reports
Periodic evaluation is carried out	Monthly assessments are carried out	observation of internal documents and periodic surveys
	Rectifications and improvements are made accordingly	observation of internal documents and periodic surveys
Benchmarking is practiced	Number of good practices disseminated to other units of hospital	observation of internal documents and periodic surveys

(13) **Related Projects:**

Project No.	Project Title
1.1.1	Functional Rationalisation by Developing a New Health Services Delivery Plan
1.1.2	Facility Development According to the Rationalized Health Services Delivery Plan
1.1.3	Strengthening of Services for Mother & Child
1.1.4	Strengthening of Laboratory and Diagnostic Services
1.1.5	Blood Safety
1.1.6	Technology Assessment

1.1.7	Emergency Preparedness & Response
1.3.1	Improved Quality of OPD & IPD Services
1.3.2	Development of Emergency Services Network for Injuries, Accidents, Poisoning & Disasters
1.3.3	Strengthening the Emergency Obstetric Care & Neonatal Care
1.3.5	Total Quality Control/Management of Promotive & Preventive Services
2.1.4	Review & Improvement of the Role & Performance of Hospital Committees & Health (hospital) Development Committees
2.2.1	Establishing a System of Improving People's Access to Regularly Updated Information on All Public & Private Facilities
3.3.1	Establishment and Implementation of an Improved Supervisory System, including Improved Performance Appraisal System
3.3.2	Development and Implementation of a Career Development Scheme for All Categories of Health Personnel
3.3.3	Strengthening of Central Regulatory Controlling Bodies to Maintain Standards & Performance Auditing Activities
3.3.4	Regular Review of Activities & Output of Training Institutions at Central and Provincial Levels to Strengthen the Management Capacity of these Institutions
5.2.1	Establishing an Improved Management System/s and Building the Capacities of Management Teams
5.2.2	Strengthening the Management Development & Planning Unit & the Planning Units at the Provincial & District Levels in Areas of Policy Analysis, Project & Plan Formulation, Monitoring & Evaluation, and Finance
5.2.3	Developing Systems & Capacities for Monitoring & Evaluation as well as Introducing System/s to Recognize Good Performance of Institutions, Individuals & Communities at National, Provincial, District, & Divisional Levels
5.4.1	Development of Policy, Implementing Guidelines and Plans for Health Information System for Public & Private Sectors
5.4.2	Promoting the Use of Information for Policy-making, Planning, Management, and Provision of Health Services
5.4.3	Strengthening of Institutional Capacity in the Management of HIS at the National, Provincial, District, & Divisional Levels
5.4.4	Introduction of Appropriate Information Technology to Health Information System
5.4.5	Nationwide Implementation & Updating of Hospital Information System and Human Resources Information System
5.4.6	Development of Information Sub-systems for Drugs, Logistics, Medical Equipment, Emergency Preparedness & Response, and Others
5.4.7	Integration of & Promoting Access to Health Information System (inclusive of Integrated Disease Surveillance & Financial Information System)

(14) **Relevant Agencies to be Coordinated:**

a. MOH

b. Provincial MOH

c. Relevant Hospitals

d. JICA

e. JASTECA

f. Castle Street Hospital for Women

(15) **Monitoring & Evaluation:**

6. Who?

a. MOH

b. Respective hospitals

7. When?

Respective hospitals

Monthly

MOH

Every 6 months

3. What actions to be taken based on results of monitoring & evaluation?

Respective hospitals

a. Identify areas for improvement.

b. Plan and execute improvement activities.

MOH

a. Reward best practices and benchmark.

b. Remedy any deficiency of resources and know how of poorly performing entities.

(16) **Major Activities:**

Activities	**Expected Results**	**Process Indicators**
Identification of 03 individual hospitals	Identification of 03 hospitals	Identification is finalised
Assessment of performance prior to TQM implementation	Documentation of pre-implementation performance	Evaluation reports are available
Implementation of TQM teams	Involvement of multidisciplinary teams	TQM teams are finalised
Training of personnel on Five-S, leadership and information management	Equip TQM teams with know how and skills to carry out the activities	Training programmes are carried out
Implementation of Five-S	Initiation of TQM/ CQI process	Five-S is practiced at the hospitals
Improvement of MIS	Improve evaluation and monitoring aspects	Improvement process is active
Establishment of reward system	Increase employee motivation	A reward system is in place
Standardisation of services, work processes	Improve service delivery is	Standards are

		developed
Formulation of a list of essential equipment and utilities for each level based on the portfolio of services	Necessary material resources are available to carry out the activities	Standards are developed
Formulation of essential human resources and a skills list for each level and employee category	Staff is adequate and they have the competences required	Standards are developed
Guidelines setting on job description of all the staff	Optimum utilisation of the human resource. Teamwork is facilitated.	Guidelines are formulated
Periodic evaluations	Identify areas which need attention and continuously improve the system	A monitoring and evaluation system is functioning.
Benchmarking	Identification of good practices and dissemination of these to other units	Benchmarking is practiced
Final evaluation of the project	Develop an implementation guidelines for implementation all public hospitals	Evaluation report and guidelines are available.

(1) **Project Title:**	Total Quality Control/Management of Promotive & Preventive Services	(2) **Project Number:**	1.3.4
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/PHS I & DDG/PHSII	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	01) MOH (HEB, FHB, Epidemiology unit) 02) PDHS office 03) DPDHS office 04) DPDHS & various staff under his supervision	(7) **Project Duration:**	05 years

Project Summary *:*

This project aims to improve the overall performance of the promotive and preventive health aspects. Improvements are expected in health care, employee satisfaction and productivity, financial and innovative aspects of the performance.
All districts of Sri Lanka are targeted. Project duration is five years.
Major activities planned include standardization of promotive and preventive activities, organization of better MIS and implementation of CQI activities through TQM teams established at each DPDHS level. The MOH and Provincial MOHs are expected to evaluate and monitor the progress.
The project is expected to improve the overall health of the nation by stimulating good promotive and preventive health practices of the public through a high quality service delivery system.

(8) Target Areas & Beneficiaries:

8.1 Target areas:

All districts of Sri Lanka

8.2 Beneficiaries:

a. Clients of preventive and promotive health/ general public

b. Service providers

(9) Justification:

Although Sri Lanka has achieved high level of health status, in light of the rising burden of communicable diseases, RTA, substance abuse, suicide and homicide levels and the persistence of significant level of communicable diseases necessitate strengthening of promotive and preventive health aspects. Recent under investment in promotive and preventive health care and lacklustre performances of some of the entities responsible for the delivery of the service, necessitates immediate action. TQM is a system used for continuous improvement of performance. As it is driven by employees the process is internalised in effect assuring continuity of activities. Further, the change of work attitude it accomplishes provides opportunities to work towards service excellence.

(10) Important Assumptions/Risks/Conditions:

a. It is assumed that trade uni0ns of health personnel will not oppose and will participate in TQM activities.

b. Ministry of Health will be able to sustain the coordination aspects.

c. PDHSs will not oppose the project.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
The objective of the project is to upgrade the quality management preventive and promotive health.	Availability of necessary equipment e.g. availability of a functioning refrigerator	Surveys/ MIS
	Staff/ local population ratio	Surveys
	Availability of essential drugs, vaccines and consumables e.g. availability of sufficient vaccine stocks for next months clinic	Surveys/ MIS
	Availability of permanent water and electricity supplies	Surveys/ MIS
	Availability of monthly monitoring/ evaluating reports	MIS
	Number of improvement activities carried out	MIS
	% of scheduled clinics held	MIS
	% of fully followed up mothers at birth	Surveys/ MIS
	% of fully immunized patients at first birthday	Surveys/ MIS
	% of TB patients fully followed up	Surveys/ MIS
	Number of health education activities carried out	MIS
	Level of local public satisfaction	Surveys
	Measures of coverage	Surveys/ MIS
	% of budget utilised	MIS
	% of budget utilised for direct preventive and promotive care aspects	MIS
	Degree of cleanliness and orderliness	Surveys
	Level of absenteeism/ leave taken	MIS

Objective	Indicators	Means of Verification
	Number of broken equipment not repaired	MIS
	Number of innovations/ new programmes initiated for patient care	MIS
	Number of new operational methods initiated	MIS
	No. of Training programmes carried out:	MIS

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
The work environment including the equipment, utilities and consumables are standardized.	Standards are set	Administrative documents of MOH Feedback from local institutions
Guidelines for organisational processes for TQM are set.	Guidelines are available	Administrative documents of MOH Feedback from local institutions
Output standards are set	Standards are set	Administrative documents of MOH Feedback from local institutions
MIS is formulated and in place	MIS is in place	Epidemiological reports Administrative documents of MOH Feedback from local institutions
A reward system is set up	Functioning reward system	Administrative documents of MOH Feedback from local institutions
TQM teams are established and are functioning	TQM monthly meetings are carried out	Reports from local institutions MOH assessment reports
Periodic monitoring and evaluation is carried out	Availability of monthly evaluations	MOH evaluation reports Reports from local institutions
Continuous improvement activities are functioning	Number of innovations practiced	MOH assessments Reports from local institutions
Benchmarking	Centres of service excellence identified and benchmarked	MOH administrative documents

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title

Project No.	Project Title
1.1.2	Facility Development According to the Rationalized Health Services Delivery Plan
1.1.3	Strengthening of Services for Mother & Child
1.3.4	Total Quality Control/Management of Hospital Services
1.4.1	Non-Communicable Diseases Control
1.4.2	Communicable Diseases Control
1.6.2	Establishment of Implementation Mechanisms for the National Nutrition Programme
1.7.2	Establishment of Implementation Mechanisms for Health Promotion Programme
2.1.2	Raising Awareness of the Community Regarding Health Needs & Services
2.1.3	Expansion &/or Revitalization of Local Joint Actions for Health
3.3.1	Establishment and Implementation of an Improved Supervisory System, including Improved Performance Appraisal System
3.3.2	Development and Implementation of a Career Development Scheme for All Categories of Health Personnel
3.3.3	Strengthening of Central Regulatory Controlling Bodies to Maintain Standards & Performance Auditing Activities
3.3.4	Regular Review of Activities & Output of Training Institutions at Central and Provincial Levels to Strengthen the Management Capacity of these Institutions
5.2.1	Establishing an Improved Management System/s and Building the Capacities of Management Teams
5.2.2	Strengthening the Management Development & Planning Unit & the Planning Units at the Provincial & District Levels in Areas of Policy Analysis, Project & Plan Formulation, Monitoring & Evaluation, and Finance
5.2.3	Developing Systems & Capacities for Monitoring & Evaluation as well as Introducing System/s to Recognize Good Performance of Institutions, Individuals & Communities at National, Provincial, District, & Divisional Levels
5.4.1	Development of Policy, Implementing Guidelines and Plans for Health Information System for Public & Private Sectors
5.4.2	Promoting the Use of Information for Policy-making, Planning, Management, and Provision of Health Services
5.4.3	Strengthening of Institutional Capacity in the Management of HIS at the National, Provincial, District, & Divisional Levels
5.4.4	Introduction of Appropriate Information Technology to Health Information System

(14) **Relevant Agencies to be Coordinated:**

- MOH,
- Ministry of Education
- Provincial Governments

(15) **Monitoring & Evaluation:**

1. Who?
   a. Central MOH
   b. Provincial MOHs

c. DDHSs

2. When?

   At DDHS level

   Monthly reports and surveys

   At central MOH and provincial MOH level

   Annual reports and surveys and ad-hoc surveys

3. What actions to be taken based on results of monitoring & evaluation?

   At DDHS level

   a. Identify areas for improvement.

   b. Plan and execute improvement activities.

   At central MOH and provincial MOH level

   a. Revise guidelines and regulations towards service excellence.

   b. Remedy any deficiency of resources and know how of poorly performing entities.

   c. Reward best practices and benchmark.

(16) **Major Activities:**

Activities	**Expected Results**	**Process Indicators**
Formulation of a list of essential equipment and utilities for each level	Necessary material resources are available to carry out the activities.	Standards are developed.
Formulation of essential human resources and a skills list for each level and employee category	Staff is adequate and they have the competences required.	Standards are developed.
Guidelines setting on job description of all the staff	Optimum utilisation of the human resource. Teamwork is facilitated.	Guidelines are formulated.
Reorganisation of regulations of MOH with regard to work processes e.g. procedures to be followed in repairing equipment	Minimise the red tape. Improve cycle time.	Regulations reorganised.
Resetting of portfolio of services which should be carried out at each level in promotive and preventive health	Provide optimum range of services to the locality.	Standards are developed.
Minimum quantitative and qualitative levels on service delivery set	Service delivery is improved.	Standards are developed.
Evaluation of the present MIS system	Identify strengths and weaknesses of the present system.	Present MIS is evaluated.
Model MIS system developed based on the needs of promotive and preventive health	Review fundamental areas, which have to be monitored and develop a system to execute this.	A Model is developed.
Upgrading the existing MIS system	Smooth transition to the new system to improve evaluation and monitoring aspects is	MIS is upgraded.

	ensured.	
Setting up of a reward system at PDHS and at central MOH level to facilitate implementation	Motivate and stimulate the TQM implementation process.	A reward system is organised
Assessment of work improvement activities carried out locally and globally	Identify factors, which influence the implementation process.	CQI efforts are assessed.
TQM implementation guidelines set	Successful TQM implementation at the local level is carried out.	Guidelines are formulated.
Training provided to health personnel on Five-S and TQM	Equip TQM teams with know how and skills to carry out the activities.	Training programmes are carried out.
Continuous monitoring and evaluation is in place to guide TQM implementation	Identify areas which need attention and continuously improve the system.	Monitoring and evaluation system is in place.

1.4 DISEASES CONTROL PROGRAMME

(1) **Project Title:**	***Non-Communicable Diseases Control:*** Integrated Non-Communicable Diseases Control	(2) **Project Number:**	1.4.1.a
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/MS	(6) **Starting Fiscal Year:**	2005
(5) **Implementing Agencies:**	D NCD	(7) **Project Duration:**	8 years

Project Summary :

The most cost effective way to control the increasing trend in Non Communicable Diseases (NCD) is to launch a comprehensive NCD prevention programme. An Integrated approach on prevention of NCD will be adopted by this project.
The project comprises 4 major components;

1. Baseline risk factor survey
2. Social marketing programme to glamourize Healthy Life Style as the effective means of preventing major NCD.
3. Community-based intervention project in pilot areas
4. Formulation of best practices in prevention and management of NCD.

(8) **Target Areas & Beneficiaries:**

The whole population. But, the community-based intervention will be conducted in 5 Health areas as a pilot project.

(9) **Justification:**

As the key risk factors for major NCD are common, it is rational to launch an integrated prevention programme rather than conducting separate programmes for each major disease. Most importantly, these risk factors (Tobacco, alcohol, physical inactivity, unhealthy diet and mental stress) are modifiable and the primary prevention is the most cost effective way to combat the current NCD trend, which is increasing.

(10) **Important Assumptions/Risks/Conditions:**

Funds to be available. Capacity building of the stakeholders and the infrastructure development are to be assured. Consistency and continuity of Government's support to the project is vital.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To reduce the prevalence of major NCD (Heart Disease, Hypertension,	Prevalence of major diseases	Hospital morbidity and mortality returns assessment
	Trends in risk factors	Survey results

Objective	Indicators	Means of Verification
Stroke, Diabetes and cancer) by adopting effective prevention strategies and adhering to standard clinical management.	% People adopting healthy life style	Mid-term and end-project surveys

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Adoption of best practices in primary, secondary, tertiary prevention and case management.	Formulation of guidelines for standard major NCD management. Standard training manuals for primary health care worker for early identification of NCD. Training module on NCD prevention for in-service programmes.	Standard guidelines are adhered. Hospital reports on referrals from the primary health care staff. No. of community programmes conducted by the field staff. Training module used in training programmes.
Understanding the magnitude of key risk factors prevailing in the community	Risk factor survey conducted	Survey report
Network on NCD prevention established with provincial teams	Establishment of provincial focal point	Provincial progress reports on NCD control.
Community-based NCD prevention project is piloted in 5 areas	Pilot community-based project started	Evaluation survey
Social marketing programme to promote healthy life style to prevent major NCD is launched	Establishment of different components of social marketing programme; School, Youth, Health staff and general public.	Quantitative and qualitative assessment – mid-term and end-project

(13) **Related Projects:**

Project No.	Project Title
	Risk factor survey project
	Development of standard protocols/ formats/ manuals for case management, training and screening.
	Community-based NCD intervention pilot project

	Island-wide Social marketing for NCD prevention project

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health, Ministry of Education, Ministry of Youth & Sports, Media and Provincial governments

(15) **Monitoring & Evaluation:**

1. Who? Central MoH, Provincial MoH.
2. When? Annual report, Periodic surveys and end-evaluation.
8. What actions to be taken based on results of monitoring & evaluation? Revision of methodology, Expansion of the implementation.

(16) **Major Activities:**

Activities	**Expected Results**	**Process Indicators**
Conduct NCD risk factor survey.	To utilize the results as a base line for project evaluation.	Magnitude of the NCD problem assessed.
Formulation of best practices for NCD prevention and management.	Effective management of diseases and implementation of effective prevention strategies.	Change and improvement of management and prevention of NCD.
Launch social marketing programme for NCD prevention.	People adopting healthy life style as the effective means of preventing NCD	Change in life style.
Community-based NCD intervention pilot project	Community involvement and partnership in preventing NCD. Reduced morbidity and mortality due to NCD.	Evaluation of pilot projects.

(1) **Project Title:**	***Non-Communicable Diseases Control:*** Injury Prevention & Management	(2) **Project Number:**	1.4.1.b
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG (MS)	(6) **Starting Fiscal Year:**	2005
(5) **Implementing Agencies:**	D/NCD	(7) **Project Duration:**	5 years

Project Summary:

The project comprises 2 major areas.
1. An integrated injury prevention programme through coordination and collaboration between government departments and other organizations.
2. Effective injury management programme.

The priority types of injuries are Road Traffic Injuries, Occupational Injuries, Home accidents (Including burns) and Poisoning.

(8) **Target Areas & Beneficiaries:**

The whole population

(9) **Justification:**

Injuries continue to be the leading cause of hospitalisation in Sri Lanka since 1995. Injuries currently result in about 11% of deaths and 16% of admissions in government health institutions, placing a heavy burden on the health services. A comprehensive prevention programme is needed to overcome this serious issue. Also, the proper management of injuries becomes important in order to minimize the consequences of injuries.

(10) **Important Assumptions/Risks/Conditions:**

Irrespective of the place of occurrence, injuries end up with health care institutions. Therefore it is important that health sector will take the lead to coordinate with other relevant departments and agencies.

(11) **Important Assumptions/Risks/Conditions:**

Consistency and continuity of funds is essential for implementation of the project. This project covers only the unintentional injuries, as a separate profile is identified for intentional injuries.

Project Objective:

Objective	Indicators	Means of Verification
■ To reduce the prevalence of injuries by active community participation.	Incidence of different types of injuries	Survey results. Statistics from police & labour departments
	Violation of road rules	Police Department Statistics
	Number of drunk driving detected	Police Department Statistics

Objective	Indicators	Means of Verification
	Number of mass media programmes conducted	Survey Assessment
	Number of school injury prevention activities	Evaluation
	Morbidity and Mortality due to injuries	Morbidity and Mortality returns

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Coordinated action for injury prevention strengthened	Implementation of plans through coordinated action	Evaluation
Awareness among general public on injury prevention raised	Number of programmes exposed by the general public	Survey
Legislative and regulatory mechanisms supporting injury prevention strengthened	Enforcement of legislation	Periodic reports
Injury prevention interventions at school and work places established	Programmes conducted	Assessment
Adoption of best practices for management of specific injuries	Formulation of guidelines for standard management	Standard management is adhered to
Knowledge of medical officers on management of specific injuries updated	Training conducted	Qualitative assessment

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Road Traffic Injury Prevention Programme
	Occupational Accidents Prevention Program
	Standardization of Management of Injuries
	School Injury Prevention Programme

(14) **Relevant Agencies to be Coordinated:**

All the stakeholder ministries/agencies though National Committee on Prevention of Injuries (NCPI)

(15) **Monitoring & Evaluation:**

1. Who? Central MoH through provincial ministries
2. When? Annual report, periodic surveys and end-evaluation

(16) **Major Activities:**

Activities	Expected Results	Process Indicators

Conduct Road Traffic Injury (RTI) Prevention Programme	Prevention of RTI reduced	RTI statistics
Formulation of guidelines for injury management	Cost-effective management of injuries	Change and improvement of injury management
Launch school injury Prevention Programme	Children actively managing injury risks and living in safe environment	Change in environment
Launch injury free week	People actively engaged in reducing risk for injuries	Attitudinal change in community participation
Incorporate module on injury prevention into in-service training at stakeholder departments	Knowledge on injury prevention enhanced	Raised awareness
Heighten the role of media on injury prevention	Importance of creating safe environment to reduce risk for injuries glamourized	Community awareness raised
National Committee on Prevention of Injuries (NCPI) conducted	Action towards injury prevention by different stakeholders coordinated	NCPI records for implementation

(1) **Project Title:**	***Non-Communicable Diseases Control:*** Renal Diseases	(2) **Project Number:**	1.4.1.c
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG MS	(6) **Starting Fiscal Year:**	2005
(5) **Implementing Agencies:**	D/NCD and provincial health authorities in the North-central province	(7) **Project Duration:**	6 years

Project Summary

This project will address the following 3 areas.
-A careful analysis of the probable reasons
-Proper management of predisposed conditions and
-Preventive measures

Specific measures will have to be implemented in North-central province as described under the justification.

(8) Target Areas & Beneficiaries:

The whole population with special emphasis on North-central province.

(9) Justification:

Statistics from Inward morbidity and mortality report shows that there is an increasing trend in renal diseases during the past years. Also, a significant caseload of renal conditions is observed in the North-central province. By controlling the predisposing conditions, the renal diseases can be effectively reduced.

(10) Important Assumptions/Risks/Conditions:

Consistency and continuity of funds is essential for implementation of the project. Project Objective:

Objective	Indicators	Means of Verification
■ To reduce the prevalence of renal diseases.	Incidence of different renal diseases.	Survey results. Statistics from health department
	Number of training conducted for preventive health staff	Evaluation
	Number of mass media programmes conducted in specific locality	Survey assessment
	Number of school health prevention activities	Evaluation
	Morbidity and mortality due to renal diseases	Morbidity and mortality returns

(11) Project Output/Product:

Output	Indicators	Means of Verification
Coordinated action for	Implementation of plans	Evaluation

Output	Indicators	Means of Verification
control of renal diseases strengthened	through coordinated action (implementation of the recommendations of the survey already conducted in North-central province)	
Awareness among public on renal diseases in specific localities where the diseases are more prevalent	Number of programmes exposed by the public	Survey
Renal disease awareness at schools and work places established	Programmes conducted	Assessment
Adoption of best practices for management of specific conditions that lead to renal diseases	Formulation of guidelines for standard management	Standard management is adhered to
Knowledge of medical officers on management of predisposed conditions updated	Training conducted	Qualitative assessment
Training of trainers of primary health care staff	Training conducted	Qualitative assessment

(12) **Related Projects (include ongoing projects & projects under the Health Master Plan):**

Project No.	Project Title
	Qualitative Survey on renal diseases in North-central province (results awaited)
	Adoption of best practices on management of Non communicable diseases
	Incorporation of renal disease awareness in to school health programme in the North-central province.
	Training of primary health staff on renal disease awareness

(13) **Relevant Agencies to be Coordinated:**

All the stakeholder ministries/agencies through the health ministry (Provincial health authorities, Education, Water board and community leaders)

(14) **Monitoring & Evaluation:**

1. Who? Central MoH through provincial ministries
2. When? Annual report, periodic surveys and end-evaluation
3. What actions to be taken based on results of monitoring & evaluation?

   Further improvement of the project

(15) **Major Activities:**

Activities	Expected Results	Process Indicators
Implementation of the survey recommendations in the North-central province	Prevalence of renal diseases reduced in the respective results	People taking preventive measures
Adoption of best practice for conditions leading to renal diseases	Effective management of predisposed conditions	Change and improvement in medical management
Incorporate renal disease awareness in school health prevention programme in prevalent areas	Children actively managing participating in awareness building	Raised awareness among school children
Training of primary health care workers on renal disease prevention	Knowledge enhanced and messages given to the community	Attitudinal change in community participation
Periodic evaluation by the clinical staff on management of renal diseases	Effective management ensured	Best practices adopted
Public awareness on renal diseases	People seeking treatment for predisposed conditions on time	Community awareness raised

(1) **Project Title:**	***Non-Communicable Diseases Control:*** Thalassemia	(2) **Project Number:**	1.4.1.d
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	Director/Non Communicable Disease, Central Ministry of Health	(6) **Starting Fiscal Year:**	2005
(5) **Implementing Agencies:**	Paediatrician (e.g. LRH Children's Hospital Colombo)	(7) **Project Duration:**	8 years

Project Summary

The Thalassaemias, the commonest inherited diseases, occur at a variable frequency in different parts of Sri Lanka reaching the highest frequency in the Kurunegala district. It is estimated that there are 2000-2500 severe cases, whose adequate care will consume about 5-8 % of the Island's health budget. A control program requires the following developments

1) A short training program for Paediatricians, Haemotologists, Nurses, Public health staff on the genetics and clinical aspects of thalassaemia
2) A public education and awareness program
3) A pilot study of the most cost effective screening methods
4) The establishment of simple laboratory screening methods in laboratories in several regions
5) The establishment of one reference laboratory to identify different types of Thalassaemia in one clinical reference centre
6) Establishment of voluntary screening program, for the whole Island, supported by counseling service
7) Discuss future possibilities for prenatal diagnosis program

If well established, this program will provide the basis for the better control and management of Thalassaemia with the incorporation of new advances in future years in most prevalent provinces; North-western, North-central; and Uva

(8) Target Areas & Beneficiaries:

Children, Families and Health Care Programme

(9) Justification:

The control of a distressing disease, which will consume 5-8 % of the Islands health care expenditure

and best use of resources

(10) Important Assumptions/Risks/Conditions:

Current Gene - Frequency is minimal estimate

Sustainability of the programme

(11) Project Objective:

Objective	Indicators	Means of Verification

To assess patients adequately To make best use of resources	Training programs on diagnosis and management of HbE Thalassaemia	Regular survey of treatment centre
Educate population To review the frequency	Public awareness increased	Uptake of screening
		Frequency of birth of affected babies
Offer screening and other approaches to prevention Provide adequate lab, services		Qualitative survey
	Screening strengthened	Records
	Comprehensive investigation procedure in place	Laboratory quality assessment

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Improved diagnosis and care	Clinical Status of the thalassaemia Major and HbE Thalassaemia patients	Regular survey of hospital Data
	Rational usage of Blood and drug	Records
Improved Public Understanding and screening	Uptake of Screening	Annual data from laboratoies

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1	Further survey of gene Frequency
2	Pilot small scale surveys in selected areas (already done)
3	Pre-marital counselling programme in endemic sreas.

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health, University of Ragama (Medical Faculty), Weatherall Institute of Molecular Medicine/University of Oxford

(15) **Monitoring & Evaluation:**

1. Who? - By the Health Ministry through Provincial Directors of the project areas
   - Annual external review established with Asian Net work
2. When? - Regularly in specified intervals.
3. What actions to be taken based on results of monitoring & evaluation?

   Expansion of the project to the other affected areas. And assess the accurate cost of the prevention programme

(16) **Major Activities:**

Activities	**Expected Results**	**Process Indicators**
1) Training clinicians, Haematologists, Nurses	Updated knowledge about the disease by the relevant persons	Coverage of training
2) Training public Health Team	Improved skills in diagnosis	Coverage of training
3) Public education / awareness	Reduce the burden of the disease	Involvement of the community
4) Pilot of screening methods	Best screening method acquired	Application of screening methods
5) Based on above, screening techniques established in several centres	A wider population is screened for thalassaemia	Number of centres established
6) Improving the reference lab (just initiated)	Well functioned Reference Lab For definitive diagnosis of the disease	Functional ability of the lab assessed.
7) Clinical Reference Centre established	Expert advise regarding the disease provided	
8) Voluntary Screening and counselling	Reduce the incidence of the disease	Number of districts covered
9) And Discuss prenatal diagnosis	Discuss the Option available for the person carrying a disease foetus	

(1) **Project Title** :	***Non-Communicable Diseases Control:*** Oral Health Services Management Improvement Project.	(4) **Project No : 1.4.1 e**
(2) **Focal Point** :	D.D.G./MS	(5) **Project Priority**: Anchor Project
(3**) Implementing Agencies**	D.D.G. (D.S) Respective Regional Dental Surgeons	(6**) Starting Fiscal year** : FY 2004 (7) **Project Duration** : 10 years

Project summary

The Oral Health Services Management Improvement Project aims to improve efficiency of the oral health care delivery system through the provision of promotive, preventive, curative and rehabilitative services of high quality, so that the entire population will achieve high level of oral health.

The following activities are implemented by Central Ministry of Health and Provincial Ministries of Health with the assistance of local and international agencies:-

- Preventive programmes directed towards improvement of Oral Health of the school-going population.
- Provision of latest developments in Dentistry in the field of Restorative Dentistry to people who cannot afford its high cost in the private sector.
- Improvement of curative dental services in the country by updating equipment in hospitals and having more Dental Specialist Services.
- Dental Services made accessible to remote areas in the country.
- Alleviate sufferings of youth affected by dental fluorosis in high fluoride areas.
- Reduce the disease burden caused by oral cancer.

(8) Target Areas & Beneficiaries

Adolescent school children in National Schools

Hospital Dental Service and population in general.

Young adults in high Fluoride area

(9) Justification

The demand for health care is high, while budgets are limited. Therefore emerging strategies and programmes of health care provision need to be pro-poor, efficient and equitable. At present oral health care provision should be viewed in such a scenario. The state sector oral health care system has the responsibility in ensuring good Oral Health Care of the population.

Promotion of oral health, preventing oral diseases and provision of comprehensive oral health care to people is the primary goal of oral health care system. However its failure needs sophisticated dental treatment such as composite fillings, root canal treatment, crowns ad bridges and dental implants could be costly and alternate funding mechanisms are needed.

Interventions for dental caries and periodontal disease has to start from the formative years of teeth and early childhood. School children up to the age of 13 years are being taken care of mainly by the School Dental Therapists. There are only a few Adolescent School Dental Clinics

in the country manned by Dental Surgeons to care for the Adolescent children. Hence the urgent need to establish more Adolescent clinics. The National Oral Health Survey 1994 revealed that the DMFT (Decayed, Missing or Filled Teeth) for 12 year olds is 1.4 which we must try to bring down further.

The equipment in most Government Dental Clinics is mostly outdated and we cannot expect a satisfactory service unless they are replaced with modern ones gradually.

The problem of Fluorosis is affecting a considerable number of young adults in the North-Western, North-Central and Southern Provinces who cannot afford treatment for their ailment. The establishment of Fluoride treatment centers in these areas and a separate campaign for this problem has become a current necessity.

The working conditions in the existing School Dental Clinics manned by School Dental Therapists need much improvement.

(10) Project Objectives

Establishment of Adolescent School Dental Clinics in all National Schools in a phased manner.

Establishment of Advanced Restorative Laboratory and the National Institute for Advanced Dental Sciences at Maharagama and expansion of Restorative Laboratory services to other parts of the country.

Improvement of Dental equipment in hospitals and School Dental clinics.

Extension of all specialist services throughout the country and training of Dental Specialists.

Extension and Improvement of mobile Dental Services.

Improvement of Referral System in the School Dental Services.

Establishment of Anti Dental Fluorosis Campaign.

Prevention, early detection and treatment of oral cancer.

(1) **Project Title:**	***Non-Communicable Diseases Control*** Mental Health (including Substance Abuse Suicide & Poisoning)	(2) **Project Number:**	1.4.1.f
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/MS	(6) **Starting Fiscal Year**	1st year 2004
(5) **Implementing Agencies:**	DDG(MS)I Director Mental Health Services Provincial Directors Deputy Provincial Directors & their staff Hospital Directors & staff NGOs	(7)**Project Duration**	10 years

Summary

The present mental health services are predominantly hospital based. In keeping with WHO recommendations, and as a long felt need it is necessary to make the services available in the periphery. Patient care and treatment, rehabilitation, social support should be available in the community. Many mental disorders are not recognised because of social stigma and due to lack of awareness among the people. This project aims at addressing these issues by improving quality of care, infrastructure facilities, human resources, awareness through proper treatment, rehabilitating and promotive activities in the community so that disease burden due to mental diseases are minimised.

(8) Target Areas & Beneficiaries- All

Hospitals

Community

Mentally disabled and community at large

(9) Justification

Mental illness (an estimated prevalence of 10 percent) causes a considerable amount of health, social and economic hardship. Further the morbidity patterns are changing, with the increasing prevalence of problems related with long-term illness, substance abuse, special psychosocial needs of children, adolescents, aged and relationships criminal offenders and needing new services.

The present mental health services are **predominantly mental hospital based** and are confined to Colombo and a few regional centres. The present services predominantly focus on acute illness in adults with minimal facilities for rehabilitation, prevention and promotion. Except for a few pilot projects community psychiatric services are non-existent and numbers / range of mental health professionals are very limited in number. **There is an urgency to develop this inadequate, under funded, understaffed and the centralized system of mental health care in Sri Lanka. Ministry of Health should consider MH as a priority and initiate an urgent development programme.**

The recent WHO recommendations for the development of mental health services reproduced in the World Health report 2001 and the National Mental Health plan prepared on similar lines by

a WHO consultant which has been accepted by the Ministry in 2001 could be a starting point. Rehabilitation and continuity of care need to be emphasised.

Drug abuse and suicides including poisoning are an expression of major health problems in Sri Lanka with over 89,426 admissions and 2440 deaths in hospitals in 2000. [Source: Medical Statistics Department]

Urgent measures have to be taken to minimise the ever-increasing incidence of suicides due poisoning and the Health Staff as well as the public have to be educated to combat this national problem.

The health cost for managing a patient who has ingested poisoning is of a considerable amount for a third world country like Sri Lanka. Therefore it is essential to minimise the patient management cost in poisoning and the best possible way to do this is by prevention through the awareness education. Awareness among the people on poisoning due to various substances is lacking in Sri Lanka. It is essential to have programs on educating the public on various problems occurring from careless handling, storing and transportation of poisonous substances. Reported cases of poisoning due to various substances (Reference - ICD 10 classification) is on the increase. Therefore, it is very important to educate the public with the intention of minimising poisoning incidence in future.

Updating the knowledge on latest management procedures and nursing care in poisoning is of vital importance. Both the senior and junior medical officers as well as the nursing officers will be benefited by the capacity building of the Health staff. There had been no clinical updating sessions conducted centrally or provincially during the past few years relevant to poisoning. This is evidence based and proved by the calls National Poisons Information Centre received from the other medical institutions.

Pesticide poisoning alone contributes to a large number of deaths and it is the 7th leading cause of death in Sri Lanka as reported from the hospitals Indoor morbidity and mortality returns. (Source: Annual Health Bulletin 2000)

(10) Important Assumptions/Risks/Conditions:

Assumptions

(1). New Draft Mental Health Act is approved by the Parliament

(2). Necessary funds are available for

(a). infrastructure development (material resources including vehicles)

(b). Human resource develop

(c). Developing guidelines and implementation.

(11) Project Objective:

Objective	Indicators	Means of Verification

■ Reduce the disease burden due to mental disorders, substance abuse, suicide and poisoning by effective community based approaches, which are equitable, assessible and affordable and of desirable quality in partnership with general health services, public health services other ministries such as social services, education, judiciary and NGOs and other local and international agencies.	* No. of patients admitted /Month / District to MH Angoda & Mulleriyawa.	
	♦ New	HIS for MH Angoda,
	♦ Referred	MH Mulleriyawa
	♦ Transferred	
	♦ Readmissions	
	* No: of patients admitted to Psychiatry Units per month.	HIS from District
	* No: of Psychiatry patients admitted to medical wards.	HIS from District
	* No: of new patients treated by MOMH	HIS from District
	*No: of patients in the acute and medium stay units for longer than 6 weeks.	HIS MH Angoda
	* No: of patient in long stay unit.	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Effective accessible quality treatment for mental disorders, substance abuse and poisoning and follow up services.	No. of patients admitted to Angoda, MH Mulleriyawa MH	
2. Effective community based rehabilitation including (social) care for long term mentally ill including those due to substance abuse, poisoning for self harm dementia and mentally retarded and childhood mental health problems.	No: of patients discharged from medium stay rehabilitation units / one month.	
3. Early detection of mental disorders among: A) Health Care Seekers B) Non Seekers	No: of patient referred to MOMH by ♦ PHM / Volunteers ♦ MO / OPD ♦ Ward MOs	
4. System for promotion of Mental Health among A). Children, Adolescent Adults, Elderly groups, Disaster Victims		
5. Effective monitoring mechanism		
6. Effective management orgarnisation structure		
7. Prevention and control of substance abuse, and suicides, including poising.		
8. Basic infrastructure developed for community mental health programmes		

including transport facilities.		
9. Necessary guidelines standards prepared.		
10.Adequate Psychiatrists Nurses OTs, Psychologists community mental health workers, Psychiatric Social Workers. are developed.		
11.Primary Health Care Workers trained in community based mental health programme including substance abuse and poisoning.		
12.Community awareness raised to seek early and community based treatment and reduce social stigma.		
13. Improvements to existing Mental Health Act and necessary legislation and Enforcement.		

(13) **Related Projects (include ongoing projects & projects under the Health Master Plan):**

Project No.	Project Title
1.1.1	Functional Rationalisation by Developing a New Health Services Delivery Plan.
1.1.2	Facility Development According to the Rationalized Health Services Delivery Plan.
1.1.4	Strengthening of Laboratory and Diagnostic Services..
1.1.6	Technology Assessment Medical supplies (including drugs)
1.1.7	Emergency Preparedness & Response
1.2.1	Medical supplies including drug.
1.2.2	Medical equipment
1.3.1	Improved quality of OPD and IPD Services.
1.3.2	Development of emergency service network for injuries Accident , poisoning and disasters
1.3.4	Total Quality Control / Management of Hospital Services.
1.3.5	Total quality control / Management of promotive and preventive services.
1.5.1	Estate Health
1.5.2	Elderly Health
1.5.3	Disabled Health
1.5.4	Health of people in conflict attached areas and displaced populations.

1.5.5	Adolescent Health
1.5.7	Health People in Urban Slums
1.7.1	Development of National policy & plan on health promotion as well as strengthening of coordinating mechanism.
1.7.2	Establishment of implementation mechanisms for Health promotion programme.
2.1	Programme for improved community involvement for health development
2.2	Programme for the promotion and protection of human rights with Relevance Health
3.1	Programme for the production and Strengthening of human resources for the Health Sector
3.2	Programme for the Rationalization of human resources for the health sector
3.3	Programme for improving job performance of Health Personnel
5.1	Effective policy development programme
5.2	Management Development programme
5.3	Health Regulatory Mechanism programme
5.4	Strengthening of health information system programme
5.5	Health research programme
5.6	Inter sectoral l l Programme

(14) Relevant Agencies to be Co-ordinated:

Ministry of Health

Ministry of Education

Ministry of Housing

Ministry of Justice

Ministry of Labourer

Ministry of Social Services

NGOs

Other agencies

(15) Monitoring & Evaluation:

1.Who – A mental health development committee.

DGHS, DDG(MS), DDG(PH) and DMHS

2. When – To start immediately, annual surveys, periodical or ad-hoc surveys

3. What actions to be taken based on results of monitoring & evaluation?

- Replanning
- Strengthening weak areas
- Human resource
- Material resource
- Organisation structure

To compare morbidity and mortality of poisoning in past and present.

To compare health costs incurred in management of poisoning in a single episode past and present.

Revising the training curriculum and the management of poisoning book on a need assess

(16) **Major Activities :**

Activities	Expected Results	Process Indicators
1 (a). Health Department Psychiatry units to be established for every 500.000 people with secure units, and facilities for paediatric and geriatric psychiatry.	Early effective Efficient treatment within easy access.	No: of planned units not Functioning.
(b). Weekly clinics in institutions with psychiatry units with a good follow up system.		
(c) Set up MH units at every DH and improve all BH, MH units	- do -	No: of vacancies at BH No:of DH without MOMH
(d). Establish out reach clinics in smaller hospitals.	- do -	No: of planned centres not Functioning
(e). Training relevant staff for early detection, quality treatment of mental disorders, substance abuse and poisoning.	- do -	
(f). Community Awareness programmes / family members / care givers	- do -	
(g) Build secure units in existing Psychiatry wards.	- do -	
(h) Appoint necessary trained staff to each Psychiatry unit, MH unit e.g. Nurses, Occupational Therapists, Psychiatrists Psychologists		
(i) Improve Forensic Psychiatry Services		
(j). Professional Liaison for treatment - To actively develop links with other professional groups like Medicine Neurology, Social Care.		
(k). Improve quality of care for special services at the mental hospitals and scale down according to plan.		
2 (a). i. Training ii. Training of family members / care givers on rehabilitation. - Acute wards - OPD clinics - Community		
(b). Community organisation for rehabilitation		
(c) . Training of Community Health Workers / Volunteers	Better community services.	
(d). Establish Rehabilitation facilities in acute wards and clinics.		

Activities	Expected Results	Process Indicators
(e). Day care centre per district and community based day services specially for elderly.		
(f). Medium stay units / 100,000/- pop or/district		
(g). Interventions for development delays and at risk and early identification.	Quality of life of mentally ill improved	
(h). Social support to long term mentally ill patients and for the care givers.		
(i). Addressing issues related to child protection/child abuse		
(j). Improve care provided in the chronic wards of Hendala and Mulleriyawa		
(k). Professional liaison for rehabilitation		
(l). Divisional public health teams for domestic care.		
3. (a). Training of MOs OPD (b). Training of PHMs /PHIs (c). Training of Volunteers (d). Training community Health Workers/ PHM social Workers. (e). Ensure continuity of care for those already diagnosed and treated to prevent relapse and for elderly with mental disorders	Early detection & treatment of mental disorders, dementia alcohol use.-DUP reduction	
4. (a). Life skills programmes - in schools - in community	Improved quality of life of community.	
(b). Raising awareness regarding Psychosocial needs of children, adolescents, aged, disaster Victims		
(c). Interventions for risk groups for developmental delays.		
(d). Promoting Bioethics specially in relation to management of mental health and mental health research .		
(e). Profession liaison with international bodies such as S.A. forum for MH, UK Royal college of psychiatrists etc.		
5 (a). Effective Mental Health Information system	Effective monitoring system.	
(b). Conduct research in Mental Health	Strategies to improve mental health services.	
6 (a). Formulation of provincial /	Well-planned	

Activities	Expected Results	Process Indicators
District Mental Health plan.	mental health services.	
(b). Set up NIMH	Well-organized mental health cares delivery.	
(c). Appoint MOMH Province/ District	Well-managed mental health services at provincial & district level.	
(d). Set up Development Committee at national level / Provincial level / District level		
7 (a). Brief interventions to MOs OPD for alcohol users	Reduction of alcohol consumption.	
(b). Detoxification of substance abuse	Rehabilitated substance abusers.	
(c). General awareness programme aiming at the community based orgarnisation (CBO) level.	Awareness among public on effects of poisoning due to various substance.	Availability of health workers paid / voluntary and others to identify and refer risky targets to smaller levels
(d). In service training to staff	Staff awareness on management of poisoning.	Number of in-service training development and printing of training material
(e). Training on first aid to voluntary health workers	Awareness for voluntary health workers on basic first and measures on poisoning .	Number of health workers trained in district level.
(f). Capacity building of the NPIC	Human resource and technology development and strengthening of the NPIC.	Availability of human resource technology other infrastructure facilities.
(g). Data bases with INTOX latest version and MICROMEDEX	nformation and to maintain a central database on poisoning in poisons information centre.	Functioning updated. Data Base on poison information.
8 (a). Building Psychiatry units in the districts with secure units.	Effective treatment of acute cases in the	* No: of planed psychiatry units not established.

Activities	Expected Results	Process Indicators
	periphery.	
(b). Building medium stay units i in the district	Effective rehabilitation of mentally ill.	No: of medium stay units to be established.
(c). Building long stay units in the district.	Effective care of long stay patients..	No: of planned long stay units to be established.
(d). Building srcure units to existing psychiatry units		Psychiatry units without secure units.
(e). Transport facilities for MOMH for out reach clinics, Community work.	Effective community mental health services in District	No: of district without Vehicle for community mental health services.
9. (a) Identify the guidelines to be prepared.		
b) Prepare guidelines and standards		
10 (a).Develop a mechanism to train more Psychiatric Nurses in consultation With DDG(ETR)	Effective nursing care to mentally ill.	* No. of batches of atry nursing/year * No of provincial atry units I units ved in basic training for in psychiatry
(b). Board of study in Psychiatry to develop a mechanism to produce more Psychiatrists.		
(c). Psychologists to be appointed	Quality care in treatment improved.	
(d). Occupational Therapists to be recruited and trained	Faster recovery of acute episodes of mental disorders.	
11. Develop new cadre for community mental health services.	Better community support enhanced.	No:of advocacy programmes No: of teledrama.
12. Advocacy programmes and media programmes for mental health.	Community support enhanced	No: of advocacy programmes. No: of teledrama
13. Revision of Mental Health Act, Training staff and Implementation.		

(1) **Project Title:**	***Non-Communicable Diseases Control:*** Cancer Control	(2) **Project Number:**	1.4.1.g
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/MS	(6) **Starting Fiscal Year:**	1st Year Financial Year 2004
(5) **Implementing Agencies:**	National Cancer Control Programme	(7) **Project Duration:**	6 Years

Project Summary:

The WHO developed Cancer Control Programs in various countries starting 1980 in order to reduce Morbidity and Mortality of cancers in the world. National Cancer Control Programme of Sri Lanka is one such organization developed with the support of the WHO by the Ministry of Health in Sri Lanka. It works under a Director and has a Field staff including Doctors. One of the main functions is Surveillance and Monitoring of the disease burden. It maintains a cancer registry data base of Pathology, Epidemiology and Public Health Related data. Times to time publications are released from these.

The second aspect of cancer control is primary health care with health education, tobacco control within the island, and the Advisory committee on Tobacco control to the MoH monitors these activities and the director of the National Cancer Control Programme is the Secretary of this committee, EX - Officio. Other Health Education work is done with the collaboration of Health Education Bureau, Family Health Bureau, UNFPA, Ministry of Education, Rotary Club and other non- government organizations.

Secondary prevention of early detection and screening is carried out for most common malignancies and Mobile Clinics, Local Health Personnel Training, Development of Health Care volunteers and Management of Project Based Screening Campaigns are carried out with the Plantation Health Trust, UNFPA and with other NGOO. Tertiary Care Management and Palliative Care Planning are done through the advisory committee for cancer control where the Secretary is the Director, National Cancer Control Programme.

Rehabilitation work and hospice care is promoted through various NGOO. Research and development activities also are promoted by the NCCP.

The following project proposal for the next 06 years will be mainly centered around the Guide lines by the WHO to increase the Monitoring and Surveillance of cancer burden in the country by developing the databases in Pathological Diagnosis, Initial Registration at Treatment, Monitoring of Follow up of cases and Mortality due to cancer.

Health Education Programme will be local area based with the development of local resource personnel and volunteers. Early detection programmes will center on development of a central referral screening laboratory and clinics centre. Mobile clinics will be conducted and peripheral cancer control units will be developed to promote screening facilities.

(8) Target Areas & Beneficiaries:

Especially the Medical Officers of Health Areas, Plantation Sector, Rural and urban Middle and Low income population group, Migratory workers.

In general, all the Groups at risk of getting cancers in Sri Lanka.

(9) Justification:

60% of the Cancers prevalent in this country are primarily preventable. Mainly through control of tobacco usage and prevention of viral infections. E.g.:- Oral and Lung cancers and Carcinoma of Cervix uteri.

Other major cancers like breast cancer and colonic cancers will be controlled by early detection. The strategies for these are simple and cost effective while the increased disease burden and the late disease will need a huge amount of public health sector funds with very low quality results as the out come. The Health Education with regard to prevention of tobacco usage, healthy life styles and diet patterns, proper hygiene and the regular monitoring of health status with surveillance of occupational risks will not only result in the control of cancers but also will give significant benefits in various other disciplines too.

(10) Important Assumptions/Risks/Conditions:

Important Assumptions is that Medical Officers of Health will be available for dissemination of knowledge and early detection at local peripheral levels.

At present, most of the funds for cancer control are obtained from various projects. To be sustainable, the flow of required funds should be from a permanent and consolidated source.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ To increase the knowledge with regard to prevention of cancers and increase facilities for early detection methodology, in order to reduce the cancer disease burden.	(a) The cancer Incidences	(a) The cancer registry database
	(b) Down staging of detected cancers	(b) Hospital patients databases
	(c) Cancer Mortality rate	(c) Registrar General records
	(d) Reduction of Smokers and Tobacco usage in the country	(d) Spot surveys and periodical surveys
	(e) Increase number of persons quitting smoking (cessation)	(e) Attendance at cessation clinics
	(f) Increased attendance asymptomatic clients for screening	(f) Screening clinic databases
	(g) Increased detection of pre-malignant lesion	(g) Pathological registry database

(12) Project Output/Product:

Output	Indicators	Means of Verification
(1) Grass root level health care workers trained in Cancer prevention and Screening Methodology.	(1) All Public health staff trained on Awareness of cancer control Methodology.	(1) Staff Assessment reports.
(2) Central Screening Clinic and	(2) A functioning central screening clinic and	(2) Work performance of the

reference laboratory established.	reference laboratory	central screening clinic and reference laboratory.
(3) Mobile cancer screening programmes organized by the Central Unit as well as the peripheral organizations.	(3) Increased early detection of Asymptomatic cancer patients.	(3) Screening clinic data and referral data to treatment centres.
(4) Smoking and Tobacco usage reduced through Public Awareness and Cessation work.	(4) Reduction of Smoking related and Tobacco related cancers and other diseases.	(4) Tobacco sales data, Spot surveys internal Mortality and Morbidity rates.

(13) **Related Projects (include ongoing projects & projects under the Health Master Plan):**

Project No.	Project Title
(1)	Re- Productive Health Development Programme with UNFPA / WWC programme
(2)	Country project of Rotary Club of Colombo on Early Detection of Cancers

(14) **Relevant Agencies to be Coordinated:**

- Ministry of Health
- Ministry of Education
- United Nations Fund for Population activity
- Rotary Club of Colombo
- Provincial Health Sector Administration

(15) **Monitoring & Evaluation:**

1. Who?
   a. National Cancer Control Programme
   b. Family Health Bureau
   c. Working group on Well Women Clinics
2. When?
   a. Annual report
   b. Periodical Surveys -Quarterly
   c. Inspection Visits regularly
   d. Database Analysis- routine
3. What actions to be taken based on results of monitoring & evaluation?
   a. Re- Assessment and regulate the training for peripheral health staff
   b. Increase awareness programmes
   c. Using Media Campaigns for promotional work
   d. Further training for clinic staff

e. Publications on disease burden status and preventive / preclinical diagnosis methods
f. News letters to be circulated
g. Health regulations to be formulated and circulated.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
(1) Establishment of Central Screening clinic and reference laboratory	(1) Good quality screening programme	(1) Increase number of early detection
(2) Training of peripheral health workers and volunteers	(2) A group capable of health education and counselling with regard to cancers developed in the peripheries	(2) Peripheral Cancer Control Unit / cells start functioning
(3) Tobacco control, Smoking prevention and cessation units established.	(3) Increased awareness of tobacco hazards and reduction of users.	(3) Number of smokers reduced tobacco removed from beetle chewing cessation unit established
(4) Advisory committee on cancer Control and Control of Tobacco usage.	(4) Health related policies developed	(4) Availability of control measures of tobacco and facilities for detection of cancers
(5) Cancer registry database improved	(5) Timely updated publications from the registry	(5) accurate and timely collection of required data

(1) **Project Title:**	***Communicable Diseases Control:*** Respiratory Diseases Control (ARI & TB)	(2) **Project Number:**	1.4.2.a
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Director/NPTCCD, MoH, Provincial Directors of Health Sevices	(7) **Project Duration:**	10 yrs.

This project aims at reducing the morbidity and mortality from Tuberculosis and other communicable and non-communicable respiratory diseases and minimizing the disability caused by them by strengthening the *most* national programme. The following activities are implemented.

a) Enhance case detection of TB by
- establishing microscopy centers in all the Out Patient Departments of Teaching Hospitals, Provincial Hospitals& Base hospitals and in all District & Peripheral hospitals
- establishing sputum collection centers in all other primary care health institutions
- active screening of high risk groups
- enhancing X-ray facilities.

b) Expansion of DOTS to increase the cure rate of TB.

c) Enhance indoor care services of good quality for TB and non TB respiratory patients.

d) Enhance diagnostic facilities so that the early and accurate diagnosis of respiratory diseases is possible to start therapeutic measures early.

e) Measures to diagnose occupational lung diseases early and to reduce the incidence.

f) Enhance the human resource in number and improve their knowledge and skills so that the service delivery by them would increase patient satisfaction.

f) Enhance the human resource in number and improve their knowledge and skills so that the service delivered by them would increase the patient satisfaction.

(8) Target Areas & Beneficiaries:

Chest Hospital/ welisara , District Chest Clinics, Patients With respiratory diseases and community

(9) Justification:

Tuberculosis (TB) is a global emergency. The incidence of TB has been increasing over the last 4 years. TB mostly affects the 15-54 age group. This being the productive age group affects the economy of the country. The spread of Human Immuno-deficiency virus (HIV) and the emergence of multi drug resistance made the control of TB even more urgent. To achieve the targets set, it is necessary to strengthen the national programme for TB control. Respiratory diseases other than TB needs focus attention. Disability caused by asthma affects the economy of the country. Urbanisation and industrialization increase the incidence of environmental and

occupational lung diseases. Increasing the facilities for early detection and proper management of respiratory diseases would reduce the disease burden.

(10) Important Assumptions/Risks/Conditions:

The existing health care system in the country will remain the same.

PDHSS and DPDHSS will extend their corporation.

The risk of Chest Physicians leaving the national programme for TB control and chest diseases and join the curative services exists.

Preventive and curative services should be integrated at all levels of health care services.

(11) Project Objective:

Objective	Indicators	Means of Verification
To reduce the mortality and morbidity from TB and other communicable and non-communicable respiratory diseases and to minimize the disability caused by the same by strengthening the national programme.	TB Case detection rate	Administration report of NPTCCD
	Sputum conversion rate	Annual Health Bulletin
	TB Cure rate	District TB register
	Disease specific mortality rate	Central TB register
	DOTS coverage	Notification register
	DALY	IMMR
	No. of days of restricted activity from resp. diseases	
	Notification rates	

(12) Project Output/Product:

Output	Indicators	Means of Verification
More cases of TB detected so that they can be cured and the sources of infection in the community is reduced.	Case detection rate Cure rate Disease specific death rate	District TB register Central TB register Notification register
DOTS expanded to all the districts and the cure rate is increased.	The population coverage of DOTS Cure rate	Administration Report of the NPTCCD
Incidence of MDRTB is reduced	Sputum conversion rate	District TB register
Indoor care of good quality provided to patients with TB and non-TB respiratory diseases when needed.	Population- Bed Ratio Average daily inpatient census of the TB wards. Average daily inpatient census in respiratory units	Monthly hospital bulletin IMMR

	Inpatient bed occupancy rates	
Laboratory facilities enhanced at the central level keeping with the international standards.	Cure rate	District TB register
Laboratory facilities established at the provincial level.	Cure rate at the district level	District TB register
Accurate and early diagnosis of the respiratory diseases is made enabling to start therapeutic measures before the disease state is advanced.	Disease specific mortality rate	Mortality data from the RGO' office Annual health bulletin
Disease burden and the disability, and mortality from asthma and other respiratory diseases are reduced.	School attendance in children Number of days of restricted activity Disease specific mortality rate	School attendance register Attendance registers at working places Analysis of leave registers
Occupational lung diseases are detected early and measures are taken to reduce the incidence.	Incidence of occupational lung diseases	IMMR
Adequate number of staff placed and trained to do the specific job and developed.	Population per qualified doctor Population pr health worker Population per qualified nurse	Director /Information

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	**Project Title**
	World Bank Project
	GFATM
1.1.4	Strengthening of Laboratory and Diagnostic Services
1.3.4	Total Quality Control/Management of Hospital Services
1.3.5	Total Quality Control/ Management of Promotive & Preventive services

(14) **Relevant Agencies to be Coordinated:**

MoH, BES, Provincial Health Ministry, Private hospitals, Independent Medical Practitioners' association, College of General Practitioners and Sri Lanka Medical Association

(15) **Monitoring & Evaluation:**

1. Who? D/ NPTCCD, DPDHS, Central MoH, Provincial MoH
2. When? Baseline, Mid – term, End, One year after completion
3. What actions to be taken based on results of monitoring & evaluation?

   Enhance supervision, Development of guidelines on the use of the facility, Internal circulars

(16) **Major Activities:**

Activities	**Expected Results**	**Process Indicators**
Establishment of microscopy centers at every hospital	Increased case detection	Number of sputum samples tested per month
Establish sputum collection centres in the peripheral health facilities	Increased case detection	Number of sputum samples collected and transported per month
Active screening of high risk groups (contacts, diabetics, HIV patients and institutionalised people)	Increased case detection Transmission interrupted	Percentage of cases detected by active screening out of all sputum positive cases monthly.
Provide X-ray facilities at each District Chest Clinic	Increased case detection Diagnosis of sputum smear negative patients and patients with non-TB respiratory diseases	Percentage of TB patients diagnosed by X-ray only in each chest clinic % of non-TB resp. diseases diagnosed monthly.
Provide mobile x-ray units to each District Chest Clinic	Increased case detection by X-raying the high-risk groups.	Number of TB cases diagnosed by doing X-rays in high-risk groups.
Incorporation of the private sector in DOTS implementation	Increase in cure rate DOTS center made more accessible to the patient Defaulter rate reduced	Number of General practitioners as treatment observers in each district No. of Sputum smear positive PTB cases treated at each private hospital
Incorporation of the Ayurvedic sector in DOTS implementation	Increased cure rate DOTS center made more accessible to the patient	Number of Ayurvedic Physicians as treatment observers in each district

	Defaulter rate reduced	
Formulation of Guidelines in Dots implementation	Increased cure rate	Guidelines prepared
Involvement of NGOs in defaulter tracing	Defaulter rate reduced Reduced incidence of MDRTB	Number of defaulters traced by the involvement of NGOs in each district monthly
Establishment of rehabilitation center for drug addicts and alcoholics	Reduced defaulter rate Reduced incidence of MDRTB	Number of drug addicts/alcoholics treated in rehabilitation centers each year
Establishment of TB wards in each District	Indoor facilities of good quality for needed TB patients	Bed occupancy rate every month
Establishment of a respiratory unit with high dependency care unit in each district	Indoor facilities of good quality for patients with respiratory disease Reduction of deaths from respiratory diseases	Bed occupancy rate in Respiratory units Disease specific death rate calculated monthly
Establishment of a high dependency care unit in each OPD, DH and Peripheral Hospital.	Reduction of asthma deaths	Disease specific death rate calculated monthly
Establishment of a well equipped Central Reference Laboratory at Welisara	Facilities for Cultue and ABST for 1st line drugs in the treatment of TB Facilities for Culture and ABST for 2nd line drugs in the treatment of resistant TB and effective management of MDRTB Facilities for pyogenic cultures and ABST for effective management of Respiratory diseases Rational use of antibiotics Facilities for Histological examination of tissues in the diagnosis of EPTB	Percentage increase of cultures and ABST done for 1st line drugs in every month No. of cultures and ABST done for 2nd line drugs every month Incidence of MDRTB Increase in the number of pyogenic cultures done each month Decreasing consumption of antibiotics Increasing no. of histological examinations done each month
Establishment of a laboratory in each Province	Culture and ABST for 1st line drugs available in provinces	Increasing number of cultures done in the province evey month
Establishment of a CT scan unit at	Accurate and early	Decreasing disease specific death

Chest Hospital, Welisara	diagnosis of respiratory diseases and to start the specific therapeutic intervention before the disease is advanced	rate
Establishment of Bronchoscopy units in each Province	Accurate early diagnosis of respiratory diseases	Decreasing disease specific death rate
Provision of inhaled drugs to all the hospitals and chest clinics for management of asthma	Reduction of uncontrolled asthma	Increasing school attendance Improvement in attendance at work place Increased productivity
Prevention among workers of disability and disease arising out of environmental factors, processes and materials used	Decreased incidence of occupational lung diseases	Guidelines produced
Human Resource planning	Adequate staff for TB control activities in the PHC, for TB wards, chest clinics, laboratories and Respiratory units	Cadre requirement prepared.
Establishment of a national training institute	Well trained staff	Training curricula prepared Training material produced
Human resource development	Staff motivation Knowledge updated Skills improved	Number of in-service training programmes

(1) **Project Title:**	***Communicable Diseases Control:*** STD/AIDS Control	(2) **Project Number:**	1.4.2.b
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG (PHS 1)	(6) **Starting Fiscal Year:**	1st Year 2003/2004
(5) **Implementing Agencies:**	Director General of Health Services National STD/AIDS Control Programme (NSACP) and other health units such as Health Education Bureau (HEB) Family Health Bureau (FHB), National Blood Transfusion Services (NBTS) and the National TB Prevention and Control of Chest Diseases (NTPCCD) Provincial Health Authorities Other related Government Ministries and Departments NGOs and CBOs With support from relevant UN agencies and World Bank Private sector – Hospitals and laboratories General Practitioners	(7) **Project Duration:**	5 years

Project Summary

The primary objective of the project is :

- to assist the Government of Sri Lanka in curbing the spread and transmission of HIV infection
- to reduce personal and social impact of HIV on the infected persons and their families (stigma and discrimination)
- Limit the spread of HIV infection in Sri Lanka among its highly vulnerable groups, particularly adolescents and youth
- Strengthen multisectoral involvement and capacity.

This project would enable Sri Lanka to make rapid progress towards the Millennium Development Goals of halting the spread of HIV and TB associated mortality.

(8) Target Areas & Beneficiaries:

Highly vulnerable groups (female / male sex workers including beach boys, drug users, other vulnerable groups such as internally displaced persons, migrant workers and clients of sex workers, People Living with HIV AIDS (PLWHA) and HIV positive pregnant women. The entire population of Sri Lanka would benefit from intervention activities and gain directly from investments in such areas as improved STD/HIV care services, communication campaigns, blood safety and TB control.

(9) Justification:

Even though since its inception, the NSACP has made significant progress in improving STD services, these advances , however may be not sufficient to prevent further spread of HIV infection among highly

vulnerable subpopulations and to the population at large. Recognising the shortcomings, GOSL formulated the National Strategic Plan for 2002-2006, which indicated a significant shift in the national STD/ HIV prevention and control strategy.

(10) Important Assumptions/Risks/Conditions:

Critical Assumptions:

(1) Investment in the health-sector immunization, communicable disease control, family welfare.. continues

(2) Investment in other sectors (water sanitation, education affecting health and nutritional status,) continues

(3) Programs among highly vulnerable groups are effective

(4) Political commitment to HIV/AIDS grows

(5) Public and private sector do not undertake repressive measures against vulnerable groups and maintain ethical standards

(6) GOSL continues to shift to public health approaches and implement prevention activities among vulnerable groups

(7) Key staff and managers are in place and retained for sufficient time

(8) Funds are made available and on time to other sectors and NGOs CBOs

(9) Capacity of NGOs/CBOs, line ministries and PHAs is strengthened to implement sub projects and work plans

(10) Capacity of private sector – Hospitals, laboratories and GPs

Reflecting these assumptions the **critical risks** are:

<u>From outputs to objectives</u>

(1) Stagnant political commitment to HIV/AIDS control

(2) Public and private sector undertake repressive measures against vulnerable groups and fail to maintain international ethical standards. This results in making groups at high risk harder to reach, thus reducing the effectiveness of targeted interventions and increasing the likelihood of a rapid spread of HIV

(3) GOSL continues to only maintain clinical and laboratory focus and fails to implement prevention activities among high risk groups

(4) Programs among highly vulnerable subpopulations are not effective

(5) Inadequate institutional and managerial capacity

<u>From components to outputs</u>

(6) Key staff and managers are not in place

(7) Delays in disbursement of project funds because of limited prior experience of certain line ministries in managing Bank funds

(8) Failure to ensure timely contracting of consultants

Overall risk is Substantial.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
To reduce the spread of STD/HIV/AIDS among highly vulnerable sub-populations and the public at large and reduce social stigma	(i) Knowledge of methods of preventing STD/HIV transmission will reach 95% amongst the general public	Questionnairs / surveys
	Syphilis prevalence rate among women attending antenatal clinics remains below 5%.	Report from antenatal clinics showing proportion of blood screened against HIV and syphilis
	100% screening of donated blood for Syphilis / HIV/ Hep B and Hep C.	Blood Bank reports
	HIV prevalence in the community	Sero surveillance reports
	80% using of condoms in sexual intercourse with non-regular partners	Behavioural surveillance report
	95% of patients with STI attending PHC institutions treated using syndromic approach	Out-patients report
	100% of voluntary, non-remunerated blood donations	NBTS report
	90% of pregnant women found to be infected with HIV receive antiretroviral therapy for prevention of MTCT	Antenatal clinic reports
	VCT services in all districts	No. of VCT centres in each district

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Interventions to promote safe sex and safe drug use behaviours among vulnerable	No. of staff from NGOs and line ministries trained in STD/ HIV/AIDS	Implementation progress reports from DGHS / NSACP

populations implemented	No. of vulnerable groups targeted	
	Coverage of highly vulnerable population by prevention activities (including behavioural change communications) increases from 10% to 60%.	Quarterly reports from NGOs / CBOs and line ministries Monitoring and evaluation by external / independent agency
	No. of NGOs / CBOs involved	
	Knowledge on HIV prevention increased among sex workers, and clients of sex workers to 75%.	Behavioural surveillance reports
	Condoms distributed in "high transmission areas'	Social marketing and campaign reports
	No. of health/STD camps set up in hot spots	Quarterly STD clinic reports
	No. of medical officers in STD clinics with training to work with vulnerable groups	NSACP progress reports
2. Communication and advocacy campaigns and interventions to raise awareness and reduce stigma in general population and key partners (e.g. media, health personnel, and police) developed and successfully implemented	Communication strategy developed for general population and key selected groups	NSACP progress report (Communications firm updates)
	No. of advocacy activities for policy makers (study tour and senior level seminars and workshops)	Provincial Health quarterly reports NSACP progress report
	No. of youth peer educators trained	NGO / CBO reports NSACP progress report
	Knowledge of HIV (identification of prevention methods and modes of transmission) among youth, underserved communities (estates), and in the North and North East post conflict areas.	Knowledge, Attitude, Practice, and Behaviour (KAPB) surveys
	No. of media pieces developed to promote positive attitudes towards PLWHA	Communications firm updates

	articles	
	Proportion of sex workers who report harassment declines by 50 percentage points	Behavioural surveillance
	Increase in percent of people expressing accepting attitudes towards people with HIV	KAPB surveys
	No. of joint educational programs developed with Health Education Bureau	Health education reports
3. Blood safety programme strengthened and expanded	3.1. Proportion of voluntary non- paid donors increases to 80% in 2000 to 95% in 2007	Annual Blood Bank reviews and reports from NBTS
	3.2 Proportion of medical staff trained in rational use of blood increases to 95%	
	3.3 Over 95% of blood transfusions are adminis-tered for essential purposes	Survey on rational use of blood
4. Mother-to-Child transmission prevention programme strengthened	4.1 Protocol developed for management of HIV in pregnancy	NSACP progress report
	4.2 No. of antenatal clinics offering VCT and PMTCT	Quarterly reports of antenatal clinics / site visits
	4.3 Proportion of pregnant mothers receiving VCT reaches 70%	
	4.4 No. of HIV positive mothers attending antenatal clinics receive anti retro viral therapy	
5. Prevention and treatment of TB improved	Proportion of health personnel in TB programme and HIV programme trained in management of TB IN PLWHA	NSACP reports and reports from the NTPCCD
6. Capacity of GOSL to	6.1 DGHS office fully	DGHS Report

manage, implement, monitor, and evaluate a multi sectoral HIV prevention programme strengthened	operational and staffed with management advisor, procurement and financial management specialists	NSACP progress report
	6.2 NSACP fully operational staffed in the areas of N & E, surveillance, behavioural and social scientist, intersectoral coordinator and regional facilitators	
	6.3 Behavioural and sero surveillance system in place by year 2	DGHS report
	6.4 Management information system in place	Provincial annual reports
	6.5 Proportion of provincial AIDS councils meeting regularly and with full representation from key sectors and civil society representations	DGHS progress report
	6.6 No. of health personnel trained in universal precaution and health care waste management	DGHS progress report
	6.7 No. of STD clinics, TB chest clinics, and blood banks with waste management activities	

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
IDA/WB - PO 74730 WHO - SRL HIV 001 UNFPA – SRL / 06 / 01 / 01 UNICEF -	

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health, Line Ministries, Provincial Health Authorities, NSACP, NGOs, CBOs, NBTS, NTPCCD, HEB, FHB, Private sector (Hospitals, laboratories and GPs).

(15) Monitoring & Evaluation:

1.Who? NSACP in co-ordination with Ministry of Health, Provincial health Authorities, Private sector and NGOs carrying out STD/HIV/AIDS activities

2.When? Monitoring to be carried out by NSACP staff by regular visits to provinces and districts and at times combined during site visits for HIV sentinel surveillance. Also from quarterly reports required from each province, relevant private sector organizations and NGOs for which the NSACP will develop appropriate, prescribed forms.

Evaluation to be done through a Prevention Indicator Survey carried out in two districts in 2003 and compared to a similar survey done in the same two districts in 1997. Care indicators will also be added in the 2003 survey.

3. What actions to be taken based on results of monitoring & evaluation?

Development of a Management Information System at the NSACP, which will be constantly updated to meet the growing information demands of the programme. This will enable to measure project progress and performance, and targets reviewed and discussed with relevant Authorities each year.

Time scheduling and identification of responsibilities

Identification of changes in the selected indicators brought about by the planned activities

Undertake the Annual Internal Review to evaluate programme implementation and coverage with the participation of the concerned organizations in the public and private sectors and NGOs to suggest measures to solve problems.

An External Review to be carried out in 2006 with inputs from the stakeholders including the multilateral and bilateral agencies to assess the adequacy and effectiveness of various components of the programme. This evaluation will help formulate the new national plan commencing Year 2007.

(16) Major Activities:

Activities	Expected Results	Process Indicators
PROGRAMME MANAGEMENT AND CO-ORDINATION		
- Advocacy	Participation and commitment of high level policy makers	No of Consultative meetings and outcome
- Management	Strengthening of NAC, Sub-committees and provincial and district level	Establishment of Committees No. of meetings held

Activities	Expected Results	Process Indicators
	AIDS committees	No. of recommen-dations made at meetings imple-mented
	Strengthening NSACP in terms of staff, office space and running costs etc.	Staff and equipment in place
	Proper Programme implementation	Progress Review meetings held
- Resource Mobilization	Strengthening of service delivery	
- Partnership with private sector		
HIV PREVENTION		
- IEC activities to be developed / Material Development		IEC material produced
	Safer Sexual behaviour Increased awareness and knowledge of STD/HIV	Proportion of population with knowledge of preventive practices
- School Education		
	Awareness of STD/HIV among youth in-school	Inclusion of HIV/ADS in school curricula
		No. of teachers and counsellors trained
		Proportion of school children with knowledge of HIV/AIDS prevention
- Provision of condoms		
	Safer sexual behaviour	No. of Condom Social marketing programmes and No. of condoms distributed
- Strengthening of early diagnosis of		Proportion of persons in selected groups using condoms during sex

Activities	Expected Results	Process Indicators
STI and treatment - Provision of Syndromic management of STDs at PHC level	Proper management of patients attending STD clinics Early diagnosis and referral	with non regular partners No. of patients who access STD services No. of MOs trained in Synd-romic Manage-ment of STDs. Proportion of STI patients managed with syndromic approach at PHC level
PREVENTION OF TRANSMISSION OF STD/HIV THROUGH BLOOD	Ensuring safe blood Reduce risk of HIV through injecting drug use Prevention of STD/HIV transmission at health care settings	Proportion of voluntary non- remunerated blood donors among all donors. National Blood Policy in place. Proportion of donated blood screened against HIV Syphilis, Malaria, HepB and HepC. Quality control standards to all HIV testing blood banks
PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV	Elimination of transmission to child through awareness, screening and treatment of pregnant mothers	No. of screening for HIV in antenatal clinics. Proportion of infected pregnant women who receive anti-retroviral therapy for prevention of MTCT
CARE AND SUPPORT TO PERSONS WITH HIV/AIDS - Provision of Voluntary Counseling (VCT) - Confidential Testing facilities at provincial level - Comprehensive Treatment and Care - Develop guideline on legal and	Awareness of the requirement of counselling Minimize stigma and discrimination Encourage VCT to minimize spread of HIV Guidelines developed	No. Accessing counselling services No. of districts with VCT services. No. trained in counselling Guidelines available

Activities	Expected Results	Process Indicators
ethical aspects		
STRENGTHENING OF LABORATORY SERVICES	Introduction of Quality Assessment Schemes	Proportion of accurate laboratory diagnosis
TRAINING IN HIV/AIDS - Basic training courses for all health care and other personnel involved in HIV/AIDS prevention and control activities - In-service training	Quality service and comprehensive management of HIV / AIDS patients	Training manuals Material produced TOT programmes held Number trained
SURVEILLANCE - HIV/AIDS Surveillance - Behavioural Surveillance - STI Surveillance MONITORING AND EVALUATION - Development of a Management Information System - Internal (mid-term and year-end) - External Review - Programme Evaluation - Research	Establishment of National STD/AIDS data base Comprehensive management of patients Improve updating of services Solution to problems arising in implementation, coverage, collaboration among various sectors and NGOs Assessment of adequacy and effectiveness of various components of the programme Information on programme adequacy and coverage Identification of research needs related to HIV/AIDS in Sri Lanka Conduct research projects	Surveillance reports MIS data base es-tablished Internal review reports External review reports Evaluation report Research findings

(1) **Project Title:**	***Communicable Diseases Control:*** Vector Borne Diseases Control Programme : Malaria	(2) **Project Number:**	1.4.2.c.1)
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	Director, Vector Borne Disease Control, Central MoH	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Director, Vector Borne Disease Control, Central MoH Provincial Directors of Health Services	(7) **Project Duration:**	

Project Summary

Vector Borne Disease Control Programme aims to achieve better control of the four main vector borne diseases: Malaria, Filariasis, Dengue & Japanese encephalitis. The control activities will be planned and coordinated by the Vector Borne Diseases Control Programme of the Central MoH and implemented through the Provincial Ministries of Health.
The Programme will endure to
- Interrupt disease transmission where and when feasible
- Maximize the use of eco-friendly control strategies and minimize dependence on chemical vector control methods.
- Increase case detection facilities in medical institutions in affected areas of the country
- Strengthen Laboratory diagnosis of vector borne diseases

(8) Target Areas & Beneficiaries:

VBDC Programme Central MoH, Provincial VBDC Programmes, Medical Institutions,

Patients seeking treatment at govt. medical institutions and population living in affected areas

(9) Justification:

Vector Borne Diseases have become a major health problem in many areas of the country, resulting in considerable morbidity and mortality. Although the Ministry has specialized programmes for the control of malaria and filariasis at present, the control of Dengue and Japanese Encephalitis is being coordinated by the Anti Malaria Campaign with the participation of the Epidemiological Unit, Filariasis Control Programme and the Medical Research Institute. This has not facilitated the effective control of Dengue and Japanese Encephalitis and has also led to several resource constraints, both at central level and at provincial levels.

A Vector Borne Diseases Control Programme would facilitate the better utilization of available resources at Central & Provincial level and result in more effective control of these diseases.

(10) Important Assumptions/Risks/Conditions:

N.I.L.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ To achieve effective control of Vector Borne	Case incidence	Disease surveillance
	Vector densities	Entomological surveillance

Diseases in the country, facilitate accurate diagnosis of vector borne diseases, provide effective treatment for vector borne diseases, prevent epidemics of Vector Borne Diseases.	Mortality	Surveillance
	Diagnosis	Strengthening of parasitological and serological diagnosis,
	Treatment outcomes including treatment failures	Surveillance
	Prevent epidemics	Surveillance & forecasting of outbreaks

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Reduction of vector densities		
Cost effective vector control		
Reduction of disease transmission		
Control of VBD in the community		
Improved case detection & management		
Forecasting & prevention of outbreaks of VBD		
Reduction of parasite reservoir in populations of endemic areas		

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Roll Back Malaria Initiative (WHO)
	Malaria control project among marginalized people in malaria endemic districts (GFATM)

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health, Provincial Ministries of Health, Environmental Ministry, Departments of GOSL (Irrigation, Education, Agriculture & others), Non Governmental Organizations (Lions, Sarvodaya & others) and Community Based Organizations

(15) **Monitoring & Evaluation:**

1. Who? Central Ministry of Health, Provincial Ministries of Health
2. When? Continuous monitoring and monthly evaluations, Annual Report

3. What actions to be taken based on results of monitoring & evaluation?
   Corrective action to remedy deficiencies, measures to enhance control

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Activities aimed at forecasting and preventing transmission of vector borne diseases	Reduction of vector densities & outbreaks of VBD	Entomological & Parasitological indicators
2. Activities aimed at reducing or interrupting transmission of vector borne diseases including application of insecticides	Reduction of vector densities & outbreaks of VBD	Entomological & Parasitological indicators
3. Activities to detect early and treat patients with vector borne diseases	Reduction in disease transmission, morbidity & mortality	Morbidity/ Mortality data & Parasitological indicators
4. Activities aimed at improving surveillance and reporting of vector borne diseases including investigation of cases	Reduction in disease transmission, morbidity & mortality	Morbidity/ Mortality data & Parasitological indicators
5. Activities aimed at increasing community participation in the control of vector borne diseases	Reduction in disease transmission, morbidity & mortality	Morbidity/ Mortality data & Parasitological indicators
6. Activities to manage insecticide resistance in vectors	Reduction of disease transmission	Entomological & Parasitological indicators
7. Activities to control the spread of drug resistant malaria in the country	Reduction of disease transmission	Parasitological indicators, Morbidity & Mortality data
8. Entomological activities aimed at identification, study of behaviour, susceptibility of vectors of VBD	Reduction of vector densities, disease transmission, morbidity & mortality	Entomological & Parasitological indicators
9. Strengthening of laboratory diagnostic facilities for detection of VBD	Reduction in mortality & morbidity	Mortality data & Parasitological indicators
10. Logistical support to the provincial programmes to purchase critical supplies including insecticides	Reduction in disease transmission, morbidity & mortality	Morbidity/ Mortality data & Parasitological indicators
11. IEC activities aimed at achieving better control of vector borne diseases in the community	Reduction in disease transmission, morbidity & mortality	Morbidity/ Mortality data & Parasitological indicators
12. Training of health services personnel in activities relating to control of VBD and management of patients with VBD	Reduction in disease transmission, morbidity & mortality	Morbidity/ Mortality data & Parasitological indicators
13. Activities aimed at improving control of VBD through research including application of GIS	Reduction in disease transmission, morbidity & mortality	Morbidity/ Mortality data & Parasitological indicators
14. Activities to reduce the parasite reservoir among populations of endemic areas.	Reduction in disease transmission, morbidity & mortality	Morbidity/ Mortality data & Parasitological indicators

(1) **Project Title:**	***Communicable Diseases Control:*** Vector Borne Diseases Control Programme : Filariasis	**(2) Project Number:**	1.4.2.c.2)
		(3) Project Priority:	Anchor Project
(4) **Focal Point:**	Director Anti Filariasis Campaign/VBDC, MoH	**(6) Starting Fiscal Year: 2004**	
(5) **Implementing Agencies:**	Director, Anti Filariasis Campaign/VBDC Provincial Ministries of Health	**(7) Project Duration:**	10 years

Project Summary

Lymphatic Filariasis is one of the major vector borne diseases in Sri Lanka. It is an important public health problem in the Western Southern & North Western provinces, causing an economic reduction in life opportunities. In keeping with the WHO resolution calling for the elimination of lymphatic filariasis as a public health problem globally, MoH has embarked on the task of elimination the disease in Sri Lanka

Anti Filariasis Campaign, central MoH & provincial ministries of health implement the following activities.

- To conduct annual Mass Drug Administration Programme to stop transmission of LF
- To strengthen morbidity control to prevent disability due to LF
- To strengthen laboratory diagnosis & vector control

(8) Target Areas & Beneficiaries:

Anti Filariasis Campaign, Central Ministry of Health/VBDC

Provincial Health Services & population living in the LF endemic areas

(9) Justification:

Lymphatic Filariasis is one of the four major vector borne diseases in Sri Lanka.9.8 million people are at risk of getting the disease. It is an important public health problem in the country, a disabling and disfiguring disease causing social stigma, psychosocial and economic reduction in life opportunities and a major burden on health and hospital resources, especially on account of the costs for surgical intervention. It is a major contribution to poverty, and the programme to eliminate will reduce suffering and disability, improve reproductive and sexual health (through reduced male genital morbidity) and will improve child and maternal health and development through ancillary benefits arising from effects on intestinal parasites.

(10) Important Assumptions/Risks/Conditions:

N.I.L.

(11) Project Objective:

Objective	Indicators	Means of Verification

■ To achieve elimination of Lymphatic Filariasis in Sri Lanka, to prevent suffering & disability of affected individuals, streangthen accurate diagnosis & vector control	Microfilaraemia Rate	Disease surveillance
	Microfilaraemia densities	,,
	Morbidity	Surveillance
	Infection &infectivity of the vector	Entomological surveillance
	Diagnosis	Strengthen the parsitological & immunolpgical diagnosis

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Mass Drug Administration Programme implemented in the endemic area	o Availability of trained drug distributors (volunteers/health workers) o Social mobilisation Campaign	Reporting by Regional Medical officers
Manpower for disease surveillance & vector control trained	% trained manpower in disease control & vector control	Reporting by central & provincial health authorities
Community based care for the prevention of disability due to LF established in all endemic districts	o % districts introduced with community home care (CHB) programme o % LF patients covered by CHB programme o Social mobilisation	Reporting by regional medical Officers
Parasitological, entomological & immunological diagnosis strengthened at central & provincial level	Fully equipped laboratories at central &provincial level	Reporting by central & provincial health staff
GIS based information system established for effective planning, monitoring and evaluation	Central & provincial information systems redesigned	Reported by central and provincial health staff

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Mass Drug Administration Programme (WHO, Global Alliance for LF elimination)

	Training of Health Workers on LF elimination (WHO)
	Community Home Based Care Programme in LF endemic districts
	Research projects

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health, Provincial Health Services, Municipalities in the endemic area, Social Service Department, Non Governmental organisations (Lions, Sarvodaya) & Community Based Organisations.

(15) **Monitoring & Evaluation:**

1. Who? **Anti Filariasis Campaign – Central ministry of Health, Provincial Ministries of Health**
2. When? **Continuous monitoring-monthly, quarterly& annually**
9. What actions to be taken based on results of monitoring & evaluation?

Modification of the plan where necessary to achieve elimination status.

(16) **Major Activities:**

Activities	**Expected Results**	**Process Indicators**
Mass Drug Administration Programme	Interrupt transmission	Parasitological indices
Strengthening morbidity treatment	Prevent disability	Morbidity data
Community based prevention of disability due to lymphoedema	Prevent Disability	Morbidity data
Strengthening of laboratory diagnostic facilities for the control of LF	Reduce disease transmission/Morbidity	Entomological & parasitological indices
Establishment of a GIS based information system	Reduce disease transmission	Parasitological & Entomological indices

(1) **Project Title:**	***Communicable Diseases Control:*** *Vector-Borne Disease DF/DHF prevention &* Control	(2) **Project Number:**	1.4.2 c .3)
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	Epidemiological Unit	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Epidemiological Unit Provincial Directors of Health services Deputy Directors of Health Services Directors of Hospitals Medical Officers of Health	(7) **Project Duration:**	10 years

Project Summary

Dengue fever and Dengue haemorragic fever (DF/DHF) continues to be a major Public Health problem in Sri Lanka. Since the 1st serologically confirmed outbreak in 1965, a wide geographical area has been affected by both the vector and the disease leading to a hyperendemicity in most urban areas in the country. Therefore it is of paramount importance to strengthen the existing national programme on prevention & control of DF/DHF further with following components;
-Strengthening epidemiological surveillance
-Reducing the disease burden through continued in-service education
-Promoting behavioral change through continued IEC programmes
-Revision of legislature & strengthening law enforcement
-Advocacy on solid waste disposal and environmental management

(8) Target Areas & Beneficiaries:

Hospital Medical staff

Medical Officers of Health

Primary health Care Staff

Community groups

(9) Justification:

Dengue was reported in Sri Lanka from the beginning of the last century with the 1st serologically confirmed outbreak in 1965. Though most of the towns throughout the country were affected during these outbreaks, western coastal belt was affected most. Colombo district recorded the highest number of cases and the first two cases of DHF occurred during this period. There were 13 cases of DHF with five deaths in 1966 and seven cases with two deaths in 1968. Very few sporadic cases of DHF were reported until 1989. In 1989 there was an outbreak of DHF, with 203 clinically diagnosed cases and 20 deaths accounting to a case fatality rate of 9.8%.

In 1990, the number of cases rose sharply to 1350 with 365 serologically confirmed cases and a significant number of DHF cases were reported outside Colombo district. Several hundred cases a

year were reported annually from 1991 to 1996 with a case fatality rate ranging from 0.9% to 6.2% (with an epidemic in North-western province in 1996).

The total number of reported cases increased sharply from 1688 in 1999 to 3343 in 2000 with the highest number of cases from Colombo (1552 cases) while most other districts were also affected.

From 1991 to 1996, 60% of dengue cases were reported in under 15 year age group. However during the epidemic in 2000 63% of the total (3343 cases) occurred in the 15 years and over age group, although 54% of the 37 deaths occurred in the under 15 year age group.

From 1989 to 2001 a total of 17, 907 suspected DF/DHF cases were reported to the Epidemiological Unit, Colombo with a peak transmission from June to July (following monsoon rains) and a second peak from October to December (inter-monsoonal rains).

DF/DHF out breaks will continue to be a major public health problem in Sri Lanka looking at the past experiences unless a continuous intensified programme is in place to tackle all related issues effectively and efficiently.

(10) Important Assumptions/Risks/Conditions:

N.I.L.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ Prevention and Control of DF/DHF in Sri Lanka	Morbidity of DF/DHF	Routine; disease surveillance data review
	Mortality of DHF/DSS	Routine; hospital mortality data review

(12) Project Output/Product:

Output	Indicators	Means of Verification
Strengthening of DF/DHF surveillance & outbreak prevention & control	o Hospital admission rate o MOH notification o Case fatality rate	Data reviews of Epidemiology Unit & Medical statistics Unit
Strengthening laboratory surveillance system	- No. of samples tested in national level reference lab. - No. of samples tested in regional/district level laboratories	Laboratory based surveys
Strengthened vector	- No. of entomological	Community based surveys

surveillance system & control	surveys done - Vector control measures implemented	
Prevention of mortality by early recognition & effective case management of DHF/DSS	o Case fatality rate o No. of days in hospital	Review data at Medical Statistics Unit
Improvement of water supply and storage	- No. of households provided with regular water supply - No. of households collecting water in receptacles/tanks	Community based surveys
Effective solid waste management system	o Availability of continuous garbage disposal plan o No. of offenders taken to courts	Community based surveys Review data at MOH/local government level
Effective response mechanism through social mobilization for DF/DHF control and prevention.	-Laval/pupa indices - No. of IEC programmes	Community based KABP study

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	**Project Title**
	Strengthening epidemiological surveillance for planning purpose and early response
	Standard clinical diagnosis and Disease management plan
	Changing behaviour and building partnership
	Formulation of guidelines and accelerating revision of legislature

(14) **Relevant Agencies to be Coordinated:**

Ministry of Environment and Natural Resources

Ministry of Local Government and Public Administration

Ministry of Education

All Provincial Councils

Non Governmental Organizations

(15) **Monitoring & Evaluation:**

1. Who? Director General of Health Services, Epidemiology Unit, Director/Vector Borne Disease

Control Unit, Director/Medical Research Institute

2. When? Quarterly at national level

Monthly at district and other levels

3. What actions to be taken based on results of monitoring & evaluation?

   Regular national/district level consultative reviews

   Periodic reviews with all possible organizations

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Establish focal point at Ministry level – National Task Force on prevention and control of DF/DHF	Policy formulation and implementation of DF/DHF control and prevention programmes	Regular quarterly meetings
To develop, refine and evaluate the national strategic plan on DF/DHF.	-To have a uniform guide lime implement activities	Regular monitoring & evaluation of implementation
Strengthen Provincial/district level emergency action committees	To plan, implement and monitor all activities at each level	Regular monthly meetings
Formation of Vector Borne Disease Control (VBDC) Unit	To co-ordinate integrated vector surveillance and control activities	Regular reviews
Revision of legislature on control and prevention of DF/DHF	- Draft new acts -Revise existing legislation -Include 'spot fines' for offenders	No. of offenders taken to courts
To provide training for Provincial / Regional hospital medical officers	- Proper clinical diagnosis and case management	Reduction in mortality /morbidity
Provide Refresher training for provincial, regional PHC staff	-To be mobilized to educate the public on preventive activities	Community surveys
Supply of dengue kits to selected Provincial and Base Hospitals in high risk areas	-early diagnosis and management	No. of tests performed
Printing and supply of IEC material for training programmes of health staff	To enhance communication facilities/IEC tools	Community surveys
Obtaining the services of a Behavioral Scientist/ Sociologist	to study the perceptions, practices and comprehension of communities on dengue.	Community surveys

(1) **Project Title:**	***Communicable Diseases Control:*** Immunisable Diseases Control : Immunisable Disease Control	(2) **Project Number:**	1.4.2. d.1)
		(3) **Project Priority:**	
(4) **Focal Point:**	Epidemiologist, Central MoH	(6) **Starting Fiscal Year:**	1st year (FY2004)
(5) **Implementing Agencies:**	Epidemiological Unit, Central MoH, Provincial Directors of Health Service ,	(7) **Project Duration:**	10 years

Project Summary

Provision of financially sustainable, safe and high quality immunization Programme while sustaining the gains achieved and adhering to the eradication, elimination and control strategies according to the national and international needs is the objective of the national immunization Programme.

Introduction of new vaccines in to the Programme should be based on correct technical evidence supplemented by disease burden and cost benefit studies.

The need for high quality, thorough surveillance supported by laboratory confirmation, is heightened by the fact that EPI target disease incidence is very low in Sri Lanka. To maintain the high coverage achieved provision of very high quality service is important with close monitoring and supervision at every level.

(8) Target Areas & Beneficiaries:

Infants, Children, adolescents, pregnant mothers and ultimately to the benefit of the total population

(9) Justification:

It is well accepted that immunization is the most cost effective public health intervention ever discovered by the medical community. Provision of immunization services in Sri Lanka is a major success story. Virtually all-eligible infants, preschool children and pregnant women, throughout the country, are receiving all their scheduled vaccines at the correct time. Impact of it is very much visible by elimination of Poliomayalitis, Neonatal-Tetanus, Diphtheria and remarkable reduction in adult tetanus, Measles and Whooping Cough. Impact of recently introduced antigens such as Rubella and Hepatitis B is yet to be seen. However, immunizations given during adolescence and adulthood (Rubella and adult Tetanus Diphtheria vaccines) coverages needs further improvements.

With the advent of more and more new vaccines and introduction of new antigens to the immunization schedules of developed countries and also into the private sector locally, may lead to pressure on EPI to introduce new costly antigens to the national schedule. Therefore Epidemiological Unit should be well equip to handle such situations based on evidence of good surveillance, disease burden and cost benefit data.

(10) Important Assumptions/Risks/Conditions:

The Government of Sri Lanka will continue it's policy of financing of immunization programmes.

The donor agencies (such as WHO, UNICEF, JICA , GAVI ect.) will continue to provide technical and financial support for the immunization.

Increasing costs, both material and human resources, may increase the cost of immunization programme exponentially may lead to gaps in the programme in the future, if the central government and provincial councils are not ready to provide enough resources to the programme and to the over all public health sector.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
Provision of financially sustainable, safe and high quality immunization service to the community while maintaining high coverage for the existing antigens and achieving similar coverages for new antigens to achieve diseases eradication, elimination and control strategies according to the national needs and international commitments	Immunization coverage	Routine reports and Periodical Survey s including data quality
	Target Disease incidence	Routine and special disease surveillance
	Adverse events following immunization rates	Routine reporting and periodical surveys
	High quality service delivery	Periodical clinic based Surveys based on standard check lists
	Client satisfaction	Questionnaire survey Focal group discussions
	Provider satisfaction	Questionnaire survey Focal group discussions

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Maintain high Coverage for existing antigens	Imminization coverage for each antigen	Routine reports and periodical surveys
Achieve high coverage for newly introduced antigens and new antigens introduced in the future	Imminization coverage for each antigen	Routine reports and periodical surveys
Achievement of disease reduction targets	Target disease incidence	Routine and special disease surveillance data Laboratory surveillance data Special community and institutional based surveys
Provision of safe immunization service	Monitoring of adverse events following immunization	Routine reports and periodical surveys
Provision of quality	% of service outlets adhering	Routine reports and

immunization service	to the minimum standards	periodical surveys

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Capacity Building Project
	Development of Health Information System
	Study Project on Job Description, Certification and Legislation of Primary Health care Workers
	MCH Project

(14) **Relevant Agencies to be Coordinated:**

MOH, FHB, HEB, MRI, WHO, UNICEF, Ministry of Education

(15) **Monitoring & Evaluation:**

1. **Who ?** Epidemiologist, MOH, Dpt' of Censes and Statistics, Registrar General, WHO, UNICEF
2. **When?** Quarterly Reports, Annual reports, Annual Surveys, Periodical Surveys (DHS), Ad-hoc Surveys
3. **What actions to be taken based on results of monitoring & evaluation?**

Situational and periodical recommendations to the relevant authorities

Revision and/or Establishment of Acts/Circulars/Regulations/Guidelines

Revision and/or Establishment of Training Curriculum

Improved monitoring and supervision

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Assure a continuous supply of good quality vaccine, syringes and other logistics	• Innovative reforms or interventions that may be useful for other facilities	• Change and improvement of Management
Develop Health Education and social mobilization plan	• individual responsibility and duty become clear, duplication of work reduce, team work to be induced	• Production of Job descriptions & guidelines
Undertake Institutional Strengthening	• To review alternative ideas on hospital management • To select some ideas for pilot	• No. of Trainers and Trainees • Evaluation of Pilot test

Activities	Expected Results	Process Indicators
	testing; and pilot test selected ideas.	hospitals
Increase coordination of immunization activities, among Epidemiology unit, FHB, HEB, MRI, Provincial EPI offices and partner agencies	• Motivation and team work to be induced	• Formation of Management teams and having regular meetings
Improve EPI Data Management EPI with computerization of recording and & reporting System	• Accurate timely data for correct management decisions	• Accuracy and timeliness of EPI reports
Strengthen the surveillance of all vaccine preventable diseases	• Understanding of the impact of the EPI programme	• Morbidity and mortality rates of EPI target diseases
Strengthen laboratory surveillance of EPI target diseases	• Understanding of the impact of the EPI programme	• Morbidity and mortality rates of EPI target diseases
Strengthen the management and supervision at each level	• Improved work output	• % of minimum supervisory visits to each staff catrgory
Regular assessment of immunization coverage by field surveys	• Verification of routine data with survey data	• No. of such surveys conducted.
Regular assessment of training needs, develop training plans and ensure implementation	• Regular updating of knowledge, skills and attitudes	• % of health personal trained
Renew and strengthen the cold chain system	• Delivery of potent vaccine and further improved quality of the EPI vaccine delivery	• No. of vaccine cold chain failures reported
Upgrade the facilities for transport of the vaccines and the field staff	• Uninterrupted transport facilities	• Availability of transport facilities
Undertake reviews/assessments and research studies	• Understanding of the pitfalls and unseen problems of the programme	• No. of such studies/ reviews conducted
Undertake Cross sectional disease burden studies/Seroprevalence studies	• Better understanding of the other vaccine preventable diseases. Rational decision making for introduction of new vaccines.	• No. of such studies undertaken.

(1) **Project Title:**	***Communicable Diseases Control:*** Immunisable Diseases Control : Elimination of measles	(2) **Project Number:**	1.4.2. d.2)
		(3) **Project Priority:**	
(4) **Focal Point:**	Epidemiological Unit Epidemiologist,	(6) **Starting Fiscal Year:**	1st year (FY2004)
(5) **Implementing Agencies:**	Epidemiological unit Provincial Director of Health Services Deputy provincial Director of Health Services Epidemiological Unit,	(7) **Project Duration:**	10 years

Project Summary

Measles is a systemic viral infection affecting all age groups. Approximately 30% of reported measles cases have one or more complications and infection during pregnancy results in a higher risk of premature labour, spontaneous abortion and low birth-weight infants. Complications of measles are more common among children <5 and adults >20 years of age.
Measles is a major public health problem in all parts of the world and an epidemic of measles occurred in Sri Lanka in 1999/2000. Sri Lanka introduced Measles vaccine into the EPI in 1984. Therefore it is important to strengthen the surveillance activities of Measles.

- Routine measles immunization programme
- Measles catch-up immunization programme
- Community based serological surveys
- Strengthening of Laboratory services
- Surveys to find out the incidence of measles
- Adequate case management

(8) Target Areas & Beneficiaries:

(9) Target Areas & Beneficiaries:

Infants, Children, adolescence, pregnant mothers and ultimately to the benefit of the total population

(10) Justification:

Measles remains one of the important public health problems in Sri Lanka. In spite of a relatively low incidence of measles during the past decade, an outbreak of the disease occurred in September 1999 to the end of June 2000. Over 15000 suspected cases of measles were notified to the Epidemiological unit. This outbreak resulted in 23 deaths and many more complications. Since there is an effective and safe vaccine available for measles and this has already being included in the EPI programme, by following the strategies mentioned above the goal of eliminating measles by year 2014 may be achieved.

(11) Important Assumptions/Risks/Conditions:

The government of Sri Lanka will continue to procure the vaccine and maintain its policy of free health services.

The donor agencies (such as WHO, UNICEF, etc.) will continue to provide technical and financial support.

Objective	Indicators	Means of Verification
Elimination of measles from Sri Lanka by year 2014	Measles Immunization coverage	Indoor Morbidity and Mortality records Field surveys Laboratory surveillance reports
	Incidence of measles	Routine and special disease surveillance

(12) Project Output/Product:

Output	Indicators	Means of Verification
Reduce incidence of measles	Measles immunization coverage of infants by districts MR coverage for children at 3 years of age by districts	Quarterly and annual immunization returns, surveys. Quarterly and annual immunization returns, surveys
Strengthening of measles surveillance activities	Notification rate of measles by district Timeliness of notification Timeliness and completeness of special investigation forms	Annual IMMR data and notification data.
Strengthening of Laboratory surveillance	Number of laboratories with facilities to diagnose measles antibodies % of laboratory confirmed measles cases. % of timeliness and completeness of laboratory reports	Hospital and laboratory data
Adequate case management	% of children receiving vitamin A at the moment of measles diagnosis or shortly thereafter	Special investigation form

(13) Related Projects *(include ongoing projects & projects under the Health Master Plan)*:

Project	Project Title

No.	
	Measles surveillance programme
	Routine measles immunization programme
	Measles catch-up immunization programme, Phase I and Phase II

(14) Relevant Agencies to be Coordinated:

MRI, WHO, UNICEF,

(15) Monitoring & Evaluation:

1. **Who ?** Epidemiologist,
2. **When?** Quarterly and annually
3. **What actions to be taken based on results of monitoring & evaluation ?**

Continuous review with Provincial, District and Divisional Health Authorities

(16) Major Activities:

Activities	Expected Results	Process Indicators
Routine measles immunization programme	Elimination of measles	100% immunization coverage of infants with the measles vaccine and 100% coverage of children with MR vaccine at 3 years of age
Measles catch-up immunization programme	To provide a second opportunity to be immunized against measles for all individuals within the target age groups	Achieve a coverage of over 95% of the target age group
Pre and post catch-up measles sero-surveys	To ascertain the impact of the measles catch-up immunization programme	
Community based serological surveys	To estimate percentage of sero conversion within the community	
Community based surveys	To estimate incidence of measles	

(1) **Project Title:**	***Communicable Diseases Control:*** Immunisable Diseases Control : Hib Prevention & Control	(2)**Project Number:** 1.4.2.d (3) (3) **Project Priority:**
(4) **Focal Point:**	The Epidemiologist, Epidemiological Unit, Central Ministry of Health.	(6) **Starting Fiscal Year:** 2006
(5) **Implementing Agencies:**	The Epidemiologist, Central Ministry of Health, Provincial Director of Health Services, Deputy Director of Health Services, Divisional Director of Health Services	(7) **Project Duration:**
The proposed plan to introduce Hib vaccination in to the Expanded Programme on Immunization (EPI) in Sri Lanka is aimed at reducing mortality and morbidity in infants and children due to a serious infectious bacterium, Haemophilus influenzae b (Hib). This disease has a high case fatality rate and severe sequalae and amount to a reasonable burden of disease preventable by vaccination. An effective and safe vaccine is available for prevention of Hib disease and widely used successfully in industrialized countries. In Sri Lanka it is already available in the private health sector for those who can afford it. Sri Lanka has an impressive international record in Child Health indicators and a successful National Immunization Programme. The EPI has recently added Hepatitis B vaccine and the Programme is functioning smoothly and there will be no extra costs on infrastructure and personnel in introducing a new vaccine.		

(8) Target Areas & Beneficiaries:

Target Areas: Child Welfare Clinics, Immunization Clinics.

Beneficiaries: Particularly children under 5 years of age, and the Nation as a whole.

(9) Justification:

Haemophilus influenzae type b (Hib) is a major cause of bacterial infection in infants and young children; Hib disease includes Meningitis, Pneumonia and blood stream infections and epiglottitis. All these conditions may result in the death of the infected child. Of Children with Hib Meningitis 10 – 30% die and 10 –35% of the survivors are left with disabling sequalae (deafness, paralysis, Learning difficulties). Hib pneumonia has a mortality rate of 2 – 25 %.

Limited surveillance studies have failed to demonstrate Hib incidence rates in Asia as high as in other parts of the world. Although Hib incidence may be truly low in Asia, the reported low incidence may be due to infected persons not reporting to clinics, antibiotics used before culture, inadequate pathogenic specimens and difficulties in isolating Hib because of it's fastidious culture requirements. Thus low reported incidences should be interpreted with caution. A community based, laboratory backed Hib surveillance study to estimate the burden of Hib disease in Sri Lanka has been started by the Epidemiology Unit and results will be available by year 2005.

It is well documented that antibiotic resistance of the Haemophilus influenzae is increasing and spreading. Resistance is documented against a variety of antibiotics including penicillin, ampicillin, aminoglocosides and chloramphenicol.

Prompt diagnosis and isolation of the organism is imperative in treatment, reducing the mortality and morbidity as well as minimizing sequalae. Infrastructure facilities for microbiology and radiology are very expensive to be made available to all smaller and peripheral hospitals. Recurrent expenses too are high in radiology and microbiology departments.

Since the introduction of Hib conjugate vaccines in the routine childhood immunization schedules, Hib disease has been reduced to elimination levels in Europe, North America and Australia. Few vaccines in the history have induced a dramatic decline of disease in such short time, as have the Hib Conjugate vaccines. All the prelicensure and post vaccination clinical studies have demonstrated the conjugate vaccines to be highly effective with over 95% efficacy and protection rates. Herd immunity, which is another key feature in Hib vaccine, is well documented in industrialized countries.

Introducing Hib vaccine in to Sri Lanka's existing very successful Expanded Programme on Immunization will no doubt improve the health status of the nation, reduce the burden of childhood diseases and contribute to the economy by reducing the cost of treatment and also by means of a healthier nation.

(10) Important Assumptions/Risks/Conditions:

Assumptions: The Expanded Programme on Immunization in Sri Lanka will continue to get the international donor assistance and the government of Sri Lanka will maintain it's free health services to the needy people.

Risks: Hib vaccine is one of the modern vaccines developed and manufactured using latest technological advancements and is an expensive vaccine. Financial commitment by the government to procure the vaccine on a regular and a long-term basis is of utmost importance in implementing the introduction of the Hib vaccination in to the National Expanded program on Immunization.

Conditions: None

(11) Project Objective:

Objective	Indicators	Means of Verification
Introduction of monovalent Hib vaccine or, if available Combination Hib vaccine (with DPT or with DPT.HepB or with HepB.) in to the Expanded Programme on Immunization in Sri Lanka, achieve a vaccine coverage of >95% over three years, monitor the programme, establish and sustain Hib disease surveillance in Sri Lanka.	1. 3 dose Hib vaccine coverage – 80% in the first year, 90% in the second year and over 95% thereafter.	Routine reporting system and special immunization coverage surveys.
	2. Seroconvertion of vaccine recipients	Special seroprevalence surveys
	3. Percentage of Hib meningitis among the target population	Establishment of sentinel surveillance of Hib disease
	4. Percentage of Hib pneumonia among the target population.	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Short term: Achievement of over 95% Hib vaccine coverage among the target group	Hib vaccine coverage	Routine reporting and special surveys
Long Term: **1.** Reduction of Hib disease in Sri Lanka to elimination levels	Burden of Hib disease	Sentinel Surveillance
2. Laboratory facilities to screen for and diagnose Hib disease in secondary and tertiary level health care institutions	Proportion of secondary and tertiary level care institutions with laboratory facilities to screen for and diagnose Hib disease	Routine reporting and special surveys.

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
(on going)	Study of Burden of Hib disease
	Introduction of Hib Vaccine into the Expanded Programme of Immunization in Sri Lanka
	Public Awareness programme on Hib Vaccination
	Planning and establishment of Hib disease sentinel surveillance programme
	Monitoring and evaluation of Hib vaccination programme and the of Hib disease surveillance programme
	Serosurveillance Studies / Research

(14) **Relevant Agencies to be Coordinated:**

Provincial and District Health administration

Medical Research Institute

Family Health Bureau

Health Education Bureau

Private sector health institutions

(15) **Monitoring & Evaluation:**

1. Epidemiology Unit, Central Ministry of Health, District technical health staff
2. Quarterly Review meetings and report, Annual Report, Annual survey

3. What actions to be taken based on results of monitoring & evaluation?
    a. Redirect toward achieving targets
    b. Strengthen the programme whenever necessary

(16) Major Activities:

Activities	Expected Results	Process Indicators
Procurement of Hib vaccine	Regular supplies of vaccine	Availability of minimal stocks
Education and awareness campaign for the public		
Education and training of Central health staff		Coverage
Education and training of District Health Staff		Coverage
Education and training of Divisional Health Staff		Coverage
Planning and implementation of Hib disease surveillance programme	Early detection of outbreaks	
Monitoring and evaluation of vaccination and surveillance programmes	Achievement of high vaccine coverage Reduced disease incidence	Vaccine coverage Disease incidence
Serosurveillance studies / Reserch	Measurement of effective vaccination programme	Hib seroconversion rates

(1) **Project Title:**	***Communicable Diseases Control:*** Immunisable Diseases Control : Viral Hepatitis Prevention & Control	(2) **Project Number:**	1.4.2.d.(4)
		(3) **Project Priority:**	
(4) **Focal Point:**	Epidemiology Unit	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Epidemiology Unit Provincial Director of Health Services Deputy Provincial Director of Health Services Divisional Director of Health Services Curative Care Institutions (All hospitals)	(7) **Project Duration:**	10 years

Project Summary :

Viral hepatitis (VH) is emerging in Sri Lanka. Hepatitis A accounts for the majority of cases in the country. Thus, the serious consequences of hepatitis B have been identified as emerging public health issues. Therefore it is important to have a national programme on control & prevention of VH with following components:
- Assess burden of VH in the country
- Establish National Task force on control & prevention of VH in Sri Lanka
- Strengthen surveillance (particularly laboratory surveillance) of VH
- Improved excreta disposal system at local settings
- Ensure safe drinking water
- Introduction of Hepatitis A vaccine for high risk groups
- Strengthening law enforcements, in order to ensure environmental sanitation

(8) Target Areas & Beneficiaries:

Target Areas: Medical Officer of Health

Beneficiaries: Community in respective MOH areas

(9) Justification:

VH is endemic in all parts of Sri Lanka, and occurs throughout the year. It is noted that VH is increasing in past few years. VH is one of the notifiable diseases in Sri Lanka. The average annual admission rate to government hospitals in Sri Lanka for VH is 22.5 per 100,000 populations in 2001. The hospital mortality rate is 0.4%. It is likely that the hepatitis A is the commonest type of viral hepatitis in the country; prevalence of hepatitis B and C ranges from 0.27% to 2.5% and 0.56% to 0.97% respectively. These data are based on epidemiological and serological surveys done in defined geographical areas in the country. However, the actual incidence of VH is likely to be more than that of reported numbers. Data on burden of VH in Sri Lanka is limited.

Health authorities have not given sufficient priority for prevention and control of VH. Laboratory surveillance of VH is limited due to many constrains. Direct and indirect impacts of socioeconomic and political /administrative re-organization on public health issues, such as unsafe water, unauthorized constructions on increase of VH in the country are significant.

There is a timely need to have a functioning national programme on control & prevention of VH in Sri Lanka. This programme has to cover all possible aspects, where active intervention could be implemented.

(10) Important Assumptions/Risks/Conditions:

Assumption:

Government commitment and policy to prevent and control of VH.

Commitment by the Department of Health with the other sectors, such as Local government to control and prevent VH, as a priority need in public health.

Public need to have a active programme on control and prevention of VH and their support and active participation into the programme.

Risk / Conditions:

Cost: Screening for types of VH, injection safety practices and immunization are important strategies in implementing a successful preventive and control programme. However, this will require an additional financial commitment by the Ministry and inability to provide such facilities would be affected the expected out puts.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ Prevention and Control of Viral Hepatitis in Sri Lanka	Morbidity of VH	Survey: review of Medical statistician and Institution records / community survey
	Mortality of VH	Survey: review of Medical statistician and Institution records / community survey

(12) Project Output/Product:

Output	Indicators	Means of Verification
Reduction of VH morbidity	- Hospital admission rate of VH - MOH notifications - No. of Outbreaks of VH	Review data at Epidemiology Unit and Medical Statistician records
Reduction of VH Mortality	Case Fatality Rate of VH (at the Government Institutions)	Review data Medical Statistician and Register General records
Immunization against Hep B - Infants - High Risk group* (*Baseline population to be estimated)	- Immunization coverage 100% by 2007 - Immunization coverage 50% by 2006; 70% in 2010	Community based Survey / Immunization coverage Survey / Sero Survey

Immunization of all high risk groups against Hepatitis A	Risk group Hep A immunization coverage 50% by 2006 ; 70% by 2010	Community based survey / Sero survey
Strengthened universal precautions with regard to all invasive procedures at all medical institutions / clinics	- Number of Hep B , HIV/AIDS caused by unsafe injection practices - % of immunizations performed with Auto Disable(AD) syringes	- Hospital records - Epidemiology Unit
Strengthening VH Surveillance	- Notification rate of VH - Timeliness notification - Timeliness and completeness of special investigations - Notification of VH from private sector	Review data at Epidemiology Unit and Medical Statistician records
Strengthened laboratory Surveillance	- Number of functioning Provincial / district laboratories with facility to carry out VH investigations - % of laboratory confirmed cases - % of Timeliness and completeness of laboratory reports	- Hospital and laboratory based survey
Availability of Safe Drinking Water	- Number of households with safe drinking water	Community survey / Other sources (DHS Survey, Local government data etc)
Availability of hygienic latrine facility	- Number of households with hygienic latrine facility	Community survey / Other sources (DHS Survey, Local government data etc)

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	**Project Title**
	Hepatitis B Immunization Programme (ongoing for infants and selected high risk groups): Immunization all at high risk
	Hepatitis A Immunization Programme for high risk groups
	Injection safety programme – Provision of Auto-disable syringes (ongoing)
	Provision of Safe Drinking Water
	Provision of hygienic latrine facility
	Provision of laboratory facility at the Provincial / district level for VH laboratory investigations

(14) Relevant Agencies to be Coordinated:

Ministry of Local Government and Public Administration, Ministry of Education, All Provincial councils and other related Ministries.

(15) Monitoring & Evaluation:

1. Who? Director General of Health Services and Epidemiology Unit
2. When? Quarterly
3. What actions to be taken based on results of monitoring & evaluation?
    - Continues reviews with Provincial / District / Divisional Health Authorities
    - Periodical reviews with other relevant agencies to be coordinated

(16) Major Activities:

Activities	Expected Results	Process Indicators
Establishing National Task force for Control and Prevention of VH	- Policy formulation / implementation - National level coordination - Monitoring and evaluation of all major activities at national level	-Regular quarterly meeting
VH Burden study (Part of this study will be based on secondary data)	- To estimate morbidity, mortality and disabilities caused by each type of VH in the country - Cost analysis for patient management at the government medical institutions	-Final report to be made available before end of year 2005
Hepatitis B Immunization Programme	- Immunization of all infants against Hepatitis B - Immunization of all high risk groups / adolescents against Hepatitis B	95% coverage by 2005; 100% in 2007 & 2010 50% coverage by 2006; 60% in 2008; 70% in 2010
Hepatitis A Immunization Programme for high risk groups	Immunization of all high risk groups against Hepatitis A	50% coverage by 2006; 60% in 2008 ; 70% in 2010
Injection safety programme – Provision of Auto-disable syringes (ongoing)	- Use AD syringes for all immunizations	100% EPI vaccines by 2005 100% Non EPI Vaccine by 2007
Strengthening VH Surveillance	- Improved notification of VH (both State & Private	- % Notification rate - Timeliness &

	sector) - Investigation of all VH outbreaks - Early prediction of outbreaks	completeness - % of outbreaks investigated - % of outbreaks predicted
Provision of laboratory facility at the Provincial / District level for VH laboratory investigations	Strengthened laboratory Surveillance	- Functioning laboratory at each Province by 2010 - > 50% reported cases are confirmed by laboratory tests by 2010 - 100% Timeliness and completeness of laboratory reports by 2010
Provision of Safe Drinking Water	Availability of Safe drinking water facility	>80% Households
Provision of hygienic latrine facility	Availability of hygienic latrine facility	> 80% Households

(1) **Project Title:**	***Communicable Diseases Control:*** *Immunisable Disease Control:* Prevention of Rubella	(2) **Project Number:**	1.4.2.d.5)
		(3) **Project Priority:**	
(4) **Focal Point:**	Epidemiological Unit	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Epidemiological Unit Provincial Director of Health Services Deputy Provincial Director of Health Services	(7) **Project Duration:**	10 years

Project Summary

Rubella is a mild disease affecting children and adults. It assumes considerable significance in pregnant women where it is transmitted to the foetus across the placental barrier with marked teratogenic effects.
Rubella is a major public health problem in all parts of the world and epidemic of rubella occurred in Sri Lanka occurred in 1994 / 1995. Sri Lanka has introduce Rubella vaccination in to the EPI in 1996.
Therefore it is important to strengthen the surveillance activities of Rubella and CRS.

Rubella Immunization Programme
Community based Serological surveys
Surveys to find out incidence of CRS

(8) Target Areas & Beneficiaries:

Institutional Staff, Public Health Staff and the Community

Justification: Rubella is one of the important public health problem in Sri Lanka. It is one of the most common intrauterine infections with an extensive teratogenic potential and can cause considerable physical and mental handicaps, which is a great burden to society. An epidemic of rubella occurred in Sri Lanka in 1994-1995.A total of 169 cases were reported during this outbreak. There is an effective and safe vaccine available for Rubella and using the same infrastructure used for EPI programme this vaccine can be administered without additional costs.

(9) Important Assumptions/Risks/Conditions:

The Government of Sri Lanka will continue to procure the vaccine and maintain its policy of free health services.

Weekly reporting of Notifiable Diseases

(10) Project Objective:

Objective	Indicators	Means of Verification
■ Prevention of Rubella and Congenital Rubella Syndrome(CRS) by 2010	Incidence of Rubella and CRS	Indoor morbidity and mortality records Field surveys

(11) Project Output/Product:

Output	Indicators	Means of Verification
Reduce incidence of Rubella and CRS	Rubella immunization coverage for females by districts	Quarterly and annual immunization returns,surveys
	Rubella immunization coverage for children at 3 years of age	Quarterly and annual immunization returns,EPI surveys
Strengthening of Rubella and CRS surveillance activities	Notification rate of Rubella Timeliness of notification Timeliness and completeness of special investigation forms	Annual IMMR data,special investigations,surveys
Strengthening of laboratory surveillance	Number of laboratories with facilities to diagnose Rubella antibodies % of laboratory confirmed Rubella cases % of timeliness and completeness of laboratory reports	Hospital and laboratory data

(12) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Rubella and CRS surveillance programme
	Rubella immunization programme

(13) **Relevant Agencies to be Coordinated:**

WHO, Unicef

(14) **Monitoring & Evaluation:**

1. Who? Epidemiologist
2. When? Quarterly and Annually
3. What actions to be taken based on results of monitoring & evaluation?

   Continuous review with Provincial/District and Divisional Health Authorities

(15) **Major Activities:**

Activities	Expected Results	Process Indicators
Rubella Immunization Programme	Prevention and control of Rubella and CRS	100% Immunization coverage of women in child bearing and immunization coverage of children at 3 years of age

Community based Serological surveys	To estimate percentage of sero conversion among community	
Surveys to find out incidence of CRS	To estimate incidence of CRS	

(1) **Project Title:**	***Communicable Diseases Control: Immunisable Disease Control:*** Poliomyelitis Eradication Initiative	(2) **Project Number:**	1.4.2d.6)
		(3) **Project Priority:**	
(4) **Focal Point:**	Epidemiological Unit	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Epidemiological Unit Provincial Director of Health Services Deputy Provincial Director of Health Services	(7) **Project Duration:**	5 years

Project Summary

Sri Lanka is on the verge of eradicating poliomyelitis after achieving and maintaining a high immunization coverage and established AFP (Acute Flaccid Paralysis) surveillance. Most of the standard WHO indicators of Polio Surveillance have been met and to improve existing AFP surveillance practices and to sustain the achieved targets it is necessary to conduct following activities.

- Routine Immunization with OPV
- National and Sub National Immunization Days
- Mopping up immunization
- Enhanced AFP Surveillance.
- Review meetings at National, Provincial and Regional level
- Consultative Meetings of Virologists, Epidemiologists, Physicians, Paediatricians and Neurologists

(8) **Target Areas & Beneficiaries:**

Institutional Staff, Public Health Staff and the Community

(9) **Justification:**

Sri Lanka is on the verge of eradicating poliomyelitis after achieving and maintaining a high immunization coverage and established AFP surveillance. Most of the standard WHO indicators of Polio Surveillance have been met and it is important to improve the existing AFP surveillance activities throughout the country. As the neighbouring country India is continuing to isolate wild polio virus from the community there is a risk of importation of wild polio virus to Sri Lanka and outbreak of polio. It is necessary to strengthen the

AFP surveillance activities in Sri Lanka

(10) **Important Assumptions/Risks/Conditions:**

Government of Sri Lanka will continue to procure vaccine

EPI programme will continue to maintain its high standard

Vaccine acceptance by the community will be 100%

(11) **Project Objective:**

Objective	Indicators	Means of Verification
Eradication of Poliomyelitis	No cases of polio occurring in the country and in the South East Asia for 3 consecutive years	AFP surveillance IMMR MRI data on AFP

(12) **Project Output/Product**

Output	Indicators	Means of Verification
Immunization with OPV	Immunization coverage	Review data at Epidemiological Unit quarterly and annually, EPI reviews
National and Sub National Immunization Days	Immunization coverage	Review data at Epidemiological Unit quarterly and annually, EPI reviews
Enhanced Surveillance	1.Non polio AFP rate in children < 15 yrs. of age. (Target >/= 1/100,000)	Quarterly review by NCCPE and NPEC
	2.Completeness of reporting.	Monthly quarterly and annually review
	3.Timeliness of reporting.	
	4.Reported AFP cases investigated within 48 hrs. of report (Target >/= 80%)	
	5.Reported AFP cases with 2 stools specimens collected within 14 days of onset of paralysis. (Target> 80%)	
	6.Reported AFP cases with a follow-up examination at least 60 days after onset of paralysis to verify the presence of residual paralysis or weakness (Target >/=80%)	
Strengthening of Laboratory Surveillance	7.Specimens of stools arriving at National Laboratory (MRI) within 03 days of being collected (Target> 80%)	Monthly quarterly and annually review
	8.Specimens of stools with a turn around time <28 days (Target>80%)	Monthly quarterly and annually review
	9.Stool specimens from which non-polio enterovirus was isolated (Target> 10%).	Monthly quarterly and annually review

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Immunization with OPV (EPI)

Project No.	Project Title
	National Immunization Days Sub National Immunization Days Immunization of children following an AFP case Mopping-up immunization
	Quarterly Meetings of National Polio Expert Committee Quarterly Meetings of National Committee for Certification of Polio Eradication Quarterly review of AFP surveillance activities at Regional Epidemiologists conferences Consultative Meetings of Virologists, Epidemiologists, Physicians, Paediatricians and Neurologists Supervisory Visits

(14) **Relevant Agencies to be Coordinated:**

WHO, UNICEF, Ministry of Health

(15) **Monitoring & Evaluation:**

1. Who? Epidemiologist /National Committee for Certification of Polio Eradication/Regional Certification Committee
2. When? Monthly /Quarterly /Annually
3. What actions to be taken based on results of monitoring & evaluation?

   Continuous review with regional / national level

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Immunization with OPV (EPI)	100% coverage	Immunization coverage
National Immunization Days	100% coverage	Immunization coverage
Sub National Immunization Days	100% coverage	Immunization coverage
Mopping-up immunization	100% coverage	Immunization coverage
Quarterly Meetings of National Polio Expert Committee	To improve AFP surveillance	4 meetings/year
Quarterly review of AFP surveillance activities at Regional Epidemiologists conferences	To improve AFP surveillance	4 meetings/year
Quarterly Meetings of National Committee for Certification of Polio Eradication	To get experts help on diagnosing doubtful AFP cases	4 meetings/year
Consultative Meetings of Virologists, Epidemiologists, Physicians, Paediatricians and Neurologists	To review AFP surveillance activities	4 meetings/year
Supervisory Visits	To improve AFP surveillance	

(1) **Project Title:**	***Communicable Diseases Control:*** Rabies & Other Zoonotic Diseases Control	(2) **Project Number:**	1.4.2.e
		(3) **Project Priority:**	
(4) **Focal Point:**	D.D.G. (PHS)	(6) **Starting Fiscal Year :**	2004
(5) **Implementing Agencies:**	Public Health Veterinary Services	(7) **Project Duration:**	5 Years

Project Summary

Rabies has been a significant health problem in Sri Lanka for a long time. The social and economic losses from this public health problem have not been computed but would be substantial. It is a matter for concern that mortality is highest among the younger age group, in whom the nation has invested heavily by way of human resource development. Being an island Sri Lanka can achieve great economic benefits as well as save human lives through rabies elimination, due to the fact that once eliminated, an island will find it easier to prevent reintroduction of rabies from other countries. Hence, it is imperative for the government to invest in a rabies control program. The knowledge base with regard to control and prevention of rabies has expanded substantially over the recent past. A sound technical base therefore exists for the launching of new national initiatives for rabies elimination. Goal of National Rabies control program is to eliminate Human Rabies first and secondly to eliminate canine rabies. In all provinces capacity is lacking for the implementation of a comprehensive rabies control program.

(8) Target Areas & Beneficiaries:

General population and entire island.

(9) Justification:

Rabies has been neglected disease during previous centuries as a result people are continually suffering from the incurable, horrible deadly rabies . All the tools are available for Rabies Elimination, Co-ordination of effective rabies elimination strategy through the effective Plan with adequate priority will eventually lead to elimination of the disease. Once eradicated, Sri Lanka could be easily kept as rabies free state.

(10) Important Assumptions/Risks/Conditions:

Provincial Councils and Local Authorities should provide adequate support for development of human resources and policy implementation required for rabies elimination strategies.

(11) Project Objective:

Objective	Indicators	Means of Verification
(a) Reduction of Human Rabies by 50% to from present level of 0.4 per 100,000 population to 0.2 per 100000 population (b) Minimised the transmission of Japanese Encephalitis from pigs.	1)No. of Human Rabies Cases per 100,000 population	Weekly Epidemiological
	.	Report
	2) Incidence of J.E.	Weekly Epidemiological
		Bulletin

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Ability of District Health Staff to vaccinate all owned dogs established	Number of Districts with all facilities for annual mass immunisation campaigns for dogs	Through review at Performance Development Meetings.
Ability of District Health Staff to reach inaccessible dogs for Rabies Vaccination established.	Number of Districts with required all facilities to conduct vaccination campaigns for community dogs and house to house oral rabies vaccination of missed dogs	Through review at Performance Development Meetings
Human resources for Rabies Elimination in District and National level are developed.	Number and categories of staff trained	Through review at Performance Development Meetings
Improved community support and multisectoral collaboration of Rabies Elimination.	No of District and Divisional rabies elimination committees effective.	Through review at Performance Development Meetings
Collaborative partnership is established for control of Japanese Encephalitis transmission pigs through vaccination.	No. of Districts with effective partnership collaboration with Dept of Animal Production and Health.	Through review at Performance Development Meetings

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	NIL

(14) **Relevant Agencies to be Coordinated:**

Local Authorities

Provincial Health Services

Non Governmental Organisations

Department of Animal Production and Health.

Ministry of Public Administration

(15) **Monitoring & Evaluation:**

1. Who? Director Public Health Veterinary Services
2. When? Periodically every 3 months.
3. What actions to be taken based on results of monitoring & evaluation?

   Actions will be decided by Director Public Health Veterinary Services in consultation with Members of Project Development Committee and Ministry of Health on the basis of problems and opportunities.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators

Activities	Expected Results	Process Indicators
Increase the transport facilities for dog vaccinations to visit villages	Operation of Dog Vaccinations in every village annually.	No . of dog Vaccinations
Establish Community Dog Vaccination Programme	Stop rabies transmission at public places	No.of Community dog Vaccinations
Establish house to house Oral Rabies Vaccination campaign for poorly supervised owned dogs.	Increase of Dog Vaccination Coverage to 75%	No. of Oral Vaccinations
Establish birth control and Rabies Vaccination Programme for Stray dogs.	Elimination of Rabies transmission at public places	No.of dogs Spayed / Castrated and Vacci-nated /
Launching Mass awareness Programme on Rabies	Increased community participation	No.of Awareness Programmes conducted.
Recruitment of Veterinary Surgeons for Management and Conduction of Animal Birth Control Programme	Improved Operational Management and establishment Humane dog population Control Programme	No.of personnel recruited
Development of Human resources for Rabies Control Prevention	All categories and relevant Officers are knowledgeable on Rabies Prevention	No. of Training Programmes conducted
Expansion of Rabies diagnosis facilities	Rabies diagnostic facilities in peripheral Provinces.	No.of suspected heads examined.
Formation of District Rabies Elimination Committees	Partnership collaboration of other Agencies like Local Authorities, N.G.O. etc.	No. of Committees formed
Strengthen the Control and Monitoring of Rabies Control Activities	Continuous improvement of the Project to reach rabies elimination	No.of Performance Management Meetings held.

(1) **Project Title:**	***Communicable Disease Control :*** Food and Water-Borne Diseases Control Prevention and Control of Diarrhoeal Diseases	(2) **Project Number:**	1.4.2.f
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Epidemiological Unit Provincial Director of Health Services Deputy Provincial Director of Health Services Medical Officer of Health	(7) **Project Duration:**	10 years
Diarrhoeal diseases are still a major public health problems in Sri Lanka. During the last 20 years admissions to government hospitals due to diarrhoeal diseases has been fluctuating between 676 and 961 cases per 100,000 population. It was the 5th leading cause of hospitalization in year 2000. With the implementation of National Programme for the Control of Diarrhoeal Diseases the death rate due to diarrhoeal diseases has reduced remarkably. But the morbidity rate has remained at same. So it is very important to have special programme for control and prevention of diarrhoea. - Strengthen the surveillance of diarrhoeal diseases - Outbreak prediction and prevention - Training of hospital staff and PHC staff on prevention and control of diarrhoea.			

(8) **Target Areas & Beneficiaries:**

Medical Officer of Health

(9) **Justification:**

Diarrhoeal diseases are major health problem in Sri Lanka. It was the 5th leading cause of hospitalization in year 2001. During last 20 years admissions to general hospitals due to diarrhoeal diseases has been fluctuating between 676 and 961 cases for 100,000 population.

With the implementation of the national programme for control of diarrhoeal diseases the mortality rate due to diarrhoeal diseases has decreased dramatically. The morbidity rate has not changed much.

This is probably due to the fact that the causes for the occurrence of diarrhoeal diseases are multifactorial, social, economic and environmental factors together with changing behaviour in society are playing a major role in keeping the morbidity rate high.

The main contributory factors are the scarcity of water during the dry season and lack of proper sanitary facilities.

(10) **Important Assumptions/Risks/Conditions:**

(11) **Project Objective:**

Objective	Indicators	Means of Verification

Objective	Indicators	Means of Verification
■ Prevention and Control of diarrhoeal diseases in Sri Lanka	Mortality due to diarrhoeal diseases	Review of institutional data received from medical statistician.
	Morbidity due to diarrhoeal diseases	Review of institutional data from medical statistician and notification data received from MOOH.
	Report of hospital admissions due to diarrhoea	Sentinel surveillance of diarrhoeal diseases
	Number of outbreaks reported in a year	Review of RE data

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Reduction of morbidity due to diarrhoeal diseases	Admissions rate Morbidity rate	Review hospital data from medical statistician and notifications.
Reduction of mortality due to diarrhoeal diseases.	Mortality rate Case Fatality Rate	Review hospital data from medical statistician/RG data.
Strengthening of diarrhoeal diseases surveillance	Notification rate Investigation rate Percentage of outbreak investigations	Review data at Epidemiological Unit , review at district/MOH level
Reduction of outbreaks due to diarrhoea	Percentage of reduction of outbreaks due to diarrhoea	Review data at Epidemiological Unit, review at districts/MOH level

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Provision of safe drinking water
	Provision of hygenic latrine facility
	IEC activities for diarrhoea related behaviour change
	Promotion of clean environment in food establishment
	Monitoring of water quality/food safety
	Laboratory Surveillance - Monitoring of organism Monitoring of ABST

(14) **Relevant Agencies to be Coordinated: NIL**

(15) **Monitoring & Evaluation:**

1. Who? DGHS/Epidemiologist
2. When? Quarterly

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Standard case management of diarrhoeal diseases implemented in all hospitals	Reduce the mortality rate	Percentage of hospitals implemented the standard case management of diarrhoeal diseases
Training of hospital and PHC staff on prevention and control of diarrhoea	Reduce the morbidity of diarrhoeal diseases Reduce the hospitalization due to diarrhoeal diseases	Percentage of hospital staff training on prevention and control of diarrhoea Percentage of PHC staff training on prevention and control of diarrhoea
Development and printing IEC materials. Social mobilization		
Strengthening of surveillance of diarrhoeal diseases and outbreak investigation	100% notification rate 100% investigation rate 100% investigation of outbreaks	Notification rate by districts. Investigation rate by districts
Laboratory surveillance (monitoring of organism)	100% confirmation of outbreaks of cholera, dysentery and typhoid	
Environmental sanitation	Provide 80% safe drinking water Provide 80% sanitary toilets	
Monitoring and evaluation of the activities		

(1) **Project Title:**	***Communicable Diseases Control:*** Integrated Management of Childhood Illnesses	(2) **Project Number:** 1.4.2.g (3) **Project Priority:**
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**
(5) **Implementing Agencies:**	Teaching hospitals, provincial , district directories	(7) **Project Duration:** **5 years**

Project Summary

Under five population in Sri Lanka is approximately 1.5 million and of them about 6600 die at a rate of 4. 4 / 1000 population under five per year. Apart from that very large number of children suffer from common illness like pneumonia, diarrhea, malaria, measles, and malnutrition causing considerable disease and economic burden. Research evidence show that these illnesses as the cause of more than 70 % of the deaths in children under five years of age.

It has been identified that delay in recognition of severely ill children by parents, caretakers and resulting delay in seeking care leads to death and severe suffering. Further delay occurs due poor skills in the health care workers at primary level of care in recognition of severely ill children. Improving the skills of health care workers at primary care level in recognizing and managing children with above problems and also in educating parents through them are important strategies in addressing these problems.

Integrated management of childhood illnesses (IMCI) is a well-established method of using holistic approach in the management of sick children with one or more problems. IMCI strategies formulate common guidelines for effective management of a sick child deviating from usual diagnosis based approach. Hence it prepares set of guidelines that are presented in charts, which show the sequence of steps to follow at the clinic or the hospital.

This project, aims to adopt this strategy to Sri Lankan context and prepare training modules, IEC materials, and to train relevant health staff. The project will initially focused on the relatively deprived districts where mortality & morbidity rates are high. Approximately 3500 PHC service providers will be involved in this project.

(8) Target Areas & Beneficiaries:

District hospitals, Peripheral units Rural hospitals, Central dispensaries, MOH

Primary health care system in general, first contact health workers in general to the benefit of children and community at large.

(9) Justification:

Larger number of children seeks care at *primary care* level; they are usually being treated for the specific illness with out considering the associated factors that causing the illness. eg. A malnourished child coming with recurrent respiratory tract illness could repeatedly end up in OPD, however only being treated the infection each time but the problem of malnutrition never being addressed. Situation is quite common and has to be addressed to effectively reduce the burden of death and disease. Further lack of standard guidelines in treating sick child and, also sometimes having too many disease specific sets of guidelines confuse health workers in adopting the best strategy. IMCI is the strategy identified in order to rectify most of these problems. Therefore it was decided to adopt IMCI strategy to suit Sri Lankan health set up. This

involves setting up technical advisory committee, setting up a national action plan concerned with IMCI integration of the plan with existing heath system, adaptation and preparation of training manuals, preparation of disease management charts, development of master trainers, and training of health staff at first contact care at curative and preventive sector. As already said the project will be started in NuweraEliya, Ampara, Monaragala, Puththalam, Rathnapura and the districts in the Nothen.n Province (Vaunia, Kilinochi, Maanr & Jappna) and aprroximalty involve 3500 PHC service providers in 151 curative care institutions(DH, PU,RH,CD) , and PHC workers at 73 MOH divisions.

(10) Important Assumptions/Risks/Conditions:

Strategy will be adopted by the paediatric experts and the drug and logistical support will be received.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ To promote the holistic approach in the management of childhood illnesses by enhancing the capacities of the heath workers at primary care level in the integrated management of childhood illnesses and thereby to reduce childhood morbidity and mortality	Case fatality rates Cause specific mortality /morbidity rates in childhood-national/primary care institutions	Periodical survey, HIS
	Rate of readmission of children with common infections at PHC institutions	Periodical survey
	% of primary care health institutions using IMCI approach	Periodical survey
	% of first contact care health workers skilled in IMCI	Periodical survey
	Prevalence of malnutrition	

(12) Project Output/Product:

Output	Indicators	Means of Verification
Establishment of a national level advisory committee on IMCI	Functioning of the advisory committee	Project reports
Creation of policy environment necessary for the IMCI program	Presence of policy and action plans	Audit of the IMCI project
Development of IEC material for IMCI programme	Presence of revised drafts of the training manuals and management protocols	Audit of the IMCI project
Capacity building of the project personnel	Number of project consultants who are trained in IMCI in overseas centres Number of trained master trainers at district level	Project report /audit

Output	Indicators	Means of Verification
	Number of PHC workers trained on IMCI	
Referral systems concerning childhood illnesses strengthened	Criteria concerned with the referrals of children with illnesses are identified Communication links between primary care institutions and higher institutions established Back referral system and criteria for back referrals are identified	Audit of the IMCI project
Information system necessary for the monitoring and evaluation of IMCI is established	Information needed to the proper monitoring and evaluation of the IMCI project identified the information is exchanged and acted upon	Records inspection

(13) Related Projects *(include ongoing projects & projects under the Health Master Plan)*:

Project No.	Project Title
1.1.3	Strengthening of services for mother & child
1.5	Programme for vulnerable populations
1.6	National nutrition programme
1.7	Health promotion programme
5.4	Strengthening of the health information system programme

(14) Relevant Agencies to be Coordinated:

Provincial governments , curative Institutions

(15) Monitoring & Evaluation:

1. Who? Family Health Bureau , MOMCH
2. When? Annual project report, Periodic & ad-hoc survey,
   Pre and post evaluation survey
3. What actions to be taken based on results of monitoring & evaluation?
   Revision of training curriculum, IMCI charts ,
   rectifying the logistic difficulties

(16) Major Activities:

Activities	Expected Results	Process Indicators
Identification of the members of technical advisory committee	Establishment of technical group consists of Community	Presence of the advisory committee

Activities	Expected Results	Process Indicators
& Routine meeting of this group to monitor IMCI activities	health experts, Paediatricians and administrators	
Series of Consultative meetings to identify the policies , contents & methodology to implement the IMCI strategy in Sri Lankan context	policy decisions are identified Components of the IMCI programme are identified in comprehensive manner from the generic IMCI strategy training curriculum prepared	presence of policy documents IMCI programme components determined Curriculum exits
Consultative meeting to formulate drug and equipment policies related to IMCI and dissemination of these policies among relevant bodies	Drug & equipment policy formulated	Existence of policy documents
Workshops to identify prepare IMCI training manuals & Charts	Identify the contents of the of training manuals and charts	Draft copies of the training manuals & charts exits
Printing of training manuals & charts	Adequate amounts of training manuals & IMCI charts are prepared	Manuals and charts exits
Capacity building of project personnel	At least 2 project personnel in central & provincial level are trained in IMCI	number trained
TOT to develop master trainers	Development of a group of master trainers	Existence of trained master groups
Training programs at PHC institutions	PHE workers are trained in IMCI	Existence of trained PHC workers
Consultative meetings to set up appropriate referrals system to facilitate the IMCI	Identification of criteria for referrals & back referrals Building up of linkages between PHC institutions and higher level curative centres	documented criteria functioning referral system
Consultative meeting to identify the relevant components of IMCI MIS system	Identification of elements of IMCI MIS	Documented components if MIS Functioning MIS to monitor & evaluate the MIS
Printing of necessary formats necessary to support the IMCI programme	Preparation of printing materials for MIS	existence of the material
Operational Research on IMCI carried out	at least one baseline survey and 2 other relevant research carried out	number of research projects completed

(1) **Project Title:**	***Communicable Diseases Control:*** Leprosy Control	(2) **Project Number:**	1.4.2.h
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Anti Leprosy Campaign PD/DPD/RE D/THH, Dermatologists	(7) **Project Duration:**	5 years

Project Summary

Leprosy Control/Elimination activities in Sri Lanka were implemented through the vertical programme, Anti Leprosy Campaign (ALC) for many decades. Due to successful implementation of MDT programme since 1983 and Social Marketing Campaign since 1990, Sri Lanka was able to achieve the elimination target set by WHO at national level in 1995, five years ahead of the targeted year. Since then ALC involved in strengthening the infrastructure for the integration of leprosy services into General Health Service.

In 2001, Integration was launched. Experience two years after integration showed that regional authorities have taken the ownership of the programme which is functioning smoothly. With the total integration of leprosy services, ALC aims to reach elimination target in remaining few districts and sustain the achievement made so far by constantly monitoring the programme with regional epidemiologists.

Actions have already been taken to repeal the Leper's ordinance 1901 which made admission to these hospitals compulsory and to delete obsolete clauses with regard to leave for leprosy patients in the establishment code. To sustain the achievement made so far and to maintain the continued surveillance, ALC may need additional funds from the Ministry of Health in the event of two funding agencies leaving the programme

(8) Target Areas & Beneficiaries:

Through entire general health system to patients and the community

(9) Justification:

Leprosy is eliminated at national level as a public health problem with the achievement of elimination target of prevalence less than 1 patients for 10,000 population. However, leprosy is not evenly distributed throughout the country. There still remain 2 districts in the Western and 3 in Eastern provinces with prevalence more than the elimination target.

In low endemic situation, it is essential that patient should have easy access to the diagnosis and treatment facilities. Moreover, the limited staff of vertical campaign will not be able to detect these cases which emerge sporadically from various part of the country. It is not cost effective to run a vertical programme when the number of patients are declining.

Leprosy is a disease which had a high social stigma in the past. With the launching of Social Marketing Campaign, stigma has been reduced to a greater extent. However, existence of special programme with 'specialised staff'' will enhance the stigma among the community. By integrating, 'specialness' of the disease will be removed and as a result, stigma will come down. It also signals the health workers and the community that leprosy is now a normal disease which can be treated at any health institutions.

Existence of legislation and leprosy hospitals which are out dated is a stumbling block to the reduction of stigma.

(10) **Important Assumptions/Risks/Conditions:**

Provisional health authorities will allocate funds and other resources to keep strict surveillance on low-priority, low endemic disease.

Frequent turnover of trained Regional Epidemiologists who are the chief implementers of leprosy elimination programme at regional level.

Unavailability of funds for training, monitoring and IEC activities in the event of foreign funding agencies leaving the programme

Inadequate supervision of the district programme by regional health administrators

Need for on-going training programme for new MOs, Pharmacists, dispensers and other health workers

Close monitoring of the drug distribution by regional health authorities

(11) **Project Objective:**

Objective	Indicators	Means of Verification
to fully integrate the all leprosy elimination activities into general health service with simultaneously achieving the elimination target in remaining 5 districts. To maintain strict surveillance with constant monitoring and evaluation both by internal and external experts	Prevalence New case detection rate Child rate Multi-bacillary rate Deformity rate	Monthly/quarterly/Annual reports on epidemiological indicators
■	Timeliness and completeness of returns	Software programme on leprosy management information system
		Individual patients forms, MDT returns, Deformity registers maintained at district level
	Availability of drugs	Annual drug estimate books Periodical survey
	Number of sentinel centres	Special epidemiological reports

	Number of Medical Officers, and other categories trained	Reports of field visits
	Number of health institutions with adequate supply of MDT	Reports of field visits

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Medical Officers, Assistant medical practitioners, pharmacists and dispensers (Health Care Providers) gained skills in diagnosing and managing leprosy patients	Number trained and number to be trained	Records at DPD Office
Patients with visible deformities are provided with essential deformity care and rehabilitation	Number of physiotherapist trained Availability of shoes, splints and ulcer care kits	Reports at DPD office Deformity register
MDT is available in all health institutions of the country	Number with MDT	Software programme MDT return Drug estimate books
MOH/DDHS gained skills in assessing leprosy situation in their areas	Number trained	Records at DPD office Leprosy register at MOH/DDHS offices
General Public is aware of the true facts of leprosy	Number of community awareness programme held Number of posters, leaflets, booklets distributed Number of exhibition held, participated	Records at DPD office
Programme is constantly monitored both at national and district level	Number of REs trained on epidemiological assessment Review meetings at district and national level Availability of software programme Trained in using the computer programme Number of sentinel areas providing specific information	Reports at DPD office
Programme is periodically evaluated by internal and external experts	Number of district programme evaluated annually by internal experts External evaluation of the national programme by WHO experts	
Obsolete clauses /legislation	Establishment code sans	

removed	clauses related to leprosy	

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Capacity building
	Leprosy management information system
	MDT monitoring
	Health education
	Deformity care programme

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health, Provincial Government, Department of Social Services, Department of Education

(15) **Monitoring & Evaluation:**

1. Who? Anti Leprosy Campaign, Provincial Health Administrators, Dermatologists
2. When? Review meetings, annual reports, periodical and Ad-hoc surveys,

   Sentinel reports
3. What actions to be taken based on results of monitoring & evaluation?

   Revision of training curriculum

   Revision of regulations and guidelines

   Improve provision of service

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Training programmes for new /untrained MOs and AMPs in all districts	Health Care Providers in the health institutions with skills to diagnose and manage Leprosy	Number of trained Mos/AMPs in the district
MDT drugs are distributed through the normal channel of GHS (MSD- Regional Drug stores-Districts)	Uninterrupted supply of leprosy drugs to health institutions	Number of institution with MDT
Close monitoring of leprosy situation in all districts	Ability to asses the leprosy situation with a view of planning further activities	Availability of periodical reports
Awareness programmes for community – low endemic areas, Northern province and high endemic areas	Voluntary reporting increased Stigma reduced	Area specific Plans of action
Comprehensive care for patients with deformity ensured	Trained physiotherapists / PHIs Patients on self care	Deformity register

(1) **Project Title:**	***Communicable Diseases Control:*** Area Specific Disease Control 1) Leptospirosis Prevention & Control	(2) **Project Number:**	1.4.2.i.1)
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Epidemiology Unit Provincial Director of Health Services Deputy Provincial Director of Health Services Divisional Director of Health Services Curative Care Institutions Respective other government Institutions	(7) **Project Duration:**	10 years

Project Summary

Leptospirosis is emerging in Sri Lanka and has been identified as a potential public health issue in the country. Leptospirosis is reported in both rural and urban parts in the country and case fatality rate is increasing. Therefore it is important to focus on following activities to control and prevent Leptospirosis in the country:

- Assess burden of Leptospirosis in the country
- Establish a National Programme on control & prevention of Leptospirosis in Sri Lanka
- Strengthening laboratory and epidemiologiacl surveillance of Leptospirosis
- Improved facilities for case detection and patient care management at the Medical institutions
- Strengthening veterinary surveillance activities, in order to prevent and control Leptospirosis
- Awareness campaign emphasizing disease transmission, prevention, control, and early referrals to minimized complications
- Chemo prophylaxis for person at a higher risk of leptospirosis
- Strengthened social mobilization programme in leptospirosis control and prevention activities

(8) Target Areas & Beneficiaries:

Target Areas: Divisional Director of Health Services (DDHS) / Medical Officer of Health

Beneficiaries: Community in respective DDHS areas

(9) Justification

Leptospirosis one of the notifiable diseases in Sri Lanka. It is an endemic in many parts of Sri Lanka, and occurs throughout the year. The actual incidence of Leptospirosis is likely to be more than the hospital admission figures, as a large number of patients with mild form of the disease do not seek treatment at all or are being treated by private practitioners, therefore not reported to the epidemiologists. A large number of undiagnosed patients treated at the OPD is not reported to the Epidemiologist, as OPD reporting is poor or due to misdiagnosis.

During the last decade, there has been an increase in the number of leptospirosis cases reported from 167 cases (0.96/100,000) in 1991 to 1399 (7.46/100,00) in 2001. This increase may be due to the occurrence of outbreaks of leptospirosis in some districts and also due to the improved case detection. However, it is noticed that there was a lack of notification from some institutions.

In the year 2002, 992 cases (5.2 per 100,000) of Leptospirosis were notified to the Epidemiology Unit.

Most of the affected were in age of 24-45 years indicating possible increased risk among working and physically activated groups. Paddy cultivation takes place in most of these endemic areas and the peak incidence is associated with the paddy harvesting seasons. During this period, there is an increase in the rodent population in and around the fields. Due to population migration pattern and urbanization, there is an increase in the rodent population in and around the urban areas too.

There is no national, ongoing prevention and control programms in leptospirosis and only ad-hoc programs at the divisional level are carried out by the interested Public Health Medical Officers. This needs to be addressed by all level of Health Authorities. It is also important to highlight, that leptospirosis control and prevention programme should necessarily to be carried out with the active support and participation of other sectors.

(10) Important Assumptions/Risks/Conditions:

Assumption:

1. Government commitment and policy to prevent and control of Leptospirosis.
2. Commitment by the Department of Health with the Active Participation of other sectors, such as Ministry of Agriculture, Local government to control and prevent Leptospirosis, as a priority need in public health.
3. Public need to have a active programme on control and prevention of Leptospirosis and their support and active participation into the programme.

Risk / Conditions:

Increased occupation hazard need a special consideration.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ Prevention and Control of Leptospirosis in Sri Lanka	Morbidity of Leptospirosis	Notification data, Review of Medical statistician and Institution records / community survey
	Mortality of Leptospirosis	Survey: review of Medical statistician and Institution records / community survey, Registrar General Office

(12) Project Output/Product:

Output	Indicators	Means of Verification
Reduction of Leptospirosis morbidity	- Hospital admission rate of Leptospirosis - MOH notifications - No. of Outbreaks of Leptospirosis	Review data at Epidemiology Unit and Medical Statistician records

Output	Indicators	Means of Verification
Reduction of Leptospirosis Mortality and improved patient care managment	Case Fatality Rate of Leptospirosis (at the Government Institutions)	Review data Medical Statistician and Register General records
Improved patient care management facilities at the government institutions	- Number of institutions with all basic facilities for managing a leptospirosis patient - Case Fatality Rate of Leptospirosis (at the Government Institutions)	- IMMR - Review data Medical Statistician and Register General records - Annual Health Bulletin / DGHS Annual Report
Strengthening Leptospirosis Surveillance	- Notification rate of Leptospirosis - Timeliness notification - Timeliness and completeness of special investigations - Notification of Leptospirosis from private sector	Review data at Epidemiology Unit and Medical Statistician records
Strengthened laboratory Surveillance	- Number of functioning Provincial / district laboratories (or Hospitals) with facility to carry out Leptospirosis laboratory investigations - % of laboratory confirmed cases - % of Timeliness and completeness of laboratory reports	Hospital and laboratory based survey
Chemo prophylaxis programme for people at a higher risk	- Number of persons with chemo prophylaxis and their morbidity rate - Number of institution with uninterrupted chemo prophylaxis supplies - % of budget allocation by DPDHS for chemo prophylaxis of leptospirosis	- DDHS data - IMMR
Improved Public awareness	- Number of educational programme conducted - Number of people aware on leptospirosis	- DDHS data - Community survey
Strengthened social mobilization programme (SMP)	- Number DDHS with established SMB	
Enhanced veterinary	- Number of veterinary	- Provincial / district

Output	Indicators	Means of Verification
surveillance activities	reports available in leptospirosis surveillance	Veterinary records

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Strengthening Leptospirosis Surveillance Network
	Leptospirosis Burden Study
	Provision of laboratory facility at the Provincial / district level (up to Base Hospital level) for Leptospirosis laboratory investigations
	Awareness programme
	Established Chemo prophylaxis programme for high risk groups

(14) **Relevant Agencies to be Coordinated:**

Ministry of Agriculture & Livestocks , Ministry of Local Government and Public Administration, Dept. of Irrigation, All Provincial councils and other related Ministries.

(15) **Monitoring & Evaluation:**

1. Who? Director General of Health Services and Epidemiology Unit
2. When? Quarterly
3. What actions to be taken based on results of monitoring & evaluation?
    - Continues reviews with Provincial / District / Divisional Health Authorities
    - Periodical reviews with other relevant agencies to be coordinated

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Establishing National Task Force / Programme for Control and Prevention of Leptospirosis	- Policy formulation / implementation - National level coordination - Monitoring and evaluation of all major activities at national level	-Regular quarterly meeting
Leptospirosis Burden study	- To estimate morbidity & mortality - To identify high risk groups and risk factors - Cost analysis for patient management at the	-Final report to be made available before end of year 2005

Activities	Expected Results	Process Indicators
	government medical institutions	
Awareness Programme	- To create awareness among people at risk on disease, risk factors, need of seeking early medical care - To aware health staff (including the private sector) of the burden of disease , importance of early diagnosis, referrals and proper management of the patients	_ Number of programmes conducted
Provision of laboratory facility at the Provincial / District level (at Base Hospitals) for Leptospirosis laboratory investigations	Strengthened laboratory Surveillance	- laboratory facilities for Leptospirosis at the each Base Hospital by 2010 - > 50% reported cases are confirmed by laboratory tests by 2010 - 100% Timeliness and completeness of laboratory reports by 2010
Un-interruped availability of supply for Chemoprophylaxis at MOH level	People at higher risk are received chemo prophylaxis	Coverage of chemo prophylaxis among people at high risk
Strengthening Leptospirosis Surveillance	- Improved notification of Leptospirosis (both State & Private sector) - Investigation of all VH outbreaks - Early warning - Outbreak prediction - Survey on animal reservoir	- % Notification rate - Timeliness & completeness - % of outbreaks investigated - % of outbreaks predicted - % seeking early treatment

(1) **Project Title:**	***Communicable Diseases Control : Area Specific Diseases:*** 2) Japanese Encephalitis Prevention and Control	(2) **Project Number:**	1.4.2i.2)
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/`HS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Epidemiological Unit Provincial Director of Health Services Deputy Provincial Director of Health Services Medical Officer of Health	(7) **Project Duration:**	10 years

Project Summary

Sri Lanka adopted immunization against J.E. as the main strategy, for prevention and control of the disease in high-risk areas in 1988. The target population is children between the ages of 1-10 years. It is important to strengthen the existing national programme on prevention & control of Japanese Encephalitis (J.E.) further with following components;

- Strengthen the surveillance of Japanese Encephalitis
- Improve the coverage and quality of immunization programme
- Improve laboratory surveillance

(8) Target Areas & Beneficiaries:

Medical Officers of Health in endemic districts

(9) Justification:

First major outbreak of Japanese Encephalitis was in 1985/1986, affecting mainly 2 districts of the country. Since then Japanese Encephalitis was endemic in number of districts. In the dry zone, the disease was reported mainly from areas where paddy cultivation was their major occupation, while in the wet zone it was reported from the areas where pig breeding and coir products are made as cottage industries. The disease occurs throughout the year, and shows a marked increase with the North East monsoonal rains (November – February).

The incidence rate of J.E. 0.4/100,000 population in year 2001 with a case fatality rate of 13.6%.

(10) Important Assumptions/Risks/Conditions:

NIL

(11) Project Objective:

Objective	Indicators	Means of Verification
■ Prevention and Control of Japanese Encephalitis in Sri Lanka	Mortality due to J.E.	Notification data, data from Medical Statistician and laboratory results

Objective	Indicators	Means of Verification
	Morbidity due to J.E.	Notification data, data from Medical Statistician and laboratory results

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Immunization of all children under 10 yrs. against Japanese Encephalitis	At least 95% all island coverage.	J.E. immunization returns.
2. Reduction of morbidity due to J.E.	Morbidity rate due to J.E.	Indoor morbidity/mortality returns
3. Reduction of mortality due to J.E.	Mortality rate and case fatality rate due to J.E.	Indoor morbidity/mortality returns
4. Notification of all encephalitis cases	100% notification of J.E. cases	Notification Registers
5. Regular vector surveillance in high risk areas	Larval indices	Vector surveillance returns
6. Laboratory confirmation of all J.E. cases	100% confirmation of all J.E. cases	Laboratory reports
7. Immunization of pigs in high risk areas	At least 90% coverage.	Returns from Veterinary Department

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	■ JE Vaccination Programme ■ Strengthening clinical diagnosis and disease management plan ■ Strengthening epidemiological surveillance ■ Strengthening vector surveillance activities ■ Strengthening laboratory diagnosis ■ Strengthening of the pig immunization programme

(14) **Relevant Agencies to be Coordinated:**

Medical Research Institute,

Provincial Directors of Health Services,

Deputy Provincial Directors of Health Services

(15) **Monitoring & Evaluation:**

1. Who? DGHS/Epidemiological Unit/PDHS/DPDHS/RE
2. When? Quarterly/Yearly
3. What actions to be taken based on results of monitoring & evaluation?

   Regular consultative meetings.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
J.E. immunization programme to be expanded to other provinces	Immunization of all children – 10 years in age.	95% coverage
Injection safety programme	Use AD syringes for J.E. immunization Provide safety boxes	100% usage of AD syringes by 2005
Strengthening JE surveillance	Notification of all encephalitis cases	100% notification of all encephalitis cases
Surveillance of AEFI due to JE immunization	100% reporting of AEFI due to JE immunization	Regular reviews
Outbreak investigation and response		Regular reviews
Vector surveillance	Vector surveillance activities in high risk areas quarterly.	Larval surveys
Laboratory surveillance	Laboratory confirmation of all cases	No. of investigations done.
Immunization of pigs	90% coverage in high risk areas	No. of high risk areas covered

(1) Project Title:	***Communicable Diseases Control:*** Emerging & Re-emerging Diseases (e.g. SARS, Ebola & Nipa virus) Control - Strengthening Surveillance System	**(2) Project Number:**	1.4.2.j
		(3) Project Priority:	
(4) Focal Point:	DDG/PHS	**(6) Starting Fiscal Year:**	
(5) Implementing Agencies:	DDG [PHS] Epidemiological unit Provincial & Deputy Provincial Directors Medical Officers of Health All curative care institutions	**(7) Project Duration:**	

Project Summary

Disease surveillance system in Sri Lanka has four major sources of information i.e. the data is collected from

1. Indoor morbidity & Mortality reports
2. Notification system
3. Vertical campaigns
4. Medical Research Institute (laboratory data)
5. Registrar General (Mortality data)

All the Hospitals in the Government Network where inpatient facilities are available send their Indoor morbidity & Mortality data quarterly to the Medical statistician.
According to an official notifiable list of diseases the communicable disease are notified to the respective Medical Officer of Health. There are 260 such MOOH in the country.
The seven vertical disease control programmes i.e. AMC, AFC, ALC, RDCP, STD/AIDS, Veterinary Service & Cancer control programmes collect their data using their own mechanisms.
The laboratory data is derived through the information collected when various specimens are received at the MRI and the information is available on request.
There is no standard system to collect data from the OPD of Government hospitals, the private sector including their laboratories, from the laboratories other than the MRI and the other systems of Medicine such as Ayurvedha. This project is aming at rectifying some of the problems in the existing system and try & improves further.

(8) **Target Areas & Beneficiaries:** All island

(9) **Justification:**

The weaknesses in the existing surveillance system can be corrected with better management and effective utilization of available resources. It only needs a few adjustments and careful allocation of resources for priority needs.

All reporting sub-systems are incomplete and may be not very accurate and need revisions.

The data is routinely analysed at the central level but not at other levels and not utilized for action at the peripheral levels.

The feed back is late and not reach all levels:

Annual Health Bulletin: takes more than one year to be published; Access to unpublished data is very difficult due to logistic issues

WER also delayed and can not be utilized in emergencies; not reach the data providers; Cost of printing is high; not in local languages

Data from vertical campaigns also not accessible for many users

The Laboratory data is limited and delay in feedback

Contribution of Infectious Diseases Hospital (IDH) in disease surveillance is minimum; Infection control, Intensive care and laboratory facilities at IDH is highly un satisfactory

Surveillance for NCD is not existing: This has to be integrated into the present surveillance system, with necessary adjustments required for NCD surveillance.

Syndrome based surveillance (eg; Fever Surveillance) need to be established

(10) Important Assumptions/Risks/Conditions:

The Government commitment in controlling the endemic diseases as well as newly emerging and re-emerging diseases will not change

Public Health Services will be maintained by the Ministry of Health with same enthusiasm

The public demand and the media alertness also remain same

(11) Project Objective:

Objective	Indicators	Means of Verification
■ Strengthening of the Disease surveillance system in Sri Lanka	Morbidity and mortality of diseases under the surveillance	IMMR, Registrar General Data, Epid Unit data
	No major disease outbreaks (DO)	Reviewing available sources of data; Opinion surveys

(12) Project Output/Product:

Output	Indicators	Means of Verification
Reduction of Communicable diseases; No major outbreaks	Proportion of OB reported Proportion of OB investigated timely & action taken Proportion of districts having functioning RRT	Opinion surveys
Establishing & coordinated surveillance system for NCD: Networking with all University & Private sector institutions	Availability of NCD Registries	Regular reviews
Strengthened & coordinated laboratory surveillance system; Networking with all University & Private sector	Proportion of labs doing the confirmation tests for common notifiable diseases Proportion of lab-confirmed	Regular reviews

Output	Indicators	Means of Verification
laboratories	Notifiable diseases	
Strengthened & coordinated disease surveillance mechanism for Out Patient Department in all hospitals	Rate of notification from hospitals OPD	Regular reviews
Strengthened & coordinated disease surveillance mechanism for private sector & other systems of medicine	Rate of notification from hospitals of private sector & other systems of medicine	Regular reviews
Strengthened & coordinated disease surveillance mechanism for IDH, Angoda;	- Rate of notification from IDH - Proportion of patients with specific diseases treated at the IDH	
Information on disease surveillance is readily available	Proportion of hospitals Sending completed IMMR; their completeness & timeliness Rate of notification it's completeness accuracy and timeliness Proportion of districts publishing their own annual / quarterly bulletins & feedbacks to peripheral staff Availability of Annual health bulletin & WER in time at all levels in both local languages	Regular reviews

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Establishment of a printing press at the National level which can be utilized by all technical institutions
	Provision of Technical & logistic supports to the Provincial & Base Hospital laboratories
	Improvement of Infection Control facilities and Intensive care management facilities at IDH, Angoda
	Establishment of Isolation Wards in all major hospitals
	Computerization of data management at district level & Networking with the centre & also with similar laboratory network
	Collaborative research projects with Local & International agencies

(14) **Relevant Agencies to be Coordinated:**

Epidemiological Unit

MRI

All Vertical campaigns

Provincial & District health Offices

(15) **Monitoring & Evaluation:**

1. Who? DGHS & Epidemiological Unit
2. When? Quarterly when relevant & annually
3. What actions to be taken based on results of monitoring & evaluation?

   Re-planning & continues monitoring & evaluation

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Continuation of Regular surveillance reviews at National level with REE	The REE will effectively utilized the data collected in their own regions.	Number of reviews conducted
Regular surveillance reviews at district level with all stakeholders	Data generated through different sources would be utilized at the regional and peripheral levels.	Number of reviews conducted
Continuation of production of WER, Annual & Quarterly Bulletin timely & supply of them in both local languages	These feed back reports when become more readable, useful will keep the officers who collect data and transfer motivated.	Number of high quality reports provided each year
Development of a mechanism to involve the Private sector in the process of surveillance	Data available would be more complete	Number of reporting institutions sending notification
Identification of Improvements urgently need by Provincial & District hospital laboratories to provide essential services in relation to disease confirmation	The data would be more accurate	Proportion of confirmed cases reported
Identification of Improvements urgently need by the Infectious disease hospital at Angoda	Surveillance of data pertaining to highly infectious or fatal diseases such as SARS will be strengthened.	Proportion of confirmed cases reported

(1) **Project Title:**	***Communicable Diseases Control :*** Strengthening of Disease Surveillance and Management	(2) **Project Number:** 1.4.2k (3) **Project Priority:**
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**
(5) **Implementing Agencies:**	Director General of Health services Provincial & District Health services	(7) **Project Duration:**

Project Summary

The master plan includes the present activities undertaken by the Epidemiology Unit as well as the future plans. This plan will reiterate the present presents and plans to undertake new areas of responsibilities consolidating it's present activities as a technical Institution in the Ministry of Health. By re-organizing the Unit will provide the necessary technical guidance to the Provincial As well as the National health Directorate. While strengthening it's traditional activities the present plan will create a new image to the Unit & the quality of services it provide will greatly enhance the health of the Nation. Once the plan is implemented primarily the Unit will function as

a. Surveillance centre for Communicable and Non-communicable diseases & other health problems
b. Information Centre for disease control & prevention
c. Research Center for Applied Epidemiology
d. Training centre for Field epidemiology

(8) Target Areas & Beneficiaries:

Public

Medical Profession including Health administrators Those in the Private Sector & PG trainees

International & Local NGO

Researchers

(9) Justification:

During the last more than 50 years of existence the Epidemiology Unit has mainly concentrated on the control & prevention of Communicable diseases in the country. It had been the Centre for Epidemiological services of the Ministry of Health and has undertaken mainly service functions. In today's context it can no longer continue without linking its services to applied research which is an integral part of the discipline of Epidemiology. The present plan will address these issues and expand the scope of it's services and will contribute the development of health services in the Country.

(10) Important Assumptions/Risks/Conditions:

The Govt. of Sri Lanka will continue it's policy of free public health services.

The International donor organizations such as the W.H.O., Unicef, JICA will continue to support the Govt. in providing the Health services.

The Cost of services

(11) Project Objective:

Objective	Indicators	Means of Verification
Strengthening of the Epidemiology Unit to function as a Centre of excellence for : ■ Training on field epidemiology ■ Public Health surveillance & response ■ An information centre on evidence related to disease control & prevention ▪ Research in applied Epidemilology	Morbidity Rates	Review of Morbidity & Mortality data
	Mortality Rates & CFR	
	No of Outbreaks	Perusal Outbreak Information available & the reports
	Availability of information on disease incidence & prevalence & Risk factor prevalence	Review of information available
	Improved quality of immunisation services in Sri Lanka; availability of certificates of eradication or Elimination of target diseases	Client satisfaction; opinion surveys, Certification of eradication & Elimination of target diseases
	Extent of the external collaboration the Unit received	
	Completeness & Timeliness of the reports the Unit received & the frequency & quality of feed back reports it produced	Review of reports

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Strengthened Integrated Multi-disease surveillance system with functioning Rapid response Teams	Morbidity, Mortality & CFR are reduced for the other target disease	No outbreaks become an epidemic No outbreak
Field Epidemiology Training Centre established	No of trainers in Epidemiology trained in the centre	Review of records Performance appraisal
Information Centre on Disease Control & Prevention established	Client Satisfaction levels	Readily availability of disease surveillance data at any given point of time
Links with External & Internal Institutes of Epidemiology established & applied epidemiology research will be carried out	No of collaborative research activities undertaken by the unit with external groups	No. of research studies carried out/undertaken
Strong Links with External & Internal laboratories established & effective Laboratory surveillance system is available	No of collaborative activities undertaken by the unit	Proportion of confirmed cases of target diseases
A strong surveillance system	Morbidity, Mortality & CFR	Review of records, data

Output	Indicators	Means of Verification
for NCD is developed	information on NCD are readily available.	
Timely quality WER QB are available & disseminated to all stake holders	No of copies produced according to the schedule & quality of the products	Review of records, administrative reports
International & Local donors will have high regards	Amount of external resources generated	Review of data, administrative reports
Effective AEFI surveillance mechanism established	Quantity of AEFI reported & the quality of information	Review of data collection system, surveys
Effective intersect-oral coordination mechanism for disease control is established	Active involvement of other stakeholders in disease control	Evidence of study responsibilities for other stakeholders

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	NIL

(14) **Relevant Agencies to be Coordinated:**

1. DDG (PHS)
2. Epidemiological Unit
3. MRI
4. All various campuses
5. Provincial and district health officials

(15) **Monitoring & Evaluation:**

1. Who? DGHS, Epidemiologist
2. When? Quarterly and annually
3. What actions to be taken based on results of monitoring & evaluation?

   Re-planning, Continuous monitoring and evaluation

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Quarterly Consultative meetings with multi disciplinary specialists	Regular consultations	No. of consultations
Timely convening of Rapid Response Teams	Timely interventions No Epidemics	Minutes of the meetings

Activities	Expected Results	Process Indicators
Procurement and supply of infrastructure facilities	Fully functional field epidemiology training centre	Completeness/availability of resources
Establishment of “Media Cell” for the Epidemiological Unit	Self sufficient media cell	Number of media releases
Communication and development of partnerships with national and international research institutions	Professional/resource collaboration with national and international institutions	No. of institutions in actual collaboration
Communication and development of partnerships with national and international laboratories.	Professional/resource collaboration with national and international institutions	No. of laboratories in actual collaboration
Carry out applied Epidemiology research	Successful completion of projects.	No. of research activities undertaken
Consultative meetings with NCD stakeholders	Establishment of NCD surveillance system	No. of NCD under surveillance
Printing and distribution of Weekly Epidemiological Report and Quarterly Epidemiological Bulletin	Printing and distribution of WER and QEB on time	Lag time in completing the information cycle
Consultative meetings and reviews with stakeholders in AEFI	Effective AEFI surveillance	Numbers and areas in reporting

1.5 PROGRAMME FOR VULNERABLE POPULATIONS

(1) **Project Title:**	Estate Health	(2) **Project Number:**	1.5.1
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS assisted by D/E&UH	(6) **Starting Fiscal Year:**	Very High
(5) **Implementing Agencies:**	Central Ministry of Health Provincial Ministry of Health Ministry of Plantation Industries Community development Ministry Plantation Human Development Trust	(7) **Project Duration:**	10 Years

Project Summary

The Health Ministry policy is that the health services in the Estate Sector should be integrated with other state health care services and the disparity that exists between the plantation sector and the other sectors of the country in provision of basic health services and the social behaviors should be reduced.
The project is to bring the health standards of the estate sector to the national level enjoyed by the rest of the population with involvement of Provincial Health authorities and Ministry of Community Development by doing need assessment, analysis, and developing and implementing the required plan with due consideration to accessibility, availability and the quality of the care and their living conditions.
The population benefited will not only of the larger estates, which are managed by private companies and monitored by PHDT but of the smallholdings, which are not monitored by anyone.
The major outputs will include improved quality and accessibility of curative care, development of preventive services, improvement of the health seeking behavior and utilization of health services, empowering the women by community participation also developing a mechanism for collaboration and coordination between estate management and estate health sector, promotion of health research and its applications specially related to social issues in the estate sector and establishment of the management information system which is used in other parts of the country.

(8) **Target Areas & Beneficiaries:**

This will include the total Plantation Population working in tea, rubber, and coconut estates in Central, Uva, Sabaragamuwa, Southern, Western and North Western Provinces.

(9) **Justification:**

Provision of Health services to all citizens including the plantation workers is the responsibility of the Ministry of Health. Provincial ministries of Health are responsible for the provision and supervision of health services in their respective areas. There should be equity and no duplication of service provision. Occupational health of plantation workers should be looked into in accordance with ILO Conventions.

The plantation industry has several unique features such as remote location, difficult and inaccessible terrain, a large and a predominantly female work force, significant resident population, with scattered housing units. The poor living conditions such as their line houses,

poor water and sanitary facilities are some of factors influencing the health status of these people.

Also their health seeking behaviour, health related behaviour like nutrition, alcohol consumption, gender issues and availability and use of the sanitary facilities, and resource availability makes it different from the rest of the country.

Health status of the plantation population is below the General Population. The morbidity and morality are reported to be higher than the rest of the country specially the Maternal Mortality Rate and infant Mortality rate. During 2000, 28 maternal deaths were reported of which 15 were due to direct obstetric causes, 7 to indirect causes and 6 to unrelated causes. Of this 15 direct causes 7 had delivered in the line rooms without trained assistance and the cause of death is due to haemorrhage. This shows the importance of registered midwife at delivery, availability of timely transport and better access to essential emergency obstetric care by upgrading selected hospitals to provide these services. The infant mortality rate is 19.1 per 1000 live births with the national average of 15.4 in 1998 and neonatal mortality rate is 13.4 per 1000 live births and still birth rate is 23.7 per 1000 live births.

Recently with the Ministry of Health policy of integrating the estate health services with the other state health care service it was decided to take over 50 estate hospitals and out of that now 21 hospitals have been taken over.

The workers and their families tend to be dependent on the management of the companies for health care, which was their practice from the colonial period. Treatment seeking is delayed due to the decision making process which involve the family, the community and the management who has to provide the transport to the nearest health facility. The people living in the small individual estates are most neglected.

(10) Important Assumptions/Risks/Conditions:

The above special characteristics of the plantation sector, necessitates an integrated approach in providing the health care needs of the sector. It will include estate management and estate health personnel, government as being responsible for overall health care and workers and dependants as beneficiaries of health services and facilities. The implementation of the health policy should be through the Provincial Health Ministries with the coordination of Central Health Ministry and Ministry of Plantation Industries and their authorised representatives. In the plantation set up health care cannot be seen in isolation. Improvement to housing, water supply and sanitation and also improved literacy and health awareness should form an overall package to improve their health status. Provision of health services to these small holdings should be the responsibility of the appropriate provincial health authority.

(11) Project Objective:

Objective	Indicators	Means of Verification
To improve the health status of the plantation community	Output Indicators – nutritional status of under 5	HIS, Periodic surveys
	Morbidity Indicators IMR,MMR	

Objective	Indicators	Means of Verification
	Utilization Indicators - % of ANC mothers registration	Periodic surveys

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Improved accessibility and use of the curative health care facilities particularly essential obstetric and paediatric care by plan and upgrade the selected hospitals	No. Hospital upgraded Hospital utilization rates	Institutional (Hospital) records, and periodic surveys
2. Developed preventive health care services by assisting in implementation of all national health services and programmes.	% of ANC care, No of planned health care programme implemented in the plantation sector % of people who accessible to selected health care programme % of using the sanitary facilities available immunization coverage Output indicators.	Periodic surveys records and returns
3. Improved empowered of women by community participation.	No. of programme in which women participated in the decision making process Reduction in Domestic violence.	Survey
4. Improved health seeking behaviour and utilisation of health services using behaviour change communication	Hospital utilisation rates, Prevalence of selected health seeking behaviours.	Hospital Statistics Behavioural surveillance
5. A mechanism established for collaboration and coordination between the Estate sector of Health services and Estate Management.	Establishment of coordinating committee	Records and retune
6. Provision of services of appropriately and qualified, health staff to maintain the Estate health services (Human resource development).	Establishment of qualified Staff employed.	Return and records data
7. Health research and its application promoted with special reference to health concerns and related social issues in the Estate sector.	Number of health system research conducted	Returns and records
8. Occupational safety standards maintained in field and factory by the estate	No of estates and factories maintained occupational standards	Retunes and records

Output	Indicators	Means of Verification
management.		
9. Establishment of Management Information System of the Estate sector.	Management and information system	Records

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	MCH Projects
	EPI programme
	National Nutrition Programme

(14) **Relevant Agencies to be Coordinated:**

NIL

(15) **Monitoring & Evaluation:**

1. Who? National Health Development Committee, MDPU, PDHS, DPDHS, RE, MO/MCH
2. When? Monthly, Quarterly, Annually

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Doing a situation analysis of the health services received by the plantation population.	Base line information of availability of health care facilities, staff position, available services and pattern of use.	
2. Preparing a policy document and action plan for estate health.	Estate health action plan formulated.	
3. Creating awareness of the Estate Health Policy and implementation of action Plan.	Estate health plan implemented by provincial authorities.	
4. Strengthening the Primary Health Care Services by Establishing additional MOH units according to the national standard.	Primary health care services strengthened by Standard Health Units established with clinic facilities, vehicle and living accommodation for the staff.	
5. Providing the ANC, Natal, post natal and family planning services.	ANC, WBC, and family planning clinics conducted	
6. Establishing an effective referral system between Primary care institution and other health care institutions.	Effective referral system established	
7. Provision of Trained Qualified staff for the estate health services. 8. Providing the necessary facilities	Cadre filled with qualified staff Hospitals are provided with necessary	

Activities	Expected Results	Process Indicators
for the curative care services by up grading selected hospitals.	equipments	
9. Conducting monthly medical clinics or arrange a system by which a qualified mo to see the problematic patients	Specialist services provided to the estate population	
10. Creating awareness among women about women empowerment conducting programmes to reduce domestic violence.	Women empowered for decision making	
11. Creating awareness about healthy way of eating and prevention of anaemia.		
12. Conducting tobacco and alcohol prevention programme in the estates.		
13. Providing oral health care by establishing new dental clinics and upgrading exciting clinics.		
14. Strengthening the cancer control programme in the estate sector		

(1) **Project Title:**	Health of Elders	(2) **Project Number:**	1.5.2
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	1st year 2004
(5) **Implementing Agencies:**	• Ministry of Health (YEDD / HEB / NCD / NIHS / Population Division / PDHS, DPDHS / Health Institutions / MOH & field staff) • Ministry of Social Services • Dept. of Social Services • Ministry of Education / Dept. of Education / NIE • Ministry of Youth Affairs & Sports, • NYSC • Ministry of Information & Media • Department of Labour • Women's bureau • Ministry of justiceUniversitiesHelpAge, Sarvodaya, Mahila Samiti & Other related NGO / CBO	(7) **Project Duration:**	10 years.

Project Summary

The division of Youth elderly, disabled and displaced persons of the Ministry of Health, in collaboration with other relevant divisions of the Ministry of Health, other governmental, non governmental and private agencies working for elders aims to improve the well being of elders and to prepare the future generation of elders for a more healthy active and productive life.

(8) **Target Areas & Beneficiaries:**

Primary Target GROUP;

- Elders & family members of elders
- Employers / employees
- Youth and adolescents (school and out of school)
- University students & Students of technical colleges
- Health volunteers

Secondary Target Group;

- Politicians
- Policy makers
- Administrators
- Members of the Provincial Councils / Pradeshiya Saba and Municipalities
- Community leaders
- Members of the NGO/ CBO
- Health personnel
- Teachers
- Media personal

(9) **Justifications:**

At present the elderly population (over sixty years) in Sri Lanka amounts to nearly two million or 10% of the total population.

Among them a large number suffer from physical mental and social health problems. In the survey conducted in year 2001 by the Unit of D/YEDD, Ministry of Health to assess the physical mental and social health needs among 162,618 elderly scattered among 50 MOH areas in 18 districts, 70% of them revealed that they suffer from one or more chronic illness. It is estimated that this percentage would have increased to about 90% - 95% if they were subjected to screening. Most of them being non-communicable chronic diseases like high blood pressure, diabetes, heart disease, joint pains, cancer mental illnesses etc

Most elders in our society lack adequate knowledge regarding the type of illnesses they are likely to suffer during old age. Moreover, most of them consider aches and pains of joints and weakness of limbs, impairment of vision and hearing, as the part and parcel of the normal ageing process or their "fate". As such this would not only make them suffer in silence, but also make them delay in taking treatment, which result in gradual deterioration of the quality of life. Moreover, they hardly persuade their children to take them to hospital as they feel that they have other priorities.

Most hospitals in our country do not have a system for giving preference to elders at the OPD or dispensary; which means they have to wait in the same long queue as others. For the elders who usually seem to take several kinds of medicine for the number of illnesses they suffer from, it is unlikely that they would be taking the drugs properly if the Pharmacist does not spend enough time in explaining.

Within the Preventive Health Care Programame screening clinics are not held for elderly to diagnose the common illnesses early. As such the complications would set in due to delay in taking treatment. A patient with undetected high blood pressure with hardly any symptom will suddenly end up in the hospital with a stroke or die before admission.

For most of the elders who suffer from chronic illnesses they need life long treatment. As a result the number of patients attending the specialist clinics to get the monthly quota of drugs keeps on increasing in spite of the fact at there are separate clinics held for High blood pressure, diabetics, heart disease, joint pains, cancer, mental illness etc in most major hospitals. Some of the patients travel a long distance bypassing a number of hospitals to attend these clinics (sometimes only to get the blood pressure checked and collect the monthly medicine).

With admission to hospital the duration of stay in hospital would be quite long as the convalescence is prolonged. It is shown that the number of beds in the hospital wards that are being occupied by elderly keeps on increasing day by day. Similarly some patients who recover from acute illnesses, may still remain in the hospital for additional number of days after they are discharged due to reasons such as reluctance of their relatives too take them home as they lack the basic facilities at home or the lack of know how to look after them at home. Lack of carers at home to look after the invalid patient is another predicament. Hence the administrators of major hospitals face a dilemma with congestion of the ward.

The lack of “long stay hospitals” in our country to accommodate those patients needing long term care after their acute management is a major obstacle. If so such patients could have been transferred to provide proper rehabilitation the nursing care, physiotherapy, speech therapy, Occupational therapy etc.

For many elders their main complaint is not a physical one but loneliness. In both rural and urban areas elders are often left behind when their children move away to find an employment. For many, this can lead to isolation and loneliness. Elders who do move with their families can also have the same feelings particularly if their children are out at work all day and the elder is unfamiliar with the surroundings and customs. For some people the solution to loneliness could be to go to an elders day centre, and setting up such a centre may be what is needed. Places like a temple; mosque or kovil would also be an ideal place for setting up a day care centre for the elderly. A visit to a day care centre would not only help them to remain integrated with the society, but also provide them an opportunity for spiritual, recreational and income generating activities, have access to health care and a means to enjoy a nutritional meal.

Following strategies & activities need to be adopted for improvement in health of elders in our country.

Resource allocation & reorientation of health services

The curative health services provided free of charge, has largely contributed to the increase life expectancy of the Sri Lankan population. The preventive health service has been mainly geared to address the health of under five children and mothers where proper anti-natal and post-natal care, infant and child care, correct timing, spacing and limiting of pregnancies, immunization and proper nutrition will all contribute to healthy ageing. It is well known that most of the degenerative diseases such as hypertension, diabetes, arteriosclerosis and some cancers have their beginnings in early childhood or much earlier than that. Hence measures adopted for healthy ageing should start early in life or from "womb" and continue throughout life. In future with the declining number of under five children will allow further improvement in the quality of existing maternal and child health services while allowing the expansion of resource allocation for improving preventive health care services for elderly. Recognising the issues and implication of population ageing on health care the Department of Health has embarked upon education and training of all health personnel on the subject of ageing by reviewing and revising the existing curricular. Five years back the post of a Director / Elderly was established at central level in the Department of Health of the Ministry of Health with the main intention of improving the planning, implementation, monitoring and coordination of health care delivery for elders in collaboration with other relevant governmental & non governmental agencies & provincial ministries.

Similarly in the curative sector too, cadre creation, appointment of specialists including geriatrician & other respective para medicals would be necessary.

National health policy & National plan of action on health of elders

The Ministry of Social Services has initiated the overall policy direction and guidance in planning and the formulation of national policies on care of elderly. The National Committee on Ageing chaired by the Secretary, Ministry of Social Services has representation from all main stakeholders including the Non Governmental sector. It has been established with a view to monitor the activities geared towards elderly that are implemented by the Government and NGO sector.

The National Policy on elders is being reviewed and revised at present by the National Council for Elders. This National Policy will be subsequently submitted to the Cabinet through the National Committee on Ageing for approval and ratification. The National Plan of action will be prepared for the next five years based on the policy document.

Each MOH division has to prepare their own plan of action to suit the needs of the community including the activities, inputs, targets, quantifiable outputs, time frame resource availability, taking into consideration the strategies laid down in the national plan of action. The indicators for monitoring the progress also need to be identified.

Strengthening inter-sectoral collaboration & community participation

For the programme to be implemented & established successfully inter-sectoral coordination at Central, Provincial, Regional levels as well as divisional & grass root levels need to be strengthened. (as per No.14)

Cadre creation, Training & Reorientation of staff

Creation of cadre & appointment of health personnel in PHC & at institutional level for improvement of planning, implementation, monitoring & coordination of health care delivery for elders need to be done.

All PHC & institutional health staff need to be trained on health promotion, needs of elderly prevention of elderly health problems care & rehabilitation.

The existing curricula for in-service and pre-service training of all medical and para-medical personnel on care of elderly needs to be reviewed and revised.

In the near future preliminary measures needs to be taken to appoint an additional category of health care worker called the Community Health Nurse to provide home nursing for elderly. The Community Health Nurse (CHN) is expected to do home visits, perform simple laboratory tests, diagnose common health problems early and refer for necessary treatment, provide health education and train family members and the volunteers on home nursing for the disabled elders. The other alternative is to train the PHM on this task with appointment of more such PHMM per population.

Health volunteers could also be trained by the divisional level staff (PHC & institutional) on home based care of house bound elders & also to relive their loneliness or provide a helping hand. This would enable the elders to continue living with their own family without being institutionalised. There is a need to improve the specialist cadre in these fields (Gen. Physicians, Surgeons, GU, Eye, ENT, Orthopaedic, Cardiothorasic surgeons, Psychiatrists & Oncologists) in addition to developing Geriatric medicine as a sub speciality in the country & to appoint at least one Geriatrician per Teaching Hospital to start with to manage those over 70 years of age. The Geriatrician should be supported by a multi disciplinary team such as medical officers designated for elderly care, nursing staff to look after mainly the bowel, bladder & skin care & the physiotherapist, occupational therapist, speech therapist to look after mobility, balance training, speech & functional independence, the dietician, physical education instructor & the social worker to counsel the patients & the family members regarding lifestyle changes, proper

care & referral. Hence the necessary carder creation & appointment of health personnel in these categories.

The trained health staff, at Regional level and Divisional level (MOH) will function as key resource persons for conducting awareness programmes in schools, work places and in community.

Creation of awareness among old age groups

In order to reduce the health care expenditure, to postpone the onset of disability in old age and for the older persons to continue to be a resource for their family and community, emphasis should be on health promotion and prevention of health problems.

Awareness programs on promotion of healthy life style needs to be carried out among different segments of the population as a means of preparing them for a productive and active life in old age physically, mentally, socially, and spiritually. Such programmes should also involve employers, employees, pre retirees & community leaders on educating them on healthy life style & common illness during old age. This would also improve prevention, self-detection & early presentation for diagnosis & treatment.

The subject of ageing should be introduced through the school curricula with emphasis on the ageing process, needs of older persons, education on values and promotion of active ageing along with practical exercises.

In addition to innovative techniques used for sensitising school children on ageing, essay and poster competition needs to be arranged among school children out of school youth and among health personnel with a sponsorship of business establishments, banks and philanthropists in the community.

Public awareness on healthy ageing, values and ethics to strengthen the family unit to look after the elders should also be promoted through newspaper supplements, news items, feature articles in newspapers and magazines and through radio and TV programmes.

Similarly for sensitising the public & to improve their awareness regarding health promotion & prevention of health problems of elderly, treatment, care & rehabilitation media programmes need to be arranged with the sponsorship of business establishments, banks etc.

Workshops, meetings and group discussions with childrens' groups, youth groups, formal and informal leaders of the community and with religious leaders needs to be organised by Community leaders along with the health staff for " Strengthening of family unit for care of older persons"

Marches, folk dramas and Street dramas involving elders/school children organised in the community especially during "International Day of the Elderly" would promote awareness among the elderly to be more conciliatory towards the young and the young to care and protect the older persons.

During home visits too, the Primary health care workers and volunteers could educate the elders and their family members on common health problems of the elderly, the ways of minimizing the complications, on prevention of home accidents and other aspects of health promotion.

Community leaders, youth leaders, and school children could also function as change agents in promotion of active ageing among family members.

Improvement of health service delivery at primary, secondary & tertiary levels

Early detection of common health problems among elderly would lead to postponement or prevention of disability, lower the health care cost and improve the quality of life of elders as well as their family members.

To spare the exhaustion of standing in long queues in hospitals as well as to promote the elders to seek early treatment, preference should be given for elders at OPD & separate counters need to be opened in pharmacy, & appointment system should be introduced in specialist clinics. Added preference could be given for those over 65, possessing the identity card issued by the Department of Social Services. The referral system also need to be enforced in the country to prevent over crowding at OPD / Specialist clinics in major health care institutions.

Health screening of the elderly is one way to promote health and improve their well-being. It results in early detection of common diseases and problems so that early intervention and remedial action can be taken. Routine medical checkups should include checking of blood pressure, urine and blood tests to check for diabetes, vision and hearing tests, check on mental health status and the ability to perform the activities of daily living. In addition to these examinations screening for prostate enlargement, breast and uterine cancer.

Access to health screening needs to be improved by conducting mobile clinics at community level by the MOH with institutional health staff to identify the most common diseases of old age (Impairment of vision including cataract, hearing effects, diabetes, hypertension & arthritis). These would be designed with adequate support for referral from curative care institutions.

These mobile clinics can be organised by the support of members of the community and assistive devices such as spectacles, intra-ocular lenses, hearing aids, walking sticks & wheel chairs and dentures should be made available for poor elderly by mobilizing community resources and through NGO support.

The capacity of the Medical Officer of Health (MOH) for conducting mobile screening clinics should be strengthened by providing the necessary instruments and equipment for health screening.

Upgrading of peripheral health care institutions with provision of necessary equipment & facilities & allocation of cadre, would enable the elders to obtain medicine for chronic illnesses of old age which need long term treatment, perhaps life-long, and for rehabilitation of elders who needs long term care.

The out reach cataract surgery need to be organized for patients from remote areas not served by particular specialists. Hence the necessity to build up & out reach service unit with necessary equipment, human resource & transport facilities.

Arrangements have to be made to convert un-utilized and under-utilized maternity homes and rural hospitals to set up "Long stay hospitals" for rehabilitation of disabled elderly who cannot be taken care of in their homes. This could be done through re-orientation of health staff in the

existing institutions for their new tasks, as well as community awareness and mobilisation programmes.

Improving services available at Ayurvedic hospitals (Indigenous Medicine) at district level to include "Panchakarma" treatment would enable them to seek treatment of their choice. Establishment of institutions for hospice at least by provincial level would be necessary for the elderly who are terminary ill for them to die with dignity.

Promotion of health of elders

Day Centres for elderly need to be established at least two to three per MOH area with the support of governmental, nongovernmental and private sector organizations and through community mobilization.

The promotion of health of elderly would also be ensured by making the elders participate in decision making, in implementing community activities, such as organising senior citizen clubs and implementing welfare programmes, and by training elders to be peer counsellors.

Encouraging the elders and their family members to involve the elderly in carrying out day-to-day household activities and social and religious activities in the community would make them more productive and active.

Youth need to be mobilised to organise social, cultural and religious activities for older persons and to provide recreational services for elderly.

Opportunities should be provided for exhibition of artistic talents of older persons in the community and conferring awards for those with special talents.

To promote active ageing elders are encouraged to share their capabilities and talents with younger generation such as teaching them languages and other subjects and share their artistic skills with them. Pilgrimages within the country and to foreign countries need to be organised through various associations and the coordinating committees functioning at community level to improve their spiritual health.

Conducting research, dissemination of information & need based planning

With the help of volunteers and field workers of other governmental & non governmental organizations, a house to house survey need to be conducted in MOH areas to collect base-line data on elderly. The information such as the socio-economic status, physical and mental health status, utilization of health facilities, the extent of involvement of elders in social and re-creational activities, their skills, their ways of contribution to the family and society and vice versa, the felt needs of the elders and the methods of interventions suggested by them to address the needs will be obtained through this survey. These base-line data maintained at divisional level will be updated once in three years.

In addition qualitative data would be collected through Focus Group Discussions (FGDs) carried out with selected groups in the community. The findings of the above research would be useful to assess the progress and to enhance community mobilization and community participation.

Monitoring & Evaluation

The implementation of the action plans designed at village level is monitored on regular basis by the coordinating committees at higher levels with a view to improve progress.

A management information system needs to establish in the health sector for continuous monitoring & evaluation of activities.

In addition the capabilities of the health staff handling the programmes need to be strengthened by providing opportunities for them to have frequent discussions with key personnel involved in this work at central level and by giving opportunity to share their experiences regarding their programmes conducted & their attitudes towards their added role with other health personal handling such programmes.

For the MOH and the primary health care staff, engaging in such programmes would provide them with more opportunities to improve their relationship with the community. From the community too, there would be more recognition and appreciation towards the health staff perhaps for paying attention to a group which lacked their attention before. This would also enhance the support & contribution of elders towards other development in the community.

The programme on "Promotion of Active Ageing" introduced in year 2000 by the unit of YEDD of the Ministry of Health with the other governmental & non governmental agencies & provincial ministries by now has covered 134 out of 265 MOH areas. Most of the activities mentioned above are been implemented satisfactorily in these MOH divisions to promote health of elders.

The population of elderly is expected to be doubled in 20 years time. There is lot more to be done and numerous opportunities for improvement. What is more important is initiating action in the correct direction without further delay.

Sri Lanka has already achieved its goal of extending the life span of elderly; the real challenge in the future is to add quality to those extra years.

(10) Important Assumptions/Risks/Conditions:

Becomes a priority concern of the Ministry of Health

Political support and support of policy makers gained

Improved collaboration of all sectors for implementation & monitoring

Adequate. Human resources. Funds & other resources allocated at Central Provincial District & Divisional levels

- Health authorities, continue to demonstrate their commitment to improve elderly health
- Committed trained staff
- Positive attitudes of Health personnel at all levels for serving elders
- Support & contribution of the community for the Primary Health Care Workers for serving elderly
- Support of community and religious leaders, pensioners & other experienced elders
- Elderly willing to obtain counselling and other services

- Trained volunteers & counsellors remain engaged in services for a long period
- Politicians, policy makers, administrators, community leaders and elderly find time to attend advocacy meetings and seminars

(11) **Project Objective:**

Objective	Indicators	Means of Verification
To improve quality of life of elders through health promotion, prevention, treatment, care & rehabilitation.	People of all age groups, particularly younger generation become enthusiastic regarding active ageing & practice healthy life style. Maintain their BMI. Follow a healthy lifestyle. - healthy eating habits - engage in exercise - get adequate sleep & relaxation - abstain from substance abuse	FGD Survey reports School health records
	Reduction in the rate of disablement of elders	IMMR Records maintain at divisional level for in the number of mobile screening clinics
	Increasing number of elders who are engaging ADL without help for a increase length of period	Survey reports
	Improvement in early identification & referral	Clinic records
	Increasing rate of intervention for prevention of disability among elders. Such as early treatment & rehabilitation	Records on place & no. of intervention done
	Increase participation & contribution of elders towards family & community activity	Survey reports
	Increase no. of physically & mentally healthy elders	Survey reports
	Increasing no. of elders get help from careres for carrying out ADL	Survey reports

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Medical / paramedical personnel (PHC, institutional) designated to work for improvement of elderly health, appointed at grass root, divisional, district, provincial and central levels	Number of Health personnel appointed to work for improvement of elderly health at specified levels	List of health personnel recruited at each level designated to work for improvement of elderly health
National Plan of Action prepared based on National Health Policy for improving	National Plan of Action for improving health of elderly in place & consensus reached for	

Output	Indicators	Means of Verification
preventive, curative rehabilitative health services related to elderly health	implementation.	
Improved health curricular for pre-service & in-service training medical & para medical personnel, for promotion of healthy life style, active ageing & other information for prevention of health problems in old age and on health promotion (including the contents on value education & skills).	Revised curricular in place No. of trainers using the revised curriculum No. of health personnel trained using the revised curriculum	Administrative reports of relevant government institutions Surveys
Training manuals & guides prepared on elderly care for training health personnel, volunteers & NGO personnel	No. of training manuals printed. No. of training manuals used for training health personnel, volunteers, NGO personnel	Records of availability of training manuals
IEC material produced	IEC material produced being used by the target group	Records on the availability of IEC material produced for each target group Records on distribution of IEC material at central district and divisional level.
Trained teachers on information provision, value education & skill building for school children & their parents on healthy life style & active ageing	Improved school curriculum in cooperating promotion of healthy life style & health problems of elderly (including the contents on value education & skills) No. of competent teachers No. of teachers using proper training methods of teaching	Evaluation report of the training programmes Feedback reports
Trained PHC, health personnel on information provision for school & out of school youth & volunteers on health of elders	No. of health personnel competent in training school & out of school youth & volunteers in dealing with elderly health problems & promotion of health of elders	Evaluation report of the training programmes Feedback reports
Family members of elders & community leaders made aware regarding elderly health problems of care of elderly	Knowledge, attitude, skills of family members & community leaders in dealing with elderly & health problems of care of elderly	Feedback reports Surveys

Output	Indicators	Means of Verification
	improved.	
Trained counsellors among NGO personnel, health personnel & elders in community	Increased number of competent counsellors in community	List of counsellors trained Evaluation report of the training counsellors performance records Survey and feedback reports
Availability of counselling centres for elders	No. of counselling centres in community. No. of elders patronizing counselling centres	Counselling centre records Survey reports Evaluation reports on client satisfaction
School children made aware regarding healthy life styles, active ageing, health problems of elderly & care of elderly.	No. of school children with improved knowledge, attitudes, values, skills & behaviour pertaining to healthy life styles, active ageing, health problems of elderly & care of elderly.	Evaluation reports of the programmes Feedback reports Survey reports News items
Elderly friendly services in hospitals & specialized clinics Preferential facilities for elders at OPD & dispensary	Number of hospitals with improved services. Number of elders satisfied regarding the services.	Clinic activity lists List of referrals Administrative reports Attendance lists Evaluation reports on client satisfaction Attendance list Survey / feedback reports
Mobile screening clinics for elders held in MOH areas	Number of mobile screening clinics held. No. of elders attended No. detected early & referred	Attendance lists Evaluation reports on client satisfaction attendance list Survey / feedback reports Progress and performance report of officers allocated
Trained youth & elderly volunteer as carers for the eldest in the community	No. of training programmes held youth & elderly volunteer as carers No. of elders provided with home based care by this programme	Progress and performance report
Long stay hospitals for chronically ill & destitute elders	No. of long stay hospitals No. of elders being rehabilitated at long stay hospitals	Administrative reports
Peripheral units offering facilities & drugs for treating	No. of peripheral units with improved facilities	Admin reports Survey reports

Output	Indicators	Means of Verification
common illnesses of elderly	No. of elders satisfied by the services	
Management information system established for collection of data & for monitoring	Management information system on elderly health in place	Progress and performance report of officers allocated responsibility for information collection and recording Survey data and reports quarterly/annual reports
System established in the health sector for continuous monitoring & evaluation of above activities	Continuous monitoring & evaluation of adolescent & youth health activities in place	Reports on operation research Mid term / final evaluation reports

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
SRL DPR 002	Integrated Health Care for the Elders
SRL DPR 001	Promotion of health & prevention of disability among older persons

(14) **Relevant Agencies to be Coordinated:**

Director YEDD / HEB / FHB / NIHS / Population Division / STD AIDS campaign
Provincial Health Directors, DPDHS
Medical Officers of Health & field staff
Health Institutions
Ministry of Social Services, Dept. of Social Services
Ministry of Youth Affairs & Sports, NYSC
Related NGO's,
Ministry of Education / NIE
Department of Education
Department of Labour
Women's Bureau
Ministry of Justice
Ministry of Media & Information
Universities, HelpAge, Sarvodaya, Mahila Samithi & other related NGO / CBO

(15) **Monitoring & Evaluation:**

1. Who? DGHS, DG/Educational Services, DG/NIE, Other relevant heads of departments & NGO's, through National Steering committee on adolescent health
2. When? Quarterly
3. What actions to be taken based on results of monitoring & evaluation?

   Improve planning and provision of services based on the identified gaps

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
• Identification & cadre creation of medical & paramedical staff at PHC / institutional at central, provincial, district, divisional & grass root levels for improvement of elderly health. - PHC staff trained on elderly health ▪ Community physicians ▪ Medical officers designated to work on elderly health ▪ Community Health Nurses ▪ MOMCH / RE / HEO ▪ MOOH / AMOH, PHM, PHNS. - Institutional staff trained on elderly health ▪ Consultants of relevant specialities including Geriatricians. ▪ Medical officers in institutions designated to work on elderly health. ▪ Other supportive staff o Nursing staff o speech, physio, & occupational therapists o psychologists o dieticians o audiologists o physical education instructors. o social workers	• Improvement of health promotion, prevention, early detection, assessment, referral, treatment, care & rehabilitation. • Improved efficiency & effectiveness of elderly health programmes • Improvement of management care & rehabilitation of elderly in institutions by the services provided by Geriatricians & multi disciplinary team	• No. of medical & para medical staff at PHC / institutional at central, provincial, district, divisional & grass root levels appointed, trained & working for improvement of elderly health. • No. of Geriatrician appointed per institution • No. of Medical Officers appointed designated to work in elderly health per institution • No. of other para medical staff appointed providing services for elderly per institution
• Identification & supply of other resources needed at central, provincial, districts, divisional & grass root levels for planning, monitoring, coordinating & implementing programming of elderly.	• Improvement of such resources at each level	• The amounts of funds, human resource, buildings, supplies and equipment and other resources provided at each level
• Advocacy programmes for - Politicians - Policy makers - Administrators - Provincial council & pradeshiya sabha members - Municipalities of provinces, district & divisions - All schools in the island - Community leaders - Family members of elders - Members of NGOO	• Continued political support • Improved funding • Improved coordination • Sustainability of the programmes ensured	• No. of advocacy programmes held for different target groups

Activities	Expected Results	Process Indicators
- Media personnel - Elders & family members of elders		
• Conducting research pertaining to problems among elderly.	• Types and extent of elderly problems identified by research priority problems identified for target interventions	• No of review meetings held for monitoring of research activities
• Formulation of National Action Plan on older persons	• National action plan on elderly health established	• No. of focus group discussions held with relevant target groups • No. of direct interviews with key personnel • No. of elders actively contributing for preparation of action plan
• Establishing channels of coordination between different sectors.	• Continued inter-sectoral participation & collaborative efforts regarding implementation of elderly care activities	• No of activities established in coordination with other sectors. • No. of donor agencies supporting • No. of sectors Agree to work in collaboration • No actively collaborated
• Production of IEC material on information provision, value education & life skills education targeted at various target groups on promotion of healthy life styles, active ageing, prevention of health problems in old age, management, care, counselling & rehabilitation of elderly health problems (user friendly books, videos & leaflets)	• Increase in KAPS among relevant people regarding prevention of elderly problems and on health promotion	• No and type of IEC material available by subject for each target group
• Establishment of day centres for elders for promotion of health of elders in MOH divisions with the support of governmental & non governmental & private sector organization and through community mobilization	• Healthy, happy, active, productive elders in community • Elders contributing for community development	• No. of elders attending day centres. • No. of elders engaged in recreational activities among income generating activities. • No. of elders following a healthy life style • No. of elders contributing for community development • No. of healthy, happy, active, productive elders in community
• Information & education of - Health personnel	• Target groups enlightened on subject	• No of persons in each target group with

Activities	Expected Results	Process Indicators
- Teachers - NGO personnel - Youth leaders - Health volunteers - Community leaders - Media personnel - Elders - Family members of elders	matter, norms, ethics, beliefs & values of the society on elders • Effective convey of messages to community • Continuity & sustainability of activities conducted in community on elderly health & interventions with efficiency • Improved knowledge, attitude, practice on health promotion, prevention, rehabilitation & value education pertaining to elderly health among the target group.	improved KAPS
• Training of - Under graduate students & post graduate students - Medical & Para Medical personnel (PHC / Institutional) - Health volunteers - Family members of elders - Elders	• Improved capacity of health personnel planning, coordinating, implementing, monitoring & evaluation of activities conducted on elderly health • Improved capacity of trained personnel in health promotion, prevention of health problems of elderly, early detection, assessment, referral, treatment, care & rehabilitation.	• No. of training programmes conducted • No of people actively participated • No of people competent in training others • The extent of training facilities provided
• Cadre creation, training & appointment of Community Health Nurses (CHN) in MOH areas	• Improved assessment, guidance, early detection & referral of health problems of elders • Improved awareness on health problems & management for elders & family members • Family members trained on looking after disabled elders.	• No. of elders benefited from early detection & referral of health problems • No. of elders & family members with improved awareness on health problems & management • No. of family members trained on looking after disabled elders.

Activities	Expected Results	Process Indicators
• Training of young & elderly volunteers to support health staff to carry out community based activities for elderly. • Training of young & elderly volunteers as careres of elders / MOH division with the help of other governmental & non-governmental agencies.	• Volunteers engaged in supporting health staff to carry out community based activities for elderly. • Volunteers functioning as careres for elders at home • Improve level of independence and ADL of elders. • Proper assessment, guidance, referral, of elderly.	• No. of volunteers engaged in supporting health staff to carry out community based activities for elderly. • No. of volunteers functioning as careres for elders at home • No. of elders benefited by careres
• Training of health personnel, NGO personnel & elderly as counsellors for elders.	• Adequate no. of counsellors working in community • Adequate no. of counsellors and counselling centres / service provision centres to cover the elderly population. • Increase no. of elders patronizing counselling services • Increase no. of elders benefited by counselling centres	• No. of counsellors working in community • No. of counsellors and counselling centres / service provision centres to cover the elderly population. • No. of elders patronizing counselling services • No. of elders benefited by counselling centres
• Establishment of counselling centres / service provision centres to cover the elderly population in MOH divisions		
• Early detection & referral of elderly health problems - Mobile screening clinics for elders held by MOOH / MO-OPDs / consultants - Preference for elders at OPDs - Preference for elders at pharmacy - Appointment system introduced in specialist clinics • Establishment of the referral system	• Improved facilities for elders at OPD / Pharmacy / specialist clinics etc. • Improvement in early detection & referral of elderly health problems at mobile screening clinics / OPD & specialist clinics	• No. of Mobile clinics held / MOH division per year. • No. of elderly attended • No. of elderly with health problems diagnosed early • No. referred for obtaining assistive devices • No. referred to health institutions for treatment • No of elders reported have benefited by clinics
• Strengthening the capacity of the MOOH for conducting mobile screening clinics of elderly. - Training. eg: to detect cataract & hearing impairment - Equipment. eg: to check blood glucose level - Transport	• Improvement in early detection & referral of elderly health problems at mobile screening clinics	
• Provision of facilities for out reach treatment & rehabilitation of elderly health problems	• Elderly treated & rehabilitated through out reach service.	• No. of elderly treated & rehabilitated through out reach service.

Activities	Expected Results	Process Indicators
- Out reach cataract surgery - Provision of assistive devices (Spectacles, hearing aids, intra ocular lenses, walking sticks, walking aids etc.)		
• Establishment of long stay hospitals for accommodating patients needing long term care & rehabilitation of disabled elders - Conversion of un-utilised & under utilised health institution to long stay hospitals. • Re training of existing staff on elderly care.	• Improvement of rehabilitation of disabled elders	• No. of long stay hospitals per division. • No. of elders rehabilitated in long stay hospitals.
• Establishment of management information system for elderly health & a continuous flow of monitoring and evaluation.	• Sustainability of elderly health activities with efficiency.	• No of evaluation reports available. • No. of review meetings conducted • No. of deficiencies reported during, process & impact evaluation

(1) **Project Title:**	Disabled Health	(2) **Project Number:**	1.5.3
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	
(5) **Implementing Agencies:**		(7) **Project Duration:**	

(1) **Project Title:**	Adolescent Health	(2) **Project Number:**	1.5.4
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	1st year 2004
(5) **Implementing Agencies:**	• Ministry of Health (D/YEDD / HEB / MCH / NCD / NIHS / Population Division / STD AIDS campaign / PDHS, DPDHS / Health Institutions / MOH & field staff) • Ministry of Education / Dept. of Education / NIE • Ministry of Youth Affairs & Sports, • NYSC • Ministry of Information & Media • Department of Labour • Women's bureau • Vocational Training Authority • National Dangerous Drug Control Board • Ministry of Defence, Ministry of justiceUniversitiesADIC, FPA, Sarvodaya, FHP & Other related NGO / CBO	(7) **Project Duration:**	10 years.

Project Summary

The division of youth, elderly, disabled and displaced persons in collaboration with other sectors in the Ministry of Health & with other relevant governmental & non governmental agencies, aims to improve the overall health of youth in the country by creating a safe & supportive environment, by enhancing their knowledge attitudes & values and improving their skills to make responsible decisions an actions leading to healthy behaviour and by providing youth friendly services

(8) **Target Areas & Beneficiaries:**

Primary Target Groups

- All school children of 1 to 12 grades in the island
- Out of school youth (employed/unemployed)
- University students

- Students of Technical Colleges & Vocational Training Centres
- Young armed personnel

Secondary Target Groups

- Health personnel
- Teachers & school administrators
- Youth Leaders of National Youth Council Services
- Politicians, Policy makers, Administrators, members of Provincial councils, Municipalities & pradeshiya sabha
- Community leaders, parents, members of NGOO / CBOO

(9) **Justification:**

The population in Sri Lanka is 18.5 Million of which approximately 5.2 Million (29%) comprise of young people between the age of 10 - 24 years.

Adolescents are generally thought to be healthy, as mortality in adolescence is lower than in any other age group. Contrary to popular opinion not all adolescents are healthy.

However the period of adolescence is also a period in which behaviours, such as truancy, unhealthy dietary and physical activity patterns, use of substances such as tobacco and alcohol & drugs, unsafe sexual practices and engaging in violence, are initiated. Though such behaviours cause morbidity and mortality in adulthood their roots can be traced back to the adolescent period. Tobacco use, for example, typically starts before the age of 15 and frequently leads to premature death later in life. HIV infection, which is often contracted in late adolescence, leads to AIDS in later years. The major cause of death in young people are road traffic accidents, injuries, suicide, violence, pregnancy related complications & HIV/AIDS that are either preventable or treatable.

Unwanted pregnancies and abortions, STD & HIV / AIDS, smoking, alcohol & drug abuse, suicide, violence, accidents & injuries, nutritional problems, sexual abuse & school dropouts encountered among the adolescents and youth pose a significant challenge to the well being of this group.

The following are some of the important barriers for programming for adolescent health,

- Lack of political commitment & inadequate understanding of ADH issues among the decision makers
- Lack of long term vision for improving ADH
- Paucity of coordination & collaboration
- Conflicting priorities & generally low resource settings for ADH
- Poor governance & lack of staff allocation in health services
- Lack of age & sex disaggregated data
- Lack of acceptable indicators & where ever available lack of utilization of such indicators

Recognizing the need for an organized programme for improvement of adolescent & youth health, the Ministry of Health, appointed a separate Director for Adolescents & Youth in 1998 June.

The Steering Committee on Adolescent Health Established in 1994 for monitoring & coordinating activities on Youth & Adolescent Health

Representatives from different disciplines, professions & youth representatives were included in the steering committee to provide expert opinions on the development of appropriate services at national, provincial & community levels.

Adolescent health programmes are often done in an ad-hoc fashion, without much coordination among government sector, NGO partner organizations and a community stakeholder, which tends to cause overlap and gaps in programming. The existence of National policy serves to set goals for joint programming and action, sharing of responsibilities & serves as a mechanism for coordination. It is also indicated that the development of policy serves to legitimate adolescent programme and lead to legislation, which provides a legal framework & budget for adolescent health & development.

In Sri Lanka there are multiple donors willing to support adolescent health. Some in planning and others in implementation stages. However for the optimisation of resource allocation and utilization, it is important to have a policy documentation specifying national priority and which provides a frame work for resource allocation, collaboration & cooperation of all key funding & implementing stakeholders. The policy will also help to enhance the image & credibility of the agencies involved in adolescent health activities.

The existence of explicit policy provides vision, coordination, strategy & sustainability for improve programming.

Amidst some services for adolescents which are being provided in an ad-hoc manner by both government & non government sectors it is appropriate to establish a **Comprehensive National Programme** in collaboration with all relevant government & non government organizations to improve the well being & health of the adolescent.**Important Assumptions/Risks/Conditions:**

Becomes a priority concern of the Ministry of Health

Political support and support of policy makers gained

Adequate. Human resources. Funds & other resources allocated at Central Provincial District & Divisional levels

- Improved collaboration of all sectors for implementation & monitoring
- Committed trained staff
- positive attitudes of Health personnel at all levels for serving unmarried youth especially on improvement of Reproductive Health (RH)
- education, Health authorities, and NGOs continue to demonstrate their commitment to improve ADH
- less resistance from the community for serving unmarried youth by the Primary Health Care Workers especially on improvement of Reproductive Health (RH)

- support /approval of the parents, teachers, community and religious leaders
- youth willing to obtain counselling and other services
- trained counsellors remain engaged in services for a long period
- politicians, policy makers, administrators, community leaders and parents find time to attend advocacy meetings and seminars

(11) **Project Objective:**

Objective	Indicators	Means of Verification
To improve quality of life of school & out of school youth by developing their knowledge attitudes values, skills & behaviours regarding biological, psychological, socio cultural, & reproductive dimensions of adolescence.	Rate of suicides among youth.	Registrar General records
	Rate of youth with mental health problems.	Periodical survey. Records of mental hospital
	Rate of youth indulged in substance abuse.	Focus group discussions.
	Rate of teenage pregnancies.	Focus group discussions DHS survey
	Rate of abortions among youth.	Periodical survey. Policy reports
	Rate of sexual abuse among youth Rates of STD / HIV AIDS among youth.	Police reports. Reported incidence of violence among youth. Newspaper reports.
	Rates of accidents among youth	Police records
	Rates of school dropouts.	Education department records
	Incidence of violence among school & out of school youth	Police reports. Newspaper reports.
	Number of youth obtaining counselling services	Records in counselling centres
	Number of youth seeking RH information from health personnel	Focal group discussion
	Number of youth using RH services in youth friendly clinics	Clinic records Clinic records. Periodical survey

A reduction in the violence, accidents, smoking, alcoholism, drug abuse, suicide, sexual abuse, teenage pregnancies, abortions, mental health problems, STD HIV AIDS, School dropouts will be seen with improvement of adolescent & youth health.

(12) **Project Output/Product:**

Project output is aimed at health promotion as well as reduction of RH problems, alcohol & drug abuse, violence among school & out of school youth etc. through provision of safe & supportive environment, improving provision of information & skills & improving health services including counselling.

Output	Indicators	Means of Verification
Cadre created for	Appointment of cadre per	Documents on cadre

Output	Indicators	Means of Verification
appointment of health personnel designated to work for youth & adolescent at all levels	year	approval & appointment of cadre
Health personnel appointed & designated for adolescent & youth health at grass root, divisional, district, provincial and central levels	Number of Health personnel appointed for working in adolescent & youth health at specified levels	List of health personnel recruited at each level - PHC - Institutional
National policy & national strategy on adolescents & youth health prepared & approved by cabinet	Documents on national policy & documents on national strategy in place	Progress reports circulars & administrative directives issued
Improved school curricular, which provides age appropriate, culturally acceptable information for prevention of adolescent health problems and on health promotion including the contents on value education & development of life skills.	Revised school curriculum in place Teachers teaching according to the revised school curriculum	Administrative reports of relevant government institutions surveys
IEC material based on information provision, value education & life skills education targeted at various groups produced for health promotion & prevention of above mentioned problems (user friendly books, videos & leaflets)	IEC material produced being used by the target group	Records on the availability of IEC material produced for each target group Procurement and distribution records at central district and divisional level.
Training manuals & guides prepared for training teachers, health personnel & NGO personnel on ADH	No. of training manuals printed. No. of training manuals used by teachers, health personnel, NGO personnel	Records of availability of training manuals on ADH
Trained teachers on information provision, value education & skill building for school children & their parents on adolescent health	No. of competent teachers No. of teachers using proper training methods of teaching	Evaluation report of the training programmes Feedback reports
Trained health personnel on information provision, value education & skill building for school & out of school youth, their parents & members of the community on adolescent health	No. of health personnel competent in dealing RH problems & youth approach health personnel vice versa	Evaluation report of the training programmes Feedback reports
Parents competent on improving health of their adolescent children	Proportion of parents with increased knowledge, attitude, skills in dealing with	Feedback reports Surveys

Output	Indicators	Means of Verification
	adolescent & youth health problems & promotion of health among their children.	
Trained peer communicators among school & out of school youth (youth club leaders)	Number of peer communicator's in each school & in youth clubs. Improved dissemination of correct information among peers. Improved referral to teacher councillors & councillors of NGO	training schedules of peer communicators List of Peer communicators trained Peer communicators records referral lists
Trained teacher counsellors, trained counsellors for out of school youth such as NGO personnel & health personnel	Increased number of competent teachers & NGO personnel & health personnel as counsellors	List of counsellors trained evaluation report of the training counsellors performance records survey and feedback reports
Availability of counselling centres for adolescents & youth	No. of counselling centers in schools & in community. No. of youth patronizing counselling centres	counselling center records survey reports evaluation reports on client satisfaction
School children with improved knowledge, attitudes, values, skills & behaviour towards promotion of ADH & prevention of ADH problems.	No. of school children with improved knowledge, attitudes, values, skills & behaviour pertaining to adolescent health. Reduction of rates of adolescent health problems among school children	evaluation reports of the programmes feedback reports survey reports news items
Out of school youth with improved knowledge, attitudes, values, skills & behaviour towards ADH (provided through "linked" programmes on career guidance, non-formal education, vocational training, micro credit schemes, youth camps & sports & recreational programmes)	Number of "linked" programmes held for out of school youth per division. No. of out of school youth with improved knowledge, attitudes, values, skills & behaviour pertaining to adolescent health Reduction of rates of youth problems among out of school youth	evaluation reports of the programmes feedback reports survey reports news items
Adolescent friendly clinics established in hospitals & MOH clinics	Number of adolescents services established in hospitals & MOH areas per province per year. Number of adolescents using the services.	clinic activity lists list of referrels administrative reports attendance lists evaluation reports on client satisfaction attendance list survey/feedback reports
Youth in work places with improved knowledge,	Number of implant educational programmes held	attendance lists evaluation reports on client

Output	Indicators	Means of Verification
attitudes, values, skills & behaviour pertaining to adolescent health	at work places for youth workers. No. of youth attended Rates of health problems among working youth Number of out reach educational programmes held at place of residence of youth for improving ADH	satisfaction attendance list survey/feedback reports progress and performance report of officers allocated
A system established for regular collection & management of information on adolescent & youth health	Management information system on adolescent & youth health in place	progress and performance report of officers allocated responsibility for information collection and recording survey data and reports quarterly/annual reports
System established in the health sector for continuous monitoring & evaluation of above activities	Continuous monitoring & evaluation of adolescent & youth health activities in place	reports on operation research mid term /final evaluation reports reports on ADH steering committee meeting & review meetings

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
SRL CAH 001	Improving life competencies of school & out of school adolescent & youth
SRL CAH 001	Development of National Strategy on Adolescent & Youth Health
UNICEF	Development of National Policy for Adolescent & Youth Health

(14) **Relevant Agencies to be Coordinated:**

Director YEDD / HEB / FHB / NIHS / Population Division / STD AIDS campaign
Provincial Health Directors, DPDHS
Medical Officers of Health & field staff
Health Institutions
Ministry of Youth Affairs & Sports, NYSC
Related NGO's,
Ministry of Education / NIE
Department of Education
Department of Labour
Women's Bureau
Ministry of Justice
Ministry of Media & Information
Vocational Training Authority
NDDCB
Donor agencies – WHO, UNICEF, UNFPA, UNAIDS, JICA, ILO, World Bank

(15) **Monitoring & Evaluation:**

1. Who? DGHS, DG/Educational Services, DG/NIE, Other relevant heads of departments & NGO's, through National Steering committee on adolescent health
2. When? Quarterly
3. What actions to be taken based on results of monitoring & evaluation?

   Improve planning and provision of services based on the identified gaps
   Improved resource allocation

(16) **Major Activities:**

The following activities will be, either school based, community based, work place based, home based, hospital & clinic based or out reach.

Activities	Expected Results	Process Indicators
• Identification & recruitment of human resource needed at central, provincial, districts, divisional & grass root levels for improvement of adolescent & youth health	• Improved human resources for planning, monitoring, coordinating & implementing programming of ADH • Improved efficiency & effectiveness of adolescent & youth health programmes	• No. of community physicians, medical officers & other staff appointed & trained for adolescent & youth health. • No. of PHC staff involved in dealing with adolescent & youth health at each level
• Identification & supply of other resources needed at central, provincial, districts, divisional & grass root levels for improvement of adolescent & youth health	• Other resources improved for planning, monitoring, coordinating & implementing programming of ADH	• The amounts of funds, supplies and equipment and other resources provided at each level
• Advocacy for - Politicians - Policy makers - Administrators - Provincial council & pradeshiya sabha members - Municipalities of provinces, district & divisions - All schools in the island - Community leaders - Parents - Members of NGOO - Media personnel	• Continued political support for ADH programmes • Improved funding • Improved coordination & support • Sustainability of the programmes ensured	• No. of advocacy programmes held for different target groups
• Conducting research pertaining to problems among youth.	• Types and extent of adolescent & youth problems identified by research Priority problems identified	• No of review meetings held for monitoring of research activities

	for target interventions	
• Formulation of national policy & national strategy on adolescents, youth and legislation of policy	• National policy & National strategy on adolescent health in place	• No. of focus group discussions held with relevant target groups • No. of direct interviews with key personnel • Active youth participation at meeting for preparation of National Policy & National Strategy
• Establishing channels of coordination between different sectors.	• Continued inter-sectoral participation & collaborative efforts regarding implementation of youth activities	• No of activities established in coordination with other sectors. • No. of donor agencies supporting • No. of sectors Agree to work in collaboration • No actively collaborated
• Production of IEC material on health promotion, prevention of adolescent health problems & counselling for adolescent health problems for different target groups.	• Increase in KAPS among relevant people regarding prevention of youth problems and on health promotion	• No and type of IEC material available by subject on health promotion, prevention of adolescent health problems & counselling for adolescent health problems for different target groups at each level
• Establishment of youth friendly health services including information provision, health screening, care, rehabilitation & counselling services. - Clinics (PHC, Institutional) - Out reach services - Hot line - Centres caring for victims of sexual abuse/rape - Rehabilitation centres for victims of drug abuse	• Adequate no of trained teachers and peer counsellors working in youth friendly services • Adequate no of counselling centres/ service provision centres to cover the in school and out of school youth population. • Increase No of youth patronizing youth friendly services • Improvement of problem prevention and health promotion among youth & adolescent	• No of youth friendly services by type of services offered per division • Clinic attendance of youth • Rates of reporting health related problems to clinics • No of youth reported have benefited by clinics
• Information & education of - Health personnel - Teachers - NGO personnel - Youth leaders - Peers - Health volunteers - Community leaders - Media personnel	• Enlighten on subject matter, norms, ethics, beliefs, values of the society & life skills on RH, nutrition, exercise & leisure time activities, substance abuse, accidents & injuries, violence & suicides,	• No of persons in each target group with improved KAPS • No of persons in each target group who were able to clarify their misconceptions and doubts

• Training - Health personnel - Teachers - NGO personnel - Youth leaders - Peers - Health volunteers - Community leaders	• Effective convey of messages to community • Continuity & sustainability of activities on ADH & interventions with efficiency	• No. of training programmes conducted • No of people actively participated • No of people competent in training others • The extent of training facilities provided
• Improvement of life skills	• Adopt skills for health promotion & prevention of adolescent & youth problems	• No of youth adopting healthy life style • Reduction in the rates of youth problems
• Establishment of management information system for adolescent & youth health & a continuous flow of monitoring and evaluation.	• Sustainability of ADH activities with efficiency.	• No of evaluation reports available. • No. of review meetings conducted • No. of deficiencies reported during, process & impact evaluation

(1) **Project Title:**	Occupational Health	(2) **Project Number:**	1.5.5
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Ministry of Health Provincial Health Authorities Ministry of Labour	(7) **Project Duration:**	05 years

Project Summary

Information on the occupational health situation prevalent in Sri Lanka, in terms of diseases, injuries and risks is very limited. Existing surveillance mechanisms and services have to be further strengthened to promote a safe and healthy working environment. Awareness on occupational health, safety and hygiene among employers and employees has to be developed and inculcated as a safety culture, to promote safety consciousness among workers and safety supervision in work places. Institutional capacity for hazard identification, risk assessment and enforcement of standards needs enhancement. This project aims to achieve the above by developing an institutional mechanism and a national plan of action, which would ensure a sustained and productive inter-sector collaboration for programme development, implementation and enforcement.

(8) Target Areas & Beneficiaries:

Working population in Public Health Inspector areas with an emphasis on vulnerable groups

(9) Justification:

Data on Occupational diseases is very little and scattered. Under the factories ordinance it is compulsory for all factories to report all injuries & diseases caused to workers if the workers do not come to work for 3 days to the Labour Department, and to send in their returns every six months. It is hardly reported and proper records are not available, except for the few studies done. The reason for this is largely attributable to lack of an institutional mechanism to ensure accountability and to make the surveillance system operational. There is a limited list of notifiable occupational diseases in Sri Lanka under the Factories Ordinance No.45 of 1942 as amended by Acts No. 54 of 1961 & No. 12 of 1976. Psychiatric problems and sexually transmitted diseases are not included in this list. However, there is considerable information available on the injuries and accidents. But the injuries in the Agriculture sector, offices (Government & Private), charitable organizations, mines, fisheries sector, & transport go unreported. Only 60 % of the occupational health hazards are reported and out of that 30% of the accidents are related to machinery. Most of the other occupational hazards are not reported as individuals take treatment on their own (Asthma due to chalk dust in teachers). According to the Dept. of Labour 500,000 man days are lost annually due to occupational health hazards. A survey done in a hospital (2000) shows 15% of the injuries are due to occupational health hazards. Out of the fatal accidents, 30% are from construction industry and 30% from electrocutions. Most of these hazards and accidents are preventable. In this context, as the "legislative protection" is limited to workers in "factories", the need to cover all workers beyond "factories" has to be recognised and implemented. The facilities and mechanisms available at present do not address adequately the training & research needs; development, harmonization and enforcement of standards; analytical facilities for hazard identification, risk

assessment for monitoring and enforcement of standards and for programme development. At present, the Ministry of Labour, which is the primary agency for the provision of occupational health & safety services, lacks the institutional capacity to address these issues on its own, while the Ministry of Health has to bear the burden of morbidity and mortality due to occupational hazards. It is the need of the hour to recognize the importance of intersectoral collaboration to address these issues by developing a national plan of action, strengthen institutional mechanisms and analytical facilities to remedy the situation.

(10) Important Assumptions/Risks/Conditions:

Assumptions

Occupational health hazards are more common among working population

Integration of primary health care services as an extension of the existing occupational health & safety services will result in better risk assessment practices and prevention of occupational hazards and accidents

PHC team is more suited to promote safety culture among employers and employees

Involvement of the PHC team is likely to strengthen surveillance, which will enhance effective enforcement of standards

Risks

Conflicting interests among officers at field level as well as national level belonging to different sectors may jeopardize the project

Conditions

Health is a devolved subject under the 13th amendment. As such, the cooperation of provincial health authorities is very essential **for implementation.**

The primary agency (Ministry of Labour) and other relevant agencies required to coordinate this project should cooperate fully for effective implementation.

(11) Project Objective

Objective	Indicators	Means of Verification
■ Occupational health & safety of the working population strengthened through divisional health system based on primary health care	Number of occupational health units established at district level	Administrative documentation by PDHS
	Number of MOHs & PHIs trained in OH &Safety	Administrative documentation by PDHS & D/ E&OH
	Hospitalization from occupational hazards -- % of occupational injuries hospitalised	Indoor morbidity & mortality return Periodical survey
	Number of factories conforming to safety standards	Ministry of Labour

12. Project Output/Product:

Output	Indicators	Means of Verification
An institutional mechanism to strengthen surveillance and services at divisional, district and national levels in place	Establishment of the system with policy guidelines	Policy document of MoH Data on occupational diseases and injuries available
A national plan of action on intersectoral collaboration for programme development and enforcement of standards developed and operational	National plan of action in place & operational Standards developed and regulatory framework reviewed & strengthened	Document available Number of inter-agency meetings held Inspection & Rating forms by MoL
Laboratory facilities for the analysis of poisons and other pollutants made available	Number of laboratories with enhanced capacity	Administrative documentation Survey

13. Related Projects *(include ongoing projects & projects under the Health Master Plan)*:

Project No.	Project Title
	NIL

14. Relevant Agencies to be Coordinated:

Ministries of Health, Labour, Environment, Plantations, Industries, Agriculture, Board of Investment, Poison Information Centre & NGOs

15. Monitoring & Evaluation:

1. Who? Ministry of Health, Inter-agency Committee of relevant stakeholders
2. When? Quarterly reviews, Annual report
3. What actions to be taken based on results of monitoring & evaluation?

   Critical reviews of progress made to make changes and improvements to the program

16. Major Activities:

Activities *(only major activities)*	Expected Results	Process Indicators
1. Formation of inter-agency Committee comprised of relevant stake holders	Establishment of an institutional mechanism for collaboration of different sectors	Periodical meetings
2. Situation analysis	Problems and priorities identified	Recruitment of consultancy services Compilation of baseline data Documentation

3. Formation of technical core group – appointed by the inter-agency Committee	Develop and finalise an inter-agency plan of action	Plan of action operational
4. Critical review of regulatory framework and enforcement mechanisms	Legislative changes made to address identified issues and mechanisms for enforcement developed	Amended legislation and standards in place
5. Development of an institutional mechanism to strengthen services and surveillance mechanisms	Policy and strategies developed to integrate occupational health services into PHC services	Collaborative mechanism in place at divisional level
6. Establishment of a national laboratory for analysis of poisons and other pollutants in collaboration with Poison Information Centre	Capacity to investigate & treat patients for occupation related poisoning strengthened	Improved management of Occupation related diseases & injuries

(1) **Project Title:**	Health of People in Urban Slums	(2) **Project Number:** 1.5.6 (3) **Project Priority:**
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**
(5) **Implementing Agencies:**	Municipal MOH and his staff MOH of the particular urban council areas. DPDHD, PDHS	(7) **Project Duration:**

Project Summary

The health problems of urban people are mainly related to their life style such as food habits, sanitation, etc and resource constrains. However, not much data is available. High risk groups specially the poor, living with in the urban that need special care. As such we have to identify the major health problems and issues, and presently available services and develop a policy and strategies to provide better health services to these under privileged urban slum people.
This project includes.
1. Situation analysis and the health problems of those who live in the urban slum.
2. Development of a policy and strategies for the Urban Health.
3. Identifying Major areas and issues for service delivery.
4. Identifying mechanisms to implement those strategies and activities.

(8) Target Areas & Beneficiaries:

All the people living in the seven Municipality areas and the Urban council areas.

(9) Justification:

Poverty in any society is a social as well as an economic phenomenon concentrated in "underprivileged groups", who have higher health needs than the general population and are usually suffer impediments to access quality health care services.

Urbanism potentate many changes in human behaviour like high tobacco smoking, traffic injuries, fatalities and adult obesity.

Urban populations around the world are increasing the pressure on the natural environment. As fuel combustion increases, as land is cleared, as the number of consumers and their expectations rise these are contributing to the degradation of the world's natural systems. The increasing number of vehicle causes intrusive noise, traffic accidents, and air pollution due to emissions. These emissions also contribute to acid rain and to the global accumulation of carbon dioxide.

Due to the local flooding and inadequate solid waste removal specially used car tyres and other small containers leading for collection of water causes breeding of mosquito and cause dengue fever.

Poor people's health status is influenced not only by access to health services and quality of care, it is even more a reflection of their access to resources (sufficient and nutritionally balanced safe food, safe water, clean air, protective habitat), the hazards to which they are exposed in society

in general (environmental pollution with refuse, petroleum products and stagnating water) and in their occupations, their own life skills and risk behaviour, and health seeking behaviour.

The proportion of the population living in the large towns, grown from 5% to 50% over the past 2 centuries. It is estimated that 50% of the city population lives in low-income settlements, therefore, the approximate population living in low-income settlement in Colombo is 321,000 or 77,612 families. 33% of those families have difficult access to drinking water, and only 33% of families have their own toilets. Only 12% have regular sources of employment, and 34% depend on self-employment activities.

The main characteristics of these communities are:

1) In Urban areas the accessibility to health care services is better compared with other areas such as rural and estates, Primary health care services are provided by local government and they have easy access and there are several teaching and specialized hospitals around the area. The well-developed public transportation in urban area contributes to the accessibility. But they are unable to obtain the services since all the government hospitals and clinics are closed after 4 pm and similarly the primary health care services also a problem as the MCH clinics are conducted during daytime and the weekdays. On the other hands they cannot afford the private health care services due to high cost.

2) Urban slum residents are often at the risk of diseases associated with poor sanitation and garbage disposal, unsafe drinking water, dangerous roads, polluted air, indoor air pollution and toxic wastes. Psychosocial health problems are also related to income including depression, alcohol, and drug abuse, suicide, violence and murder.

3) Malnutrition is among the most serious health problems in these communities because children, elders and working adults by and large consume unbalanced diets. Mostly convenience foods are consumed, which leads to high fat consumption with little micronutrient content. Malnutrition is closely related to the demands of their livelihood, their life style and environment because they don't cook much at home and buy the meals packets from shops, and they think buying from shops is cheaper and quicker.

The parents are working outside do not have a proper kitchen and no home garden. Most of their food is to fill rather than aim for a balanced diet. These energy dense processed foods and decline in physical activity and recreational activity is cause of obesity in city dwellers.

4) Urbanism, increased mobility, and relaxation of traditional cultural norms leads to new pattern of human behaviour including changes in sexual activities and use of alcohol and drugs. Alcohol and drug addiction, and HIV/AIDS is high in urban slum and is difficult to tackle. Because the problem is deeply connected with political and social structure. Alcohol and drug addict is the power full determinant of ill health as well as poverty. According to the available data age range of drug addicts varies and includes children of aged 13-14 years, there are significant numbers of females including pregnant, and lactating mothers. Alcohol and drugs are acceptable forms of recreation in their society. They seek relief from hard manual labour work and many existential worries by using them. Rehabilitation efforts for drug addicts are often useless because of their environment, drugs are sold around the corner, and most of their friends are addicted.

5) Family violence and neighbourhood brawls are also a serious problem specially after alcohol intake.

Therefore, it is important to address the needs of the urban slum poor as one of the key planning issues in formulating a master plan for health sector in Sri Lanka. Remedial activities for health benefits include improving housing and providing safe water, sanitation and waste removal.

(10) Important Assumptions/Risks/Conditions:

Health status of a population is dependant on the living condition and water supply and sanitation.

We have to have a multi-sectoral approach in health prevention and promotion strategies and it should be through appropriate technology in delivering the services. Most of the activities we have to work with the water board, and the Municipal council or urban councils. Also we have to use the exciting systems and mechanism to implement the programmes. Also political factors.

(11) Project Objective:

Objective	Indicators	Means of Verification
To develop strategies to provide better health services to the urban population with special reference to street children, migrant workers, slum dwellers and home less people.	Strategic frame work available	Records and retunes
	% Utilisation of health services	Periodic survey
	Selected health indictor segregated for urban areas	Periodic survey

(12) Project Output/Product:

Output	Indicators	Means of Verification
1. Identified service needs and developed strategic framework for Urban population	Strategic frame work available	Records
2.Enhanced service accessibility at all level.	% of population utilising basic public health services	Periodic survey
3. Facilitated to establish proper refuse disposal for safe physical environment.	Amount of solid waste disposed currently and in the past.	Periodic survey
4. Advocated to meet the basic needs such as food, water, shelter, safety and work for the urban people.	Changes in public policies in favour of urban health.	
5. Enhanced community participation in making decisions affecting their lives, health and well-being.	No of programme / activities with high community participation	

(13) Related Projects *(include ongoing projects & projects under the Health Master Plan)*:

Project No.	Project Title
	National programmes on environmental pollution
	MCH, HIV/AIDS, and EPI programme
	Malaria and filarial Control programme
	Mental health and ageing

(14) **Relevant Agencies to be Coordinated:**

Municipality and Urban councils and water supply and drainage board,

Non-governmental agencies,

Ministry of Social services, Ministry of Urban Development and planning, Ministry of Housing and Ministry of Education

Police, local top political leaders.

(15) **Monitoring & Evaluation:**

1. Who? Provincial, Central and local government health authorities.
2. When? Periodical monitoring and Evaluation at the end of the programme

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Need assessment and strategy development		
1.1 Situation analysis to find out the current status and GIS mapping of composition (by age, gender, education) of urban slum areas. And also find out nutritional status and educational standards.	Needs identified	
1.2 Develop a policy for urban health services	Policy document for urban health	
1.3 Develop strategies to provide the services.	Strategic framework developed	
2. Enhanced service accessibility at all level	Increased service accessibility	
2.1 Health promotional activities on sexual health.	Increased service accessibility for sexual health	
2.2 Health promotional activities on substance abuse including tobacco and alcohol.	Increased service accessibility for substance abuse	
2.3 Health promotional activities	Enhanced healthy weaning practices	

on wearing practices.		
2.4 Health promotional activities on healthy life style.	Enhanced healthy life style practices	
2.5 Life skill development of street children	Developed life skills for street children	
3. Facilitated to establish proper refuse disposal for safe physical environment.		
3.1 Health promotional activities on proper disposal of waste.	Enhanced proper disposal of waste	
3.2 Health promotional activities on prevention of vector borne diseases	Reduced Vector Borne disease prevalence/incidence	
4. Developing advocacy programme to facilitate basic needs of the urban slums	Developed advocacy programmes	
5. Enhanced community participation in making decisions affecting their lives, health and well-being.		
5.1 Assessment of factor affecting community participation of people living in the urban slums	Survey report on community participation	
5.2 Training project mangers on enhancing community participation	Developed skills on community participation	

(1) **Project Title:**	School Health	(2) **Project Number:**	1.5.7
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG./PHS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	D.MCH Ministry of Education	(7) **Project Duration:**	5 yrs

Project Summary

The school population in Sri Lanka consist of about 4.2 million children of the age group of 5-18 yrs. Of this about 60% belong to the adolescent age group of 10-18 yrs. The goal of the school health programme is to ensure that children are healthy, capable of promoting their own health and health of the family and the community and are able to optimally benefit from the educational opportunities provided. This includes opportunities provided to obtain correct information and develop life skills to prevent reproductive health problems including teenage pregnancy, HIV/AIDS, nutritional problems, substance abuse, stress, violence & suicide which are the common problems among these children. A major area of service delivery in the project is providing school health services for detection of health problems and correction, referral of needy children to specialist clinics and follow up, immunization, school dental services & counseling services for reproductive health problems. By providing a healthy school environment and life skills based health education, behavioral changes which are necessary to improve the health of the school child can be achieved. Also the burden caused by most of the prevailing health problems in the country including the non communicable diseases could be addressed in a cost effective manner through this. Community participation for this has to be developed for mobilization of resources. These services are delivered by the Medical Officers of Health & their staff at the Primary Health Care level. In addition to this some urban areas there are School Medical Officers designated to deliver these services. Since the health of the school child is a shared responsibility of the Ministries of Health & Education a close collaboration is maintained between the two sectors. Monitoring & evaluation of these activities is achieved through the Management Information System of the Family Health Bureau .

(8) Target Areas & Beneficiaries:

5 – 18 year old children in schools.

(9) Justification:

The school population in Sri Lanka consist of 4.2 million school children. Almost 60% of them belong to the adolescent age group of 10-18 years. The adolescent children are in the period of transition from childhood to adulthood. Therefore these children have health problems specific to their age group. They are a high risk group for nutritional problems such as Iron deficiency anaemia and other nutritional deficiencies.

A survey done by MRI in year 2002 has revealed that 13.1 – 20% of the adolescent children are anaemic, 8.6 – 26.2 % are stunted and 10.4 – 22% are wasted. The same survey has shown that 5-10% of the urban children are over weight and about 30% of children attend school without having breakfast. These nutritional problems unless addressed during the adolescent period will result in malnourished mothers and low birth weight infants and a high incidence of non communicable diseases in the future generation. Other important problems of this age group include tobacco and alcohol abuse, drug abuse, violence, stress related illnesses, suicide, teenage pregnancies, abortions and other reproductive health problems such as HIV AIDS. In

addition to these there are other problems that could be corrected if early action is taken such as dental problems , eye problems and problems relate to ear, nose, throat etc.Thus it appears that health promotion of these children in schools is very essential to reduce maternal mortality, infant mortality, non communicable diseases and other problems related to stress such as suicides. These could be effectively addressed through the school health programme in order to enable early detection and correction .Some of the very important activities that should take place for these children in the schools through this programme are correction of health problems, development of life skills and life skills based health education, healthy school environment and community involvement. Correction of nutritional deficiencies including anaemia, visual & hearing problems and other health problems through this programme will have direct impact on educational achievements of children. Screening of school children to detect health problems & correcting them is one of the very important activities of the School Health Programme in order to make them achieve their full educational potential. The capacity of the teachers need to be developed to involve them in establishing an environment conducive to health promotion in their schools. Child care practices & the knowledge of the problems faced by their children & the measures that should be adopted by them should also be addressed through the School Health Programme.

(10) Important Assumptions/Risks/Conditions:

Strategy will be a joint programme where Ministry of Education, Ministry of Health, Provincial Ministries and Departments of Health and Education are responsible & accountable.

- all existing vacancies of health staff involved in school health activities should be filled.
- Transport should be provided to staff involved in school health activities.
- large MOH and PHI areas should be redemarcated
- referral system should be strengthened

(11) Project Objective:

Objective	Indicators	Means of Verification
* *To ensure that all school children are healthy, capable of promoting their own health and health of the family & community, and are able to optimally benefit from educational opportunities provided.*	• Proportion of schools where school medical inspection done. • Proportion of health problems corrected. • No.of life skill based health education programme conducted for adolescent children for prevention of HIV/AIDS, substance abuse, reproductive health problems & nutritional problems	Quarterly school health return H 797 Quarterly school health return H 797 Quarterly school health return H 797 Surveys

Objective	Indicators	Means of Verification
	• Percentage reduction in anaemia among adolescent school children • Percentage of health promoting schools /school health clubs established • No. of programmes developed to inculcate social responsibility	Quarterly school health return H 797 Quarterly school health return H 797

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
School health policy including a policy for human resources from health & education sectors to be developed	School health policy is established	Availability of policy document
National Coordinating Committee established	National Coordinating Committee established & quarterly meetings held	Minutes of the meeting
Partnership between Health & Education Sectors strengthened	No.of meetings held with the participation of all relevant sectors No.of school health activities carried out with the participation of the relevant sectors	Minutes of the meeting
A group of master trainers for school health available at district level	Percentage of districts having a group of master training	Report from MO.MCH
Capacity of the central focal point developed for school & adolescent health (Extra regional training)	Two officers from the centre trained overseas	Data from FHB.
Capacity building of district level staff – overseas training	Two MO.MCH/MOH to be trained overseas on new concepts of school health	Reports from DPDHS
Capacity of health & education personnel at central & district level developed	Availability of protocols & guidelines with all the relevant health and education staff Proportion of schools having trained teachers Proportion of field health staff trained on new concepts of school & adolescent health	Reports from MO/MCH and Zonal Directors of Education

Output	Indicators	Means of Verification
A conducive School environment established	Proportion of schools having 1. Sanitation facilities according to the norm provided 2. Water supply according to the norm provided 3. Facilities for refusal disposal No. of schools provided with 1. Sanitary toilets during the quarter 2. Water supply during the quarter Proportion of schools where sanitation survey done during the quarter Proportion of schools implementing healthy environmental policies.	H 797 Quarterly School Health Return
School children developed necessary knowledge & life skills for reduction of risk behaviour	Proportion of children receiving life skill based health education programme Proportion of children improved in knowledge, attitude and practices on healthy life style Number of inter school quiz competitions conducted.	Reports from MOH KAP survey Quarterly School Health H 797
All correctable health problems detected & corrected	Proportion of schools SMI conducted Proportion of Eligible children examined Proportion of defects corrected Proportion of referred children received care at the referral centre	Quarterly School Health H 797
Nutritional status of school children improved.	Proportion of children 2. stunted 3. wasted 4. over weight No.of intervention programmes carried out at school level by MOOH Proportion of children with corrected nutritional deficiencies	Quarterly School Health Return H 797 Quarterly School Health Return H 797 & nutrition surveys
Counselling facilities accessible to all children	Proportion of schools having counselling services	Quarterly School Health Return H 797
All school children are	Proportion of Eligible School	Quarterly School Health

Output	Indicators	Means of Verification
immunized according to the immunization schedule	children receiving DT OPV, Rubella, aTd	Return H 797
School Dental services made accessible to all schools	Percentage of schools having access to dental care facilities and services	Report of SDT
Supply of essential equipment & other supplies made available to all relevant staff	Proportion of PHII having necessary equipment (weighing scales, height measuring tapes snellen charts) Proportion of MOOH, PHII and PHNS having the book containing the growth chart Proportion of MOOH having required amounts of printed forms	Report from MO.MCH
All human resources necessary for school health programme made available	No.of vacancies in all categories at all levels Availability of hospital medical officers for school health work Availability of trained teachers for school health work Availability of peer communicators	Report from MO.MCH
Implementation of programmes to promote healthy life style.	Proportion of schools having programmes to improve physical activity Proportion of schools having nutritional programmes	
Implementation of programmes to promote social responsibility	No. of clubs for extra curricular activities in operation No . of school club activities for the quarter No. of outreach projects carried out during the quarter No. of health programmes conducted with community participation	
Appointment of additional MOOH for school health work	Proportion of MOH areas having an additional MOH	Report from MO.MCH
Needs of school children including adolescent identified	Number of Operational research carried out Proportion of recommendations implemented	Report of the researchers. Minutes of the National Coordinating meeting

Output	Indicators	Means of Verification
Appropriate IEC materials developed and made available	Proportion of health/education staff having IEC materials Proportion of schools receiving IEC materials	Report from MOH
Supervision, monitoring & evaluation carried out	Proportion of Quarterly review meetings conducted at District level Annual review meetings at National level	Minutes of the meetings & surveys
Transport facilities provided to health staff	Proportion of MOO.MCH having vehicles Proportion of MOOH having vehicles Proportion of PHII having motor bicycles	Report from MO.MCH

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1.2.1.	Medical supplies including drugs
1.4.1.	Non Communicable diseases control
1.4.2.	Communicable disease control
1.7.1.	Development of national policy & plan on health promotion as well as strengthening of coordinating mechanism

(14) **Relevant Agencies to be Coordinated:**

Ministry of Education, Non Governmental Organizations (UNICEF, WHO, World Bank) , Environmental Authority, Ministry of Agriculture, Ministry of Housing & Construction, Ministry of National Planning, Provincial Health & Education Ministries & Departments,

(15) **Monitoring & Evaluation:**

1. Who? Family Health Bureau, MO.MCH, Ministry of Education , Zonal and Divisional Directors of Education
2. When? Monthly at MOH level, Quarterly at DPDHS level and Annually at the Family Health Bureau
3. What actions to be taken based on results of monitoring & evaluation?

   Identify problems in implementation replanning with necessary corrective action

   Provide feedback reports to the relevant personnel & follow up

   Provide training and guidance where necessary

   Rectify logistic difficulties and transport problems

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Appointment of a working group and regular meetings to develop school health policy	School health policy formulated	Availability of policy document
Routine meetings of National Coordinating Committee	Establishment of National Coordinating Committee and regular meetings to address issues & take decisions	Number of meetings held at the scheduled time Proportion of meetings where more than 80% of participants participated
Advocacy programmes for implementing Health Promoting Schools	Advocacy programmes for relevant officials carried out	Number of Advocacy programmes carried out at DPDHS level
Planning and review meetings for implementing Health Promoting Schools at DPDHS level	Planning and review meetings conducted	Number of Planning and review meetings conducted
Awareness programmes conducted for school principals, teachers on Health Promoting Schools	Partnership between the school and MOH/PHI improved	Number of awareness programmes conducted
Preparation & printing of guidelines for health & education staff	Availability of guidelines for health staff & teachers	Guidelines are available
Provision of equipment (weighing scales, height measuring tapes, snellen charts, book containing the growth chart Auriscope) for medical inspection of children	Equipment and growth charts available for nutritional assessment & medical examination of school children	Availability of equipment and growth charts
Supply of necessary drugs & micro nutrients	Availability of drugs (Mebandazole) & iron folic acid tablets, vit.C & other vitamins	Availability of necessary drugs & vitamins
Consultative Meetings with Hospital Directors and other Heads of Institutions to improve participation in school health activities	Mobilization of more medical officers from hospital for SMI. Improve the referral facilities in hospital clinics	Proportion of hospital doctors participating at SMI. Proportion of specialist clinics providing referral facilities to school children.
School Sanitation Survey conducted annually and data provided to the Ministry of Education and other relevant Ministries and Departments	Availability of sanitation & water supply	Percentage of MOOH providing data to the MO.MCH Number of schools provided with the sanitation facilities and water supply.
Printing of Guidelines & IEC materials	Guidelines & IEC materials are available for the health & education staff	Proportion of the needed number printed
TOT to develop master trainers	Availability of a group of master trainers at district level	Percentage of DPDHS areas with a group of master trainers

Activities	Expected Results	Process Indicators
Training programmes for field health staff	All field health staff trained in school health work	Percentage of Field health staff trained in school health activities
Printing of necessary formats for implementation of school and adolescent health programme	Printed forms available for school children to assess their health status	Proportion of the needed number available
Operational research to identify the needs of school children including adolescents and implement necessary projects	Needs for school children identified and project proposals prepared	Availability of new projects for adolescent school children
Capacity building of national focal point	National focal point trained overseas	Availability of two trained medical officers at national focal point
Transport provided for public health staff	MO.MCH, MOH, PHI are provided with transport facilities	Percentage of MOO.MCH/ MOOH/ PHII with transport facilities
Life skills Based Health Education programmes for school children	Children will develop Knowledge and skills required for prevention of HIV/AIDS, substance abuse and reproductive health problems	Proportion of school conducting such programmes by MOH area
Awareness programme for parents on adolescent health problems & their needs	Awareness created among parents	Percentage of schools where at least one such programme conducted per year
Addressing cross cutting issues to improve service delivery 1. Appointment of a additional MO.MCH at DPDHS level for supervision and monitoring of school health activities 2. Appointment of additional MOOH to allMOH offices 3. Filling of vacancies of MO.MCH, MOOH and PHII 4. Redemarcation of large MOOH and PHII areas	Additional MO.MCH appointed to all DPDHS areas Additional MOH appointed to all MOH areas All MO.MCH, MOOH and PHII vacancies filled All large MOOH and PHII areas redemarcated	Proportion of DPDHS areas having an additional MO.MCH Proportion of MOH areas having an additional MO Percentage of MO.MCH, MOOH and PHII vacancies filled Proportion of large MOOH and PHII areas redemarcated
Monitoring & evaluation	Quarterly review meetings held at district level to review progress. Annual progress review at national level	Number of Quarterly review meetings held at district level Annual progress review meeting held at national level

(1) **Project Title:**	***Health in North – East and border Provinces :*** Strengthening Health Services for People in Conflict-Affected Areas and Displaced Populations	(2) **Project Number:**	1.5.8.a
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	Secretary	(6) **Starting Fiscal Year:**	2003
(5) **Implementing Agencies:**	Ministry of Health, Nutrition & Welfare and Provincial Ministries of Health in North & East, North Western Province, North Central Province, Uva and Southern Provinces.	(7) **Project Duration:**	2003-2008

Project Summary

The project for "Health of people in Conflict-Affected areas" aims at improving the accessibility to health services to a level comparable with the rest of the country within a five-year period. As such the key issue is the acceleration of the restoration process with more emphasis on establishing effective management structures and procedures and thereby the efficient management of resources. The project spans across many of the ongoing health programmes in the country; primary health care, secondary and tertiary care, emergency health services, Blood bank services, management of health services, transport facilities, laboratory facilities, Safe water and waste management systems in hospitals, Management information systems and making available the required Human resource for service delivery.

It can be assumed that after successful completion of the project activities during the specified period that the normal health care delivery programmes will continue to be implemented. Implementation of these activities after the 5-year period will be defined through other relevant project profiles.

The project also emphasizes on the need for an effective mechanism to address policy issues at the central and provincial level in order to facilitate the implementation process.

While a comprehensive needs assessment has already being carried out at District level for the north & east province, a similar assessment will be required in other districts bordering these areas that have been affected as a result of the conflict situation.

(8) Target Areas & Beneficiaries:

North East province (of which mainly the northern region), other provinces bordering north east province such as North western, North Central, Uva and Southern provinces which were directly or indirectly affected by the conflict and in which displaced persons were/are located in welfare centres.

The Beneficiaries will be the general community in these regions and also the health care providers.

(9) Justification:

A comprehensive approach is required when addressing the issue of improving the health of populations affected by conflict. Currently health care delivery and the health status of the people affected can be seen as the outcome of the conflict situation that prevailed over the past 2 decades, which had disrupted the general health services in the areas. The situation is worse in the northern region. The health service delivery system was in disarray to a larger extent in this region and to a lesser extent in the Eastern region. Other areas bordering these two regions have also been affected. Welfare centres have been set up in border districts and general health services have been disrupted on and off due to the conflict situation. The main problem is a general lack of Human resource in professional and skilled staff categories. Destroyed health infrastructure has lead to some communities being relatively in accessible to basic health care. The situation is further aggravated by the deficiencies in Management of health services due to

lack of trained staff in management and at technical supervisory levels, lack of support staff and proper epidemiological surveillance and data management systems.
There is a clear difference and deterioration of health status and resource accessibility indicators between conflict affected areas and others in the island. A restoration programme needs to be planned with the aim of bridging this gap and at least restoring health care services in conflict affected areas to a level on par with the rest of the country.
Many of the currently used programme strategies and resource development mechanisms are seen to be inefficient to cater to the development that is envisaged in the restoration of health services in conflict affected areas.
This project aims at delivering the restoration programme in a more coordinated and efficient method.
The project also aims in providing better co ordination and guidance to the provincial management in order to plan and achieve the expected outcome within the stipulated time frame.

(10) Important Assumptions/Risks/Conditions:

10.1. Current ceasefire remains and that there is progression towards lasting peace situation

10.2. Relevant short-term policy changes could be made to intervene with regards to certain critical issues in the restoration programme such as the acute shortage in selected Health Human resource categories.

10.3. Detail needs assessment have been made for status of health delivery systems in the North & East. However the areas bordering North & East have not been subjected to formal assessment. A formal rapid needs assessment will be required.

10.4. All plans for improving accessibility to health services in conflict affected areas will require intensive input to make good the deficiencies in Human resources in health, and this will be an important precondition to the restoration of health services in these areas.

10.5. A detail operational plan needs to follow the Master plan and relevant management systems /organization changes /new structures are required to be in place at central and provincial level in order to carry out the activities during the transition period.

(11) Project Objective:

Objective	Indicators	Means of Verification
To restore accessibility to health services in conflict affected areas to a level on par with other areas in the country by year 2008	Staff: population ratios (Grade Medical Officers : 100,000 population Specialists: 100,000 population Nurses : 100,000 population Paramedicals: 100,000 population Field health staff* : 100,000 population) Dr : nurse ratio Proffessional : non professional staff ratios	Comparison of ratios with other parts of the country Information from DPDHS/ PDHS Only selected indicators on staffing are mentioned here. A detailed list is included under the project profile for Human Resource development in conflict-affected areas. * *field health staff – MOH,*

Objective	Indicators	Means of Verification
		PHI, PHNS, SPHM , PHMW,SDT
	Availability of detail operational plan at district and provincial level	
	Availability of appropriate management structure at central, provincial and district level to deliver the restoration programme	Appropriate management structure will be defined A qualitative assessment can be done by Ministry of National Planning
	% Availability of trained technical staff at DPDHS and PDHS office Availability of service management institutions such as Drug stores, Biomedical engineering units etc	Staff in-position returns from DPDHS office and PDHS office (*Based on approved cadre and requirements for MO planning, MO MCH, Regional Epidemiologist, Regional Dental Surgeon, Supervising PHI(district), Regional Supervising Public Health nursing officer, Health Education Officers.)*
	Primary health care centre : population ratio	
	% Registration of pregnant mothers before the 4th month of POA	
	% of deliveries conducted in health institutions by trained health personnel	
	% of secondary care institutions with blood bank facilities of acceptable standard according to national blood bank guidelines	
	%Availability of facilities to carry out the expected basic laboratory investigations in secondary care institutions.	The laboratory tests that should be performed in secondary care level institutions to be determined. A score to be developed and averaged for a district/area. This can be included in the hospital information system
	% of Primary Medical care institutions which have the required facilities to attend to medical emergencies	The equipment that should be provided to primary medical care institutions has to be determined. A score to be developed and averaged for a district / area
	% of Secondary care	The equipment that could be

Objective	Indicators	Means of Verification
	institutions which have the required facilities to attend to medical emergencies	provided to Secondary care institutions to be determined. A score to be developed and averaged for a district / area
	% Availability of Essential Obstetric care facilities in health institutions that require such facilities	The type of facilities required and the number of health institutions that should be provided will be determined according to the plan for providing essential emergency obstetric care facilities.
	% Availability of the planned number of ambulances in primary and secondary care level institutions	From DPDHS/PDHS according to their district Health plan
	% Availability of the planned number of transport facilities for management of health services	This will include transport facilities for supervisory staff, Medical officers of Health, transport of drugs and vaccines, bioengineering services, control programmes etc…
	% of health institutions that have safe drinking water % Of health institution that have hospital waste management systems.	Water supply of Health institutions are expected to be assessed by the range PHI. Water sample to be collected from every health institution (a standard for frequency of testing is required, a mechanism of reporting this by PHI through MOH to DPDHS is needed. A reliable mechanism for testing the samples is required) The type of waste management system to be adopted at each level and type of institutions is to be determined.
	% Of health institutions that have 24 hr water supply	Periodical (Half yearly) survey to be done by DPDHSs
		DPDHS Office
	% of health institutions that have epidemiological surveillance systems in place	Components of Epidemiological surveillance system with regards to the institution to be defined

Objective	Indicators	Means of Verification
	% of Health institutions that have management information systems in place	'Management information systems in place' needs to be defined and a score can be developed with checklist for assessment.
	Selected Outcome indicators; 1. % Reduction in Incidence of neonatal tetanus per 100,000 live births	Outcome indicators are composite indicators and will not point to a particular area for intervention. However can be sufficiently sensitive as the rates and % will be high to reflect change in overall situations.- from hospital records
	2. % Reduction in Maternal mortality rate	,,
	3. % Reduction in Infant mortality rate	,,
	4. % Reduction in deaths due to diarrhoeal disease	,,
	5. Bed occupancy rate and average length of stay in secondary care and primary medical care institutions	,,
	6. Mental Health	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Appropriate health care management systems developed at central, provincial and district level 1. Management structure in place 2. Detail HRD plan available 3. Detail operational plans available 4. Management information systems in place 5. Epidemiological surveillance systems in place		
1. Primary health care strengthened 1.1. Increased number of functioning primary medical care institutions	1.1.1 Number of functioning Primary medical care centres per 100,000 population	'Functioning' status to be defined. Other indicators to be used in conjunction with given indicator to describe the situation – *from DPDHS- Half yearly information from Hospitals to DPDHS to be*
1.2. Increased number of functioning community	1.2.1. Number of functioning community primary health	

Output	Indicators	Means of Verification
primary health care centres	care centres per 100,000 population	*introduced* 'Functioning' status can be defined as those centres that provide antenatal care, immunization, family planning, growth monitoring etc.. Hence other indicators that reflect these activities can be used in conjunction with the given indicator to describe the situation – information from MOH through DPDHS
1.3. Increased number of trained deliveries	1.3.1. % trained deliveries out of total deliveries	Routine reporting from PHM through MOH
1.4. Increased number of pregnant mothers receiving care in early pregnancy	1.4.1. % of estimated pregnant mothers who are registered in antenatal care before the 4th month of pregnancy	Routine reporting from PHM through MOH
2. Secondary health care strengthened		
2.1. Buildings reconstructed in place of destroyed health institutions	2.1. % of destroyed buildings reconstructed to a level that is suitable to provide secondary care	Reporting system to be adopted at relevant DPDHS level during the period of restoration of services
2.2. Existing health facilities at health institutions improved	2.2. % of improvements carried out in existing buildings that required improvements (on a health facility basis) i.e. :No. of health institutions in which improvements were carried out X 100% Total number of health institutions that required improvement	Requirements for improvements will be as identified in the District health plans of DPDHS
2.3. Secondary health care provided (with placement of professional staff)	2.3.1. Number of functioning secondary health care institutions per 100,000 population 2.3.2. Number of secondary care beds per 100,000 population	'Functional' status to be defined *eg. The four basic specialties + emergency care with laboratory and basic radio diagnostic facilities to be provided*
3. Tertiary health care developed / newly set up		
3.1. Teaching hospital Jaffna developed according to recent Master plan of the hospital	3.1. Progress on implementation of the Master plan for TH Jaffna	From Director TH Jaffna, DDG Logistics, MoH
3.2. Cancer curative services established	3.2. % of cancer patients transferred/referred out of district for management	A Cancer registry needs to be maintained. *Other indicators are required to further describe the situation. Such as All*
3.3. Chest hospital	3.3. Progress on construction	

Output	Indicators	Means of Verification
constructed in Jaffna	of Chest Hospital in Jaffna	*causes of cancer : 100,000 population*
3.4. Detoxification unit for mental health services	3.4. Availability of a functioning Detoxification unit.	
3.5. A secure unit established at DH Thellipalai	3.5. Availability of a functioning Secure unit	Functional status to be described – Consultant Psychiatrist TH Jaffna
3.6. Other tertiary care institutions		,,
4. Development of Psychosocial care support systems 4.1. Need identified 4.2. Stakeholders meetings 4.3. Framework for development identified 4.4. Plan for development identified 4.5. Currently available mechanisms strengthened – trained volunteers retained /absorbed into regular service. 4.6. Relevant policy interventions to accommodate Psychosocial care development made	Process indicators	
5. Blood bank services strengthened 5.1. Regional blood bank established at TH Jaffna and GH Ampara	5.1.1. *Indicators for a functioning regional Blood bank (? identified from Blood bank programme)*	From DPDHS. Could be included in a routine information system – Half yearly information from health institutions
5.2. Blood bank services established in all secondary care institutions	5.2.1. % Of secondary care institutions with trained staff in blood bank services 5.2.2. % Of secondary care institutions with the full complement of required equipment for blood bank services relevant to secondary care	*Relevant set of equipment for blood bank services at secondary care level to be determined by NBTS*
6. Emergency medical services strengthened 6.1. Emergency medical care facilities available in secondary care institutions	6.1. % of secondary care institutions with emergency care provided *(Level of emergency care to be provided at secondary care level to be defined – eg list of*	From DPDHS. Or? Could be included in a routine information system – Half yearly information from health institutions

Output	Indicators	Means of Verification
	equipment available)	
6.2. Emergency care facilities available in Primary care medical institutions	6.2. % of Primary Medical care institutions with emergency care facilities *(Level of emergency care to be provided at primary care level to be defined – eg list of equipment available)*	,,
6.3. Trained staff available to manage medical emergencies in Secondary care institutions	6.3. % of secondary care institutions with trained staff available to manage medical emergencies	*Training level/nature of , to be defined. -Based on a report from the health institution*
6.4. Trained staff available to manage medical emergencies in Primary care institutions	6.4. % of Primary medical care institutions with trained staff available to manage medical emergencies 6.6 .Outcome indicators for selected clinical conditions can be introduced	*Training level/nature of , to be defined. -Based on a report from the health institution*
7. Improvement in the availability of trained human resource in health Note: that a separate project profile has detailed the plan for Human Resource development	7.1. Grade medical Officers : 100,000 population 7.2. Specialists : 100,000 population 7.3. Nurses : 100,0000 population 7.4. Paramedical staff : 100,000 population 7.5. Field health staff (MOH, PHNS, PHI, SPHM, PHM, SDT) : 100,000 population *(separate rates for each category can be used also)*	From DPDHS
8. Improvement in availability of transport facilities for curative care and preventive health programmes		From DPDHS
8.1. Ambulances for secondary and Primary medical care institutions	8.1. % of Primary medical and Secondary care institutions planned to have ambulances, that have ambulances	
8.2. Vans to transport EPI vaccines	8.2. %Availability of vans to transport EPI vaccines out of the number required for province	From PDHS/DPDHS
8.3. Lorries to transport drugs	8.3. %Availability of Lorries to transport drugs out of the number required for province	,,
8.4. Vehicles for Rabies	8.4. % Availability of vehicles	

Output	Indicators	Means of Verification
control programme 8.5. Vehicles for Bio engineering maintenance work	for Rabies control programme out of the number required for province	
8.6. Vehicles for technical and supervisory staff at DPDHS offices	8.6. % Availability of vehicles for technical and supervisory staff out of the number required for the district	From DPDHS
8.7. Vehicles for all MOH Offices	8.7. % Availability of vehicles for MOH offices	From DPDHS
8.8. Motor cycles for Public Health Inspectors	8.8. % Availability of Motor cycles for PHIss	Through MOH , from DPDHS
8.9. Scooters for Public Health Midwives	8.9. % Availability of Scooters for Public health Midwives out of the PHM identified as requiring this mode of transport	*Criteria for identifying PHM who will require Scooter as against the usual accepted mode of transport provided through the DoH (bicycle) to be defined.*
8. **Laboratory services strengthened in secondary and primary medical care institutions**		
8.1. Optimum laboratory services provided in primary medical care institutions	8.1. % of Primary Medical care institutions providing optimum laboratory services for that level	*Laboratory services to be provided at Primary medical care level to be defined*
8.2. Optimum laboratory services provided in secondary care institutions	8.2. % of Secondary care institutions providing optimum laboratory services for that level	*Laboratory services to be provided at Secondary care level to be defined*
9. Improvement in information management systems		
9.1. Database at DPDHS level , health institution level (secondary and tertiary care hospitals and at MOH offices)	9.1. Availability of an appropriate Database at DPDHS *(Qualitative indicator)*	Appropriate databases to be defined and relevant training to be given
9.2. Trained staff to record, analyse and report data	9.2. Availability of appropriate database at secondary and tertiary care hospitals 9.3. Availability of relevant database at MOH office level.	Assessment to be made at MoH level and feed back given *Internal mechanism at provincial and district level needs to be developed to assess and give feedback on the quality of the data base at curative and preventive care institutions. –* Report of this can be made to MoH
10**. Improvement in availability of trained technical support staff for management of health**		

Output	Indicators	Means of Verification
services 10.1. Trained Technical support staff available at DPDHS and PDHS offices	10.1. % Availability of technical support staff categories from the required number The rate can be given for each category separately too. *(Note: required number may be different from currently approved cadre)*	From DPDHS
11. **Improvement in availability and safety of water supply and sanitation and waste management systems in health care institutions**		
11.1. Availability of 24 hr water supply in all Tertiary, Secondary and selected primary medical care institutions	11.1. % Availability of 24 hr water supply in Tertiary care Institutions 11.1.2. % Availability of 24 hr water supply in Secondary care Institutions 11.1.3 % Availability of 24 hr water supply in Primary medical care Institutions	Periodical (Half yearly) survey to be done by DPDHSs /to be included in a routine ½ yearly information report to DPDHS from Health institutions. ,, ,,
11.2. Mechanism for regular testing of quality of water in all health care institutions established	11.2.1. % of health institutions examined for quality of water by range Public Health Inspector per month	To be assessed at Medical Officer of Health level and can be reported to DPDHS
11.3. Trained hospital staff in waste management	11.3. % of health institutions that have trained staff for implementation of proper waste management systems	Level and content of training to be determined – can be included in the ½ yearly report from health institutions
11.4. Low cost incinerators in all Secondary and Primary medical care institutions	11.4. % of health institutions that have low cost incinerators in Secondary and primary medical care institutions	From DPDHS - can be included in the ½ yearly report from health institutions

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

This project profile presents several cross cutting issues that will/are to be addressed in other projects. Some of them are mentioned below:

Project No.	Project Title
1.2.2	Medical Equipment
1.3	National Quality Assurance Programme

1.3.2. 1.1.3.c	Development of Emergency Services ….. Strengthening the Emergency Obstetric Care …..
1.4.2.	Diseases Control programme Communicable Diseases Control
3.1.	Programme for the production and Strengthening of Human Resources for the Health Sector
5.2.	Management Development Programme
5.4.	Strengthening of Health Information System Programme
5.6.	Inter – Sectoral Programme

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health

Chief Secretaries of the provinces mentioned

Provincial Health Ministries, Provincial and Regional Health Managers

Non governmental and International Non Governmental organizations

Respective health care Institutions and or Hospital development committees

Local Authorities, Provincial councils

Water supply and Drainage board

Electricity boards

Central Engineering Consultancy Bureau / Buildings Department

(15) **Monitoring & Evaluation:**

1. Who? Provincial Ministry of Health, Ministry of Health
2. When? On- going regular at operational level (process indicators, output indicators) – time series

   Quarterly/ half yearly at Central level (out put indicators) – comparison between areas/institutions
3. What actions to be taken based on results of monitoring & evaluation?

   Central level – intervention to overcome policy constraints, with special regards to Human resource

   Operational level (Province) – intervention to facilitate, better coordination of resources & management inputs and timely action to overcome local operational barriers

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Primary health care : 1.1. Reconstruction of damaged institutions 1.2. Improvements to existing primary	Increased coverage of primary medical care	% Completion of planned reconstructions,

Activities	Expected Results	Process Indicators
medical care institutions 1.3. Construction of new primary medical care institutions in service deficient areas. 1.4. Construction of Gramodaya health centres 1.5. Construction of MOH office buildings 1.6. Construction of accommodation facilities for health staff 1.7. Make available required trained staff – see section 6.	services ,, ,, Increased coverage of primary community health services ,, As above As above	constructions and improvements % Completion of planned constructions ,, ,, % Availability of required trainers % Availability of required trainees
Activities	**Expected Results**	**Process Indicators**
2. Secondary care strengthened: 2.1. Reconstruction of damaged institutions 2.2. Improvements to existing secondary care institutions 2.3. Construction of new institutions 2.4. Construction of accommodation facilities for health staff 2.5. Make available required trained staff – see section 6.	Accessible secondary care that enable future development of a proper referral system for health system	% Completion of planned reconstructions, constructions and improvements
3**. Tertiary care services** c. Development of Teaching Hospital Jaffna d. Construction of cancer hospital e. Construction of Chest hospital in Jaffna f. Construction of Detoxification centre g. Establishment of Secure unit Add – on Development of framework for psycho social care	Provision of comprehensive tertiary care for the region Patients be cared in surroundings closer to home, thereby reducing number of transfers for cancer care outside the northern region Improved management ot respiratory diseases in the northern region Improved management of patients with Psychiatric disorders	% of activities accomplished according to the Master plan for TH/Jaffna % Availability of required staff % Availability of required facilities According to a master plan that will be developed for this purpose
4. Blood bank services 4.1. Establishment of regional blood banks at TH Jaffna and GH Ampara 4.2. Establishment of blood bank services in	To make blood transfusion services available and accessible to all tertiary and	% Availability of trained staff to manage blood transfusion services % Availability of the

Activities	Expected Results	Process Indicators
secondary medical care institutions	secondary care institutions	required equipment
5. Emergency medical care 5.1. Training of health staff 5.2. Provision of medical equipment for management of emergencies	To improve the health outcome of patients with selected morbidities that may require emergency care	 % of staff trained from numbers planned for training % of medical equipment purchased from the numbers planned for purchase
6. Human Resource in Health 6.1. Establishing suitable mechanism within MoH to discuss policy issues and constraints for development of Human Resource 6.2. Making available Specialists to tertiary and secondary care institutions 6.3. Oncologist and Physicist for establishing cancer care to Jaffna 6.3. Making available grade medical officers 6.5. Training of adequate paramedical staff 6.6. Training of nurses 6.7. Training of Public health midwives 6.8. Management support staff included in section 10	 An effective and efficient mechanism for taking timely policy decisions at the central level in consultation with the relevant stakeholders The availability of sufficient numbers of staff will make a significant impact on the health services at all levels	 % availability of specialists from the required cadre according to the re- categorization of health institutions
7. **Transport services** 7.1. Purchase of vehicles	To improve coverage and accessibility of services through improved mobility of patients and health care providers	% of planned numbers of vehicles purchased.
8**. Laboratory services** 8.1. Developing standards for services to be provided at tertiary, secondary and primary care levels 8.2. Purchase of equipment 8.3. Making available required trained staff	Standards that will be developed will be useful as a guide for implementation island wide. Availability of laboratory services appropriate to the level of care will minimize bypassing of smaller institutions	
9. Management information system 9.1. Development of appropriate database at different levels	Databases developed will be a useful guide for	

Activities	Expected Results	Process Indicators
9.2. Training of staff in information management	implementation island wide	% of staff trained as per the plan
9.3. Purchase of hard ware and software	Data presentation (analytical tool) software to be developed which can be used for the whole country	
10. Trained technical support staff for management of health services 10.1. Making relevant cadre provisions 10..2. Recruitment of staff 10.2. Training of staff	Improved management of health services	% of cadre approved from the required number of staff % of staff trained
11. Adequate Safe water and hospital waste management systems 11.1. Constructions/improvements to water supply, storage. Distributions systems in health institutions	24hr water supply available in all tertiary, secondary and primary medical care health institutions	% of institutions identified to improve water supply that have been assessed by water management engineers % of institutions that have a plan for improvement of water supply % of institutions that have carried out the plan for improvement % of hospitals in which the staff have been trained in waste management
11.2. Training of hospital staff in waste management	Proper hospitals waste management systems developed in all tertiary and secondary care institutions	% of hospitals that have planned for low cost incinerators
11.3. Construction of low cost incinerators		% of MOH areas (by district) that have access to a suitable arrangement for testing the quality of water as given in the guideline
11.4. Setting up Public health laboratories	Setting up of Public health laboratories – one for at least 2-3 districts	
	Guidelines for testing	% reporting by PHIs of

Activities	Expected Results	Process Indicators
11.5. Supervision of Public health inspectors in the testing of quality of water in health institutions	quality of water by PHIs developed Safe drinking water available in all health institutions.	routine testing of quality of water in health institutions (minimum, maximum and average levels for each MOH area)

(1) **Project Title:**	***Health in North – East and boarder Provinces :*** Development of Human Resources for Health, North - East Province	(2) **Project Number:**	1.5.8.b
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	Secretary	(6) **Starting Fiscal Year:**	2003
(5) **Implementing Agencies:**	Ministry of Health, Provincial Ministry of Health	(7) **Project Duration:**	2003-2008

Project Summary

This project aims at making health services more accessible to people in conflict-affected areas through improving availability of human resource in health.
Planning of Human resource for health services in such situations should be given special emphasis as regular human resource development strategies usually do not suffice in bringing the desired effect in that they are not responsive to the urgency of the demand and hence timely action cannot be taken.
The project profile is described in two sections;
1. Developing a mechanism within the Health Sector that can respond to such situations
2. Developing a HRD plan for the transition period, with the incorporation of short-term policy changes and new strategies to address the urgency in conflict-affected areas with special reference to North & East.

(8) Target Areas & Beneficiaries:

North East province (of which mainly the northern region), other provinces bordering north east province such as North western, North Central, Uva and Southern provinces which were directly or indirectly affected by the conflict and in which displaced persons were/are located in welfare centres.
The Beneficiaries will be the general community in these regions.

(9) Justification:

Providing adequate Human Resource for health care delivery is the crucial rate-determining step in restoration of health services in the conflict-affected areas and particularly in the North & East.

Other infrastructure developments will not bring about the expected impact in health service delivery unless adequate Human Resources are provided for curative, preventive and health management services. In fact many of the health institutions and community services are under performing due to severe deficiencies in staffing in these areas.

Human Resource Development consists of several functions of which Training is the responsibility of the Central Health Ministry. Recruitment, Transfer and Deployment of Specialist doctors and Grade Medical Officers are also functions of the Health ministry. Recruitment and in-service training of some categories of staff and their deployment and transfers are carried out by the Provincial Health Authorities.

Currently there are island wide deficiencies in HR in health in several categories of the professional and para professional staff categories. Whilst this is so, the deficiencies are seen to be more acute in the conflict-affected areas.

Presently HRD functions are scattered in different units within the Ministry of Health and this type of functional arrangement is not seen to be effective to bring about the desired result. The system is also not geared to handling short-term HR policy changes.

As current usual practises of HRD will not suffice, in order to plan for restoration of Health services in the transition period, a more responsive HRD plan must be implemented for the conflict affected areas.

This profile aims at describing a mechanism whereby restoration of health services is possible through:

1. The development of mechanism within the Ministry of health that can respond to the urgent and unusual demands of post conflict situations
2. The development of an HRD plan for the transition period, with the incorporation of short-term policy changes and new strategies to address the urgency in such areas.

(10) Important Assumptions/Risks/Conditions:

10.1. Current ceasefire remains and that there is progression towards lasting peace situation
10.2. A HRD unit is established within the Ministry of health which can deal with HR policy and strategic management issues and that,
10.3. This unit can work in close coordination with a special team appointed for Urgent HRD Planning and with the provincial health authorities for N & E and that,
10.4. The special team can identify short-term policy changes that are required or can sufficiently address the issues concerned for this purpose with the provincial health authorities.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ To improve availability of Human resource in health with the required skill mix, by filling at least the current cadre vacancies by end of 2005 on an equitable basis and or make alternate short term arrangements to improve service coverage.	Staff: population ratios (Grade Medical Officers : 100,000 population Specialists: 100,000 population Nurses : 100,000 population Paramedicals: 100,000 population Doctor : Nurse ratio Professional staff : non professional staff ratio Field health staff* : 100,000 population)	Comparison of ratios with other parts of the country Information from DPDHS/ PDHS * *field health staff – MOH, PHI, PHNS, SPHM , PHMW,SDT*
	% Staff vacancies filled (by category of staff)	
	% Staff available from the required number by category of staff	

(12) Project Output/Product:

Output	Indicators	Means of Verification

1. HRD team for N & E	HRD team identified	
2. HRD plan for conflict affected areas	Availability of HRD plan	
3. Mechanism to identify and discuss HRD policy issues	Time allocated for discussion on HRD policy issues at NHDC	
4. Relevant short term Policy changes to facilitate improvement of HR availability		
5. Availability of Specialist Doctors		
6. Availability of Grade Medical Officers		
7. Availability of field health staff (PHNS, PHI, PHMW)		
8. Availability of health management and technical support and supervisory staff. (DPDHS, Hospital managers, MOOHs, Regional Epidemiologists, MO (MCH)s, MO(Planning), HEOs, SPHI, Food & Drug Inspectors		
9. Suitable mechanism for engaging the services of already trained Volunteers.		

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1.5.4.	Programme for Vulnerable populations - Health of the people in Conflict – affected areas and displaced populations
3.1	Programme for production & Strengthening of Human Resources for health sector
3.2 3.2.1 3.2.2. 3.2.3.	Programme for rationalization of Human Resources for the health sector
3.3.	Programme for Improving job performance of health personnel

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health, Nutrition & Welfare
Provincial Health Secretaries
Provincial and Deputy Provincial Health Directors
Public Service Commission
Political Organizations
Treasury
Ministry of National Planning
External Resource Department

International Non Governmental Organizations
Funding agencies
UN agencies

(15) Monitoring & Evaluation:

1. Who – Provincial Health Ministries and Central Ministry of Health, Nutrition & Welfare
2. When – Quarterly at central level, Monthly / bi monthly at, Provincial Health Committee.
3. What actions to be taken based on results of monitoring & evaluation?

Central level – intervention to overcome policy constraints, Negotiations with relevant stakeholders

Operational level (Province) –

1. Making relevant stakeholders aware of the HR situation with regards to numbers(in position and vacancies) , level of training , continuing education programmes

2. Interventions to facilitate better coordination of resources & management of inputs and timely action to overcome local barriers to the actual physical availability of Human resource at the institutions (eg. Accommodation facilities, communication, transport,)

(16) Major Activities:

Activities	Expected Results	Process Indicators
1. Development of the HRD plan for conflict affected areas	HRD Plan developed	
2. Implementation of Plan	Improvement in staff availability and service coverage	
3. Improvements to training	Improvement in availability of trained staff	
4 Obtaining services of selected types of Specialist Doctors to high priority areas	Secondary and tertiary care institutions to provide expected level of care	
5. Obtaining services of Specialists for cancer services	Cancer care services reestablished	
6. Urgent improvements/new construction of accommodation facilities for health staff.	Improvement in availability of health staff	
7. Strengthening mechanism for management of health services through new recruitment and training of Health management and technical support staff.	Enhanced management skills and performance management system to be established	
8. Identifying mechanism for continued engagement of services of the already available health volunteers.	To sustain at least existing service coverage by continuing services of already trained volunteers.	

1.6 NATIONAL NUTRITION PROGRAMME

1. Project Title: Formulation of a National Food and Nutrition Policy & Plans including Strengthening of Coordinating Mechanism.	**2. Project Number:** 1.6.1 **3. Project Priority:** Anchor Project
4. Focal Point: **A**dditional Secretary **(**Nutrition / Medical Services)	**6. Starting Fiscal Year:** 2004
5. Implementing Agencies: Coordinated by Director, Nutrition Coordination Division with the support of all relevant agencies within the Ministry of Health	**7. Project Duration:** 4 years *

Project Summary:

Formulation of a Food and Nutrition Policy for Sri Lanka with special emphasis on the following;

- Examine the present nutritional status of the population highlighting the incidence of malnutrition and the prevalence of nutrition imbalances.
- Examine the status of the food security of the population in relation to nutritional value of the main food items, dietary habits/food consumption patterns and assess their impact on the nutritional status of the people, in order to determine the necessary interventions.
- Review the present food and nutrition policies, strategies and programmes and their implementation at household level to determine their adequacy and efficacy to achieve the desired food and nutrition levels and standards.
- Develop food and nutrition policies, strategies and programmes for the improvement of household food and nutrition security to the required standards during the period 2004 to 2010 with special emphasis on health sector interventions.
- Identify the means of mobilizing resources for the implementation of food and nutrition policies, strategies and programmes, which are coming under the purview of the health sector.

Propose an effective coordination, monitoring and evaluation system at the operational level and the policy making level to ensure effective implementation of the health sector food and nutrition policies and programmes.

* **The Task Force to develop a Food and Nutrition Policy for Sri Lanka** established under the Cabinet decision dated 18th September 2002, has already engaged in preparation of a Food and Nutrition Policy for Sri Lanka and to develop a Plan of Action for the period of 2004 – 2010. Based on this policy interventions in relation to health sector should be identified separately.

(8) Target Areas and Beneficiaries:

When being implemented the policy and strategies should help to, support household food security specially in vulnerable groups, improve nutritional status of the population with special emphasis on mothers and children, take life long course of prevention of non–communicable diseases, improve the health of the aged and evaluate & correct nutritional status, PEM and micronutrient deficiencies.

(9) **Justification:**

Despite success in many social development and health indicators, and heavy investment in social sectors, the malnutrition problem persists in Sri Lanka. The stunting, wasting and under weight particularly among children have been identified as significant problems. In addition, micro nutrient deficiencies such as Iron Deficiency Anemia, Vitamin A Deficiency and Iodine Deficiency exist particularly among children and women. On the other hand, unhealthy diet related non- communicable diseases such as diabetes, hypertension and cardiovascular diseases are emerging problems in Sri Lanka.

Malnutrition is recognized as a multi- sectoral problem. The control of malnutrition will be facilitated through the formulation of a Food and Nutrition Policy, leading to Nutrition oriented National Development Plans.

Thus, nutrition is a key development issue and therefore should occupy the center stage in the development planning, policy formulation and implementation. This reinforces the need for a multi-sectoral and integrated approach in developing a sound Food and Nutrition Policy for Sri Lanka. Within this broad policy framework health sector interventions are the main concern under this project.

(10) **Important Assumptions/Risks/Conditions:**

The future policy and strategies will need to be inter- sectoral and accept a variety of delivery channels not only in the health sector but also in other relevant sectors such as Food and Agriculture, Education, Public Utilities and non governmental organization and community based organizations. This approach needs constant guidance and protection and also the political-will and the consensus among higher-level policy-makers.

Within the Health sector several units should play a role in the formulation of plans as well as in implementation such as Director/ FHB, Director/HEB, Director/Nutrition, Head/Nutrition Division MRI, Director/NCD, Director/E&OH, Director/E & UH, Director/for Elderly, Director/Nutrition Coordination Division. This major innovation in joint planning may be difficult.

The outline of the policy is clear, but the plan will involve improved new delivery methods, clear standard messages for improved food and nutrition security (in Sinhala, Tamil and English) which include only scientifically responsible advice but take into account Indigenous Medicine concepts and popular cultural terminology. This may need pilot testing and evaluation before being generalized.

(11) **Project Objective:**

Objectives	Indicators	Means of Verification
1. Formulation of a National Food and Nutrition Policy for Sri Lanka.	Policy document Inter sectoral plans/ sectoral plans Programmes and Projects implemented. Results based monitoring and evaluation system established. Process indicators (No of beneficiaries	Approval of the Cabinet of Ministers / Govt. Gazette Acceptance of the respective sectors/sector Review meetings & Progress Reports Progress Reports

Objectives	Indicators	Means of Verification
	covered, Goods/services delivered etc.) Outcome indicators - % Improved/changed	 Impact evaluation reports

(12) **Project Output/Product:**

Out put	Indicators	Means of Verification	Identification of Linkages
1.National Food & Nutrition Policy formulated	Acceptance by the implementing agencies (Relevant government sectors/sector and NGOs)	Acceptance letter/letters/documents	The Task Force on Food and Nutrition Policy for Sri Lanka and relevant agencies of MHNW, involved in the formulation of the policy
2. Health sector plans on Food & Nutrition prepared.	All concerned implementing agencies and authorities agreed and plans are available with them.	Action plans of health sector	FHB, HEB, MRI, Director/Nutrition and the Nutrition Coordination Division
3.Intervention Programmes/projects prioritized and implemented.	Number of interventions programmes and projects in operation	Review meetings /Progress reports	Above mentioned agencies will prioritize the programmes/projects
4. Inter-sectoral coordination/ inter–agency coordination within the health sector established and functioning.	Decisions taken at the Inter-sectoral coordination/ inter–agency coordination within the health sector	Minutes of the meetings/reports on Inter-sectoral coordination/ inter-agency coordination within the health sector	FHB, HEB, MRI, Director/Nutrition, NCD and NGO sector will be coordinated under Addl. Secretary (Nutrition)
5. Monitoring & evaluation and feedback mechanism on health sector programmes established and functioning	Decisions taken at the Monitoring and Evaluation meetings	Review if indicators through regular meetings and studies conducted.	Monitoring & Evaluation functions will be coordinated under Addl. Secretary (Nutrition)

(13) **Related Projects:**

Programme/Project No	Project Title
1.1.3	Strengthening of Services for Mother & Child
	Emergency Preparedness & Response
1.3.3	Strengthening the Emergency Obstetric Care & Neonatal Care
1.4.1	Non-Communicable Diseases Control
1.4.2	Communicable Diseases Control
1.5.1	Estate Health
1.5.2	Elderly Health
1.5.3	Disabled Health
1.5.4	Health of People in Conflict-Affected Areas and Displaced Populations
1.5.5	Adolescent Health
1.5.7	Health of People in Urban Slums
1.7.	Health Promotion Programme
2.1.2	Raising Awareness of the Community Regarding Health Needs & Services

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health Nutrition & Welfare, Ministry of Education, Ministry of Agriculture & Livestock, Ministry of Fisheries, Ministry of Social Welfare, Ministry of Housing & Estate Infrastructure, Ministry of Samurdhi, Ministry of Mass Media & Communication and Ministry of Policy Development & Implementation and with in the Ministry of Health Director/ FHB, Director/HEB, Director/Nutrition, Head/Nutrition Division MRI, Director/NCD, Director/E&OH, Director/E&UH, Director/for Elderly, Director/Nutrition Coordination Division etc.

(15) **Monitoring and Evaluation**

Monitoring and Evaluation will handle by an Inter Ministerial Committee at National level and sector level by the Sectoral Monitoring and Evaluation Committee.

(1) **Project Title:**	Establishment of a mechanism to implement the national nutrition program	(2) **Project Number:**	1.6.2
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG.PHS	(6) **Starting Fiscal Year:**	Jan 2004
(5) **Implementing Agencies:**	M/HNW, Provincial Health System	(7) **Project Duration:**	10 years

Project Summary

This project is designed to encompass all sectors responsible for improvement of nutrition Sri Lanka and is primarily with a focus on the department of health services nutrition care delivery programs.
Integration of services provided through the hospital and field health system has been emphasized o strengthen the existing programs and also minimize duplication of services. Focus on population groups which are not emphasized in the current program such as the adolescents, elderly and disadvantaged groups have been included. Management of nutrition in crisis situations has shown a disarray as well as catastrophy after the disaster. A scientific basis for early warning & also management during disaster including mobilizing donor assistance systematically has been included. Nutrition Information is conducted as a routine requirement with the significance of such information not been realized and utilized for improvement of services at field level. Use of the triple A process in information management has been included in this project
Collaboration and also utilizing services of the private sector for improvement of nutrition has been included. Food fortification in accordance with national nutrition policies is a certain method of improving the micro nutrient deficiency status in the country. Recognition of priorities of the private sector and developing mechanisms for bilateral benefits are important for successful implementation of this project.
Community based organizations which often operate independently of the government sector will provide services which are concrete efforts to improve the nutritional status of the communities which they serve. Partnership in growth promotion & monitoring will definitely ensure a much more successful coverage of children and also promote growth which is an identified fall back in the field based system.
Collaborative promotion of nutrition services delivered through other government sectors such as agriculture (to promote household level of food security) has been included in this health sector plan as the health (field) nutrition delivery system has to operate with a holistic view on nutrition. The close contacts the field health system has with the communities will help in promoting these services.

(8) Target Areas & Beneficiaries:

All population groups

(9) Justification:

Protein energy malnutrition depicted by about one in every fourth child not reaching its full growth potential emphasises the need for the national nutrition program. Micro nutrient deficiencies still affect the population and the high-risk groups such as pregnant mothers and children have evidence of these diseases. The existing programs have been in operation for more than two decades and certainly needs a review and revision to suit the currents trends and findings. Use of experiences in other countries must be utilized in revising these existing programs. Some of the evaluations have shown poor compliance, which has still not been

addressed. The economic changers with market economy been successfully established in Sri Lanka, provides opportunities for expansion of services to spheres not considered before.

With benefits of market economy, hazards of changing lifestyles result in the emerging problems of diet related diseases, which need to be addressed in a national health sector plan on nutrition. Much control can occur with nutrition related interventions such as occurred in Finland. Therefore new interventions to promote healthy eating and adequate physical activity have to be included in new nutrition plan.

(10) Important Assumptions/Risks/Conditions:

The proposal is designed with consideration of the existing health system. Although there is a decentralised health system, program implementation has been in collaboration with the central health administration. If full autonomy is given to the provincial administration, re-organisation of the focal points will have to occur.

Current trends and future predications were considered in developing this proposal, but if unexpected changes natural or man made occur, the design may need adaptation to suit either a crisis situation or a improved status.

(11) Project Objective:

Objective	Indicators	Means of Verification
■ To reduce the prevalence of Macro and Micro nutrient deficiencies and its related consequences and control the emergence of obesity & diet related diseases.	Prevalence of under nutrition weight/ age, Height /age, weight/ height, VAD prevalence, IDD prevalence, IDA prevalence	Routine reporting system
	Obesity prevalence	H 509, indoor out door morbidity mortality registers
	CVD , hypertension age specific trends	Cancer register
	Diabetes mellitus age specific trends.	Special Surveys
	Diet related cancer	DH survey
	Osteoporosis prevalence	

(12) Project Output/Product:

Output	Indicators	Means of Verification
1.Hospital based nnp established to address growth promotion, improved nutritional care in pregnancy and effective nutritional management of patients admitted to hospitals.	Number of hospitals implementing nnp	Routine reporting system, special surveys, surveillance programs
2. Field based nnp established to strengthen existing programs and improve the nutritional status of other	Number of MOH areas implementing new field based nnp	H 509 routine reporting system, surveys, surveillance systems, review meetings

Output	Indicators	Means of Verification
vulnerable groups & more effective management of nutrition in special situations.		
3. Community based nnp established to ensure active participation of the community in improvement of nutrition and collaboration with government sector field based nnp.	Number of community based programs implemented in collaboration with field based nnp,	New reporting system , field based monitoring
4. Private Sector based nnp established to seek collaboration on nnp and increase facilities for improvement of nutrition.	Number of mass media campaigns, compliance with nutrition labelling, number of foods fortified in concurrence with govt nutrition policies, nuber of private health sector institutions implementing nnp	Number of private sector organisations collaborating

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Currently WHO 2002-3 funds are available

(14) **Relevant Agencies to be Coordinated:**

Provincial Health System, other Government departments, Community based organizations, Private health care delivery system.

(15) **Monitoring & Evaluation:**

1. Who? DDG PHS 11, Provincial Health System
2. When? Monthly, Quarterly, Annually
3. What actions to be taken based on results of monitoring & evaluation?

   Remedial: action taken including staffing problems

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
A. Establish hospital based nnp		
1. Establish a micro nutrient control program	Effective control of micro nutrient deficiencies	Supplies data on micro nutrient, hospital morbidity data
2. Establish a growth promotion	Effective promotion of growth	Number of education

Activities	Expected Results	Process Indicators
program 3. Establish nutritional management of obesity & diet related diseases. 4. Establish a clinical nutrition program 5. Effective implementation of the breast feeding code . 6. Collaborative (field hospital) management of pregnancy 7. Collaborative (field hospital) management of small for dates babies 8. Recruitment of new cadre 9. Conduct an evidenced based research program 10. Revise hospital nutrition information system .	Effective management of obesity & diet related diseases Clinical nutrition facilities in hospitals Breast feeding promoted in hospitals Effective referral – re –referral Improved growth of small for dates babies Adequate cadre to mange nutrition in hospitals Evidenced based research findings used for program improvement Effective provision of information	programs, number of children whose growth has improved Number of patiets couselled Number of hospitals implementing clinical nutrition program Number of hospitals violating code Number of mothers managed collaboratively Number of small for dates babies followed up Number of new cadre recruited Number of research contracts Number of hospitals implementing new information system
B. **Establish field based Nnp** . 1. Establish an effective gmp program . 2. Strengthen anc care programs 3. Establish school and adolescent nutrition programs . 4. Establish elderly nutrition care programs .	Reduced prevalence of under nutrition Improved nutrition in pregnancy Improved nutritional status among school children, adolescents. Increase awareness on nutrition of the elderly Control of diet	Weight/ age, Height/ age, Weight / height Wt. Gain in pregnancy Number of schools collaborating Number of new elderly food security programs,

Activities	Expected Results	Process Indicators
5. Establish program to manage nutrition in special situations	related diseases Reduced macro and micro nutrient deficiencies among elderly. Early warning of nutrition disasters, , effective management of nutrition in emergencies	New nutrition plan to mange disaster nutrition, number trained in early warning, number- MOH with improved capacity
6. Revise nutrition information system .		
7. Conduct an evidenced based research program	Data used for field , central level program improvement	Number of MOHs reporting with new format
	New research used for program improvement	Number of research projects completed
C. Establish community based nnp		
1. Establish a data base of community based organizations implementing nutrition programs	Database – availability and accessibility……..	Number of CBS collaborating.
2. Implement collaborative household level food security programs with CBOs .	Improved household level food security	Number of food security program
3. Establish a reporting system for community based activities implemented by CBOs.	Availability of nutrition activities implemented by non government organization.	Number of CBOs using new System
4. Establish a collaborative mechanism to implement the GMP programs	Improved coverage of GMP	Nutrition of MOH areas collaborating with CBO.
5. Establish a collaborative mechanism to implement in nutrition emergencies	CBO support in Managing emergencies Collaboration in training and awareness program at field level.	Acceptability of nutrition plan by CBOs.
6. Develop a mechanism to share technical expertise f.		Number of collaborative training programs
D. Establish private sector based NNP		
1. Collaborative provision of nutrition information to public.	Uniformity in nutrition information	Number of foods - nutrition labels, numbe r of mass media programs,

Activities	Expected Results	Process Indicators
2. Develop a mechanism to promote fortification of foods in keeping with nutrition policies	Effective control of micronutrient deficiencies	number of advertisements complying with food regulations
3. Develop a partnership in production of nutritionally healthy food based on consumer needs .	Nutritionally healthy foods available to consumers	Number of food fortification programs
4. Establish a partnership with consumer organizations to protect consumer rights to nutritionally healthy foods.	Increased awareness among consumers on nutritionally healthy foods	Number of private sector organisations complying
5. Establish consensus programs with private sector hospitals to deliver nationally accepted nutrition programs.	Uniformly in delivering of nnp	Number of programs conducted
6. Develop a program to share technical expertise .	Staff of technical resources.	Nutrition of private sector hospitals implements.
		Number of resources shared

1.7 HEALTH PROMOTION PROGRAMME

(1) **Project Title:**	Development of National Policy & Plan on Health Promotion including Strengthening of Coordinating Mechanisms	(2) **Project Number:**	1.7.1
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG (PHS)	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Ministry of Health D/PHC, Provincial Health authorities NGO sector agencies	(7) **Project Duration:**	10 Years

Project Summary :

The health system in Sri Lanka has realized the importance of health promotion to achieve its goals. **The Key Stake Holder Forum** will bring together a number of influential people with key roles in health promotion in Sri Lanka. They will articulate **a vision for health promotion:** how they would like to see health promotion in Sri Lanka and formulate **policy** statements for health promotion. **Establishment Leadership Coalition** for specific health issues will enhance partnerships, pool resources and avoid duplication of work. They will develop a **Strategy Coordination Framework** for specific issues, which identify key elements of all major strategies and hence facilitate linkages. Respective Coalitions will review and re-focus existing health programmes to address more on health determinants than individual behavior change.

(8) **Target Areas & Beneficiaries:**

Total population countrywide

(9) **Justification:**

Health Promotion is not only a concept but also a working strategy for addressing health issues in the present socio economical context. Today, the health system in Sri Lanka has realised the importance of health promotion to achieve its goals. However, there is no documented health promotion policy for Sri Lanka. Furthermore, focus of health care delivery system is more towards curative and preventive services than promotion of health.

Therefore, it's important to develop a health promotion policy for Sri Lanka, considering the strategies proposed in the Ottawa Charter and other consequence international conference of health promotion. A forum of key Stakeholders of health promotion should be established in order to formulate such policy document and to advocate for commitment of all sectors for health promotion.

Focus of many health promotion projects are mainly on changing behaviours. These projects need to be refocused to address the effects of system factors; the determinants of health, to achieve health promotion goals. Developing health promotion vision will enable project managers to direct their respective projects towards optimising health rather than minimising diseases.

Health promotion efforts should involve multiple strategies, it is also important to synergies activities to achieve sustainable and effective change. However, Overlapping duplication of work, fragmented projects on the same issue is common features of the present health promotion efforts. A great diversity of funds and resources are available for health promotion. But these funds have not been used effectively due to lack of a coordination mechanism. Therefore, Leadership coalitions will provide a mechanism for coordination and will improve the quality of health promotion efforts by sharing technical expertise. It is important to tryout several models such as pooling resources and frame work for strategy coordination in health promotion.

(10) **Important Assumptions/Risks/Conditions:**

Key Stakeholders and Health promotion project leaders are responsive and sensitive to the issue.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
Development of a National Policy and plan on health promotion as well as strengthening of the coordination mechanism.	Produce a policy document on health promotion	Submission of report
	Establish Key Stakeholder forum	Reports and records
	Establish leadership collision (partnerships)	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Established KEY STAKEHOLDER FORUM for health promotion in order to develop and advocate for health promotion policy, and vision for Sri Lanka.	Number of National level forum meetings Develop a draft policy document	Review of reports and minutes
2. Leadership coalition developed for specific areas of health promotion efforts with the view to developing effective partnerships and pooling of resources.	National level partnerships (Leadership Collisions) established	Review of reports
3. Developed a model for pooling resources for health promotion and coordination framework for health promotion strategies.	Develop framework for 'Pooling Resources' Develop frameworks for 'Strategy Coordination'	Reports and records

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	NIL

(14) **Relevant Agencies to be Coordinated:**

Ministry of Health, Provincial Ministries of Health

(15) **Monitoring & Evaluation:**

1. Who? Director PHC
2. When? Monthly, Quarterly, Annually
3. What actions to be taken based on results of monitoring & evaluation?

   Review the existing policies and amend appropriately. Evaluate the partnerships and improve program coordination accordingly.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1.1 Review Key Stakeholders of Health Promotion programme in Sri Lanka including NGO sector and established Key Stakeholder forum.	Establish a Key stakeholder forum	Number of meetings held
1.2 Formulate and document health promotion policy and vision for Sri Lanka for next ten years.	Policy document developed	Draft documents
1.3 Developing models for pooling resources for health promotion.	Models for 'Pooling resources'	Review existing programme
1.4 Training to enhanced lobbing capacity (advocacy) for health promotion leaderships.	Developed advocacy skills Identified issues for advocacy	No of trainers and trainees
2.1 Establishment of leadership coalition for specific areas of health promotion such as smoking, violence and healthy life style.	Established leaderships colosions in selected areas/issues of health	Listing of health promotion leaderships by issues
2.2 Review existing health promotion strategic plans for each area in order to re-focus on determinants of health, and exchange technical knowledge.	Refocused health promotion projects	Change in programme frameworks
2.3 Develop Strategy Coordination Framework for specific health promotion areas.	Develop Strategy Coordination Frameworks for specific issues	Formulation of frameworks
2.4 Pilot testing of Strategy coordination framework	Working framework agreed up on by stakeholders	Formulation of framework

(1) **Project Title:**	Establishment of implementation mechanism for Health Promotion Programme	(2) **Project Number:**	1.7 2.a
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS, D/HEB	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Health Education Bureau National programme directorates Provincial Depts. Of Health	(7) **Project Duration:**	5 years.

Project Summary

In Sri Lanka there is a well established infrastructure setting for Health Care and Health Promotion. There are five(5) national programmes for prevention of communicable diseases and a unit for implementation of specific programmes and timely action for preventive interventions. There is a reasonable PHC network and institutional care system. Behaviour Change Communication(BCC) interventions and health promotional strategies need to be strengthened for prevention of communicable diseases. Community participatory and extension education techniques need to be effectively adopted for preventive action, intervention, need to be planned monitored and evaluated with active participation of relevant infrastructure facilities – personal and institutions and the community. Community and social mobilization interventions need to be intensified.

(8) **Target Areas & Beneficiaries:**

National Ministry of Health, Provincial Ministries of Health, National Programme Directorates and management PHC managers and PHC workers.

(9) **Justification:**

Prevention of communicable diseases is major component of health promotion in Sri Lanka. considering the need for strengthening the planning, implementing, monitoring and evaluation of interventions for prevention of communicable diseases the propose implementation plan has been prepared.

(10) **Important Assumptions/Risks/Conditions:**

Health Education Bureau of the Ministry of Health has to co-ordinate the proposed activity implementation with active participation of relevant national programme directors and managers. Provincial Ministries of Health need to be committed for activity implementation.

Risks:

Non availability of funds

Assumptions :

Ministry of Health will provide financial and technical assistance

Conditions: Programme to be implemented with the existing manpower without recruitment of new staff

(11) **Project Objective:**

Objective	Indicators	Means of Verification
Prevention and control of communicable diseases	Co-ordinating mechanisms at National Provincial and district levels established.	Progress reporting and guidelines for activity implementation through periodical planning and review
	Task forces and technical teams established at relevant programme implementation settings	Activity implementation plans and progress reporting
	Extension education community participatory and Health Promotional interventions planned implemented and evaluated	Periodical reports, progress review and evaluation Improvement indicated with data.

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Effective and realistic planning at all levels of implementation	Periodical review.	Monitoring forms
Proper schemes and materials for training manpower development	Availability of materials and guides for trg/manpower development	Formats and documents on progress review.
Implementation plans and development of extension education and participatory techniques.	Plans for activity implementation and monitoring with proper delegation of responsibilities.	Reports on achievements and shared experiences.
Activity implementation and evaluation at all levels.	Progress review and corrective action at implementing levels	Impact analysis based on dates.

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1	IEC implementation plans of national programmes
2	IEC implementation plans reproductive health
3	Implementation plan Health Promotion in schools
4	Voluntary Health Worker Programme for Health Promotion

(14) **Relevant Agencies to be Coordinated:**

- Ministry of Health,
- Provincial Ministries of Health
- Ministry of Education
- National Institute of Education (NIE)
- National Programme Directors/Health Sector

- Provincial and Zonal Directorate of Education
- Dy. Provincial Directors of Health

and Divisional Directors/Health

(15) Monitoring & Evaluation:

1. Who? Programme Directors/Managers at different levels.
2. When? Quarterly and annually
3. What actions to be taken based on results of monitoring & evaluation?

   Corrective measures as indicated and sharing of experience with relevant National/International agencies.

(16) Major Activities:

Activities	Expected Results	Process Indicators
National level consultative review and planning meetings	Guidelines and admn. support for activity implementation at national level	Availability of guidelines and activity implementation plans
Provincial level consultative review and planning meetings	Guidelines and admn. support for activity implementation at provincial levels	Availability of guidelines and activity implementation plans
Organisation of task forces at national programme Directorates for program implementation	Activity implementation plans and plans for review and evaluation.	Availability of activity implementation plans
Conduction of training and Orientation programmes	Persons with new skills	Involvement in activity implementation
Review and evaluation at different levels	Processes/methods for review and evaluation	Availability of reports/data availability of information/data
Review and evaluation at national programme centres	National level review and evaluation	Availability of information/data
Material development and research	Empowerment of population to prevent communicable diseases	Materials developed, research reports

(1) **Project Title:**	Capacity building in Health education and promotion	(2) **Project Number:**	1.7.2.b
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS, D/HEB	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Ministry of Health, Health Education Bureau, NIHS/D/Training	(7) **Project Duration:**	5 years with intention of extending.

Project Summary

Health education and health promotion needs a group of competencies and skills, which are relatively new for officers coming from different educational background and qualification. Therefore periodic tanning of officers including new recruitment is an essential component in the HEB

Following strategies should be adopted to face above challenge.
1. Establishment of training unit in the HEB
2. Development of distance education modules for officers
3. Organized periodic and fixed training programme

(8) Target Areas & Beneficiaries:

Health workers of all categories.

(9) Justification:

Capacity building is an important component to ensure quality of services. As a national institution Health Education Bureau has a mandate to train other health staff within and out side the department of health on health education and promotion. Therefore, officers of the HEB as well as other health workers should be empowered with new knowledge and strategies.

(10) Important Assumptions/Risks/Conditions:

Assumptions:

Funding and support of Ministry of Health and non health sectors is present.

Risks :

Lack of rescores personals

(11) Project Objective:

Objective	Indicators	Means of Verification	relevant agencies
■ Capacity building of health workers including HEB staff on necessary knowledge , skills and	No trained HEB staff	evaluation reports	Relevant directors of Ministry of
	% of trained health workers	evaluation reports	

competencies on health education and health promotion	Establishment of tanning unit	evaluation reports	Health, and provinces.
	Developing distance education package.	Evaluation reports	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification	Relevant authorities
1.Establishment of training unit in the HEB	Training unit established	Reports	
2. Development of distance education modules for officers	Number of distance education package developed	Reports	
3. Organized periodic and fixed term training programme	Number of training courses conducted	Reports	

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	Human resource development programme

(14) **Relevant Agencies to be Co-ordinated:**

Relevant directors of Ministry of Health, Provincial authorities

(15) **Monitoring & Evaluation:**

1. Who? HEB
2. When? Periodic reviews and evaluation workshops
3. What actions to be taken based on results of monitoring & evaluation?

   Further improvements in programme planning, and implementation after evaluation of programme

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1.Establishment of training unit in the HEB		

1.1 identify and trained resource personals in HEB	HEB staff trained on new competencies and skills on health education and promotion	No of training programme
1.2 providing training resources including materials and equipment .	Training unit equipped with resources	Number of equipment purchased
1.3 Training need assessment	Training need assessed	Training need assessment survey
2. Development of distance education modules for officers		
2.2 Assessment of distance education needs	Training need assessed	Training need assessment survey
2.1 Development and distribution of distance education modules	No of modules developed	No of consultative meetings held
3. Organized periodic and fixed term training programme		
3.1 Development of training course units	Training course units developed	No of consultative meetings held
3.2 Training course conducted	No trained	No of training course held

(1) **Project Title:**	Health Promotive Setting Approach	(2) **Project Number:**	1.7.2.c
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS, D/HEB	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Ministry of Health, Health Education Bureau, Provincial Directors of Health Services Deputy Provincial Directors of Health Services.	(7) **Project Duration:**	5 years with intention of extending .

Project Summary

The concept of health promotion (HP) and the "settings approach" to health promotion is used as strategies by developed countries to achieve health of the population. This is a new development in the health field of Sri Lanka and Health Education Bureau has identified 'settings' such as schools, hospitals, workplaces, estates, religious institutions and communities for HP programme planning and implementation. HP activities such as individual capacity building through training and education for HP in one end to Advocacy, Facilitation, and social mobilisation to promote supportive environments and health literacy to improve the health and social outcomes of the general population is done through a "settings approach"

1.Health promoting schools program 4.Health promoting hospitals
2.Health promoting estates 5. Health promoting communities
3.Health promoting workplaces program

(8) Target Areas & Beneficiaries:

General public, and disadvantaged populations and target groups of each individual setting

(9) Justification:

The declaration of Ottawa charter on health promotion in 1986 has provided considerable guidance on the actions and strategies that could be used to promote health of people. The competencies of health managers and relevant officers in the non health field need to be strengthened on health promotion interventions using the settings approach to promote health of people more effectively and cost effectively.

(10) Important Assumptions/Risks/Conditions:

Assumptions :

The resource allocation and support of Ministry of Health and non health sectors is present.

Trained health personnel continue to engage in public health field and at HEB

Risks :

Intersectoral coordination difficult to achieve

As a 'system and organisational change' is needed for proper establishment of health promotion settings, successful implementation needs time and commitment of stakeholders

Conditions :

Trained staff and funds present who can initiate the Health Promotion program planning and implementation

(11) **Project Objective:**

Objective	Indicators	Means of Verification	relevant agencies
■ Improved health status of the population through settings approach to health promotion program	Pre test	Pre test	Ministry of Health, Director PHC, Director (MCH), Director training, Ministries of Education and Labour,
	no of health promotive settings established in identified settings	periodic surveys	
	% availability of smoke free workplaces	review of reports	
	Implementation of policies which support health	review of reports	
	% change in knowledge and attitudes on health issues	periodic surveys	
	% of officers in each trained category with competencies on health promotion	Evaluation reports	
	Curriculum revision of Public health officers , under and post graduates to include health promotion concept	review curriculum	
	%improvement of behavioural risk factors		

(12) **Project Output/Product:**

Output	Indicators	Means of Verification	Agencies
1.Health Promotion settings concept accepted as a means to promote health of people, by Ministry of Health	Establishment of a policy on different health promotion settings programmes formulated in the Ministry of Health	Reports	Relevant directors of MOH
2.Health promotive settings established under each setting	Establishment and functioning of health and Fitness centres in institution.	Report from Institution.	-MOH, MOE,
3.Establishment of an information system for evaluation and information at National and provincial level	Formulate Reports on health promotion activities	periodic reviews/ reports	

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	capacity building of middlelevel managers on Health promotion
	Health promotive schools programme

	Health promotive hospitals programme
	Health promotive workplaces programme
	Estate health programme

(14) **Relevant Agencies to be Co-ordinated:**

Relevant directors of Ministry of Health, MOL, Ministry of Education, Ministry of Environment, Ministry of Local Government, Provincial health ministries,

(15) **Monitoring & Evaluation:**

1. Who? HEB
2. When? Periodic reviews and evaluation workshops
3. What actions to be taken based on results of monitoring & evaluation?

   Further improvements in programme planning, and implementation after evaluation of programme

(16) **Major Activities:**

Activities	**Expected Results**	**Process Indicators**
1.Development of policy guidelines for each health promotive settings	Implementation of planned programs in all areas	
1.1Establish a coordinating body at National level	Review of HP Program	Monitoring body established
1.2 Conduction of Advocacy workshops for HP programme at national level and provincial level under different settings	Programme implemetation facilitated	Review of advocacy strategies used
2 Health promotive settings established under each setting	Improved health indicators	Review reports
2.1Development and printing of training & reading material on health promotion in different settings	Developed & printed training guides	Drafts prepared and material printed
2.2 Health promotiive schools programme implemented at national and district level	health promotive schools established	% of particular settings established
2.3Health promotiive hospitals programme implemented at national/provincial and district level	health promotive hospitals established	% of particular settings established
2.4Health promotiive estates programme implemented at national and local level	health promotive estates established	% of particular settings established
2.5Health promotiive workplaces programme implemented at national and local level	health promotive workplaces established	% of particular settings established
2.6Health promotiive communities programme implemented at national level	health promotive community settings established	% of community settings established
3. Establishment of an information system		
3.1 Developing Information system	Information system developed	Forms and records designed

4. Research on HP settings	Planning process streamlined	Research information
5. Monitoring and review of programs	Improve quality of HP programs	Monitoring reports

(1) **Project Title:**	Establishment of implementation mechanism for HP program	(2) **Project Number:**	1.7.2.d
		(3) **Project Priority:**	
(4) **Focal Point:**	DDG/PHS, D/HEB	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Ministry of Health, Health Education Bureau, Provincial Directors of Health Services Deputy Provincial Directors of Health Services.	(7) **Project Duration:**	5 years with intention of extending .

Project Summary

Lifestyle related diseases are on the increase in Sri Lanka. The 10 commonest causes for hospital deaths are related to unhealthy lifestyles of people.
The commonest causes for these are wrong dietary habits, poor physical exercise, stress, alcohol and smoking.

A comprehensive health program to address all the issues related to this problem is needed to improve the lifestyles of the people to reduce the mortality and morbidity related to LSR Diseases.

1. Nutrition improvement and weight control program
2. Promotion of Physical activity program
3. Alcohol and smoking prevention program
4. Stress reduction and relaxation program

(8) Target Areas & Beneficiaries:

General public, and high risk groups

(9) Justification:

Due to rapid urbanisation and consequent change in lifestyles, diseases like Hypertension, diabetes, heart diseases, stroke, cancers and suicides are increasing in Sri Lanka. The major risk factors causing them are poor dietary habits and obesity, lack of physical activity, alcohol and smoking and stress. People need to be empowered to act to improve their lifestyle through skills building and education.

At present exercise habits are poor due to cultural inhibitions especially among females with high humidity & sweating adding to this problem. The trend towards fast foods among young causing obesity and high expectations for achievement leading to increased stress and high suicide level is a serious concern. Hence, skills building to improve individual health behaviour and making a supportive environment for people to make the healthy choice easily are a high priority area in the health sector.

(10) Important Assumptions/Risks/Conditions:

Assumptions :

Trained health personnel continue to impart training of population on skills on LSRD Prevention

Funding and support of Ministry of Health and non health sectors is present.

Risks :

Socio cultural and system factors causing people to engage in unhealthy behaviour

Cultural inhibitions to engage in exercise

Conditions :

People will accept the physical activity program andbe motivated to participate and practice

Supportive environments present to practice healthy lifestyles

(11) **Project Objective:**

Objective	Indicators	Means of Verification	relevant agencies
■ Improved lifestyle related behaviour of population to reduce morbidity and mortality of LSRD's	Improved lifestyle related KAPB of target population	Periodic surveys	Relevant directors of Ministry of Health, Ministries of Education and Labour, Urban and municipal councils
	Reduce incidence of mortality and mortality due to LSRD five years after implementation of program	review of hospital reports, census and statistics data	
	% improvement in BMI in high risk and target populations	evaluation reports	
	% of individuals who practice exercises consciously to promote health	periodic surveys	
	% of health workers in each category trained on HLS	Evaluation reports	
	% of underweight premarital females in their 20's		

(12) **Project Output/Product:**

Output	Indicators	Means of Verification	Relevant authorities
Established LSRD Prevention program in all preventive and curative health institutions	% of institutions with LSRD prevention program established	Review meeting	Directors of MOH
Developed information and training package on healthy lifestyles	No of items developed from IEC package	Rreviews	Other relevant directors
health workers competent on LSRD prevention present in field	Project progress reports confirms establishment % health workers trained	evaluat' reports	PDHS/RDHS/ MOH

Field health staff trained in MOOH's	Performance of trainers shows adequate competency	observation	PDHS/RDHS/ MOH
Information and evaluation programme developed on LSRD	Areas using evaluation Program	reviews	PDHS/RDHS/ MOH

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
1.72	Healthy lifestyle program
	Alcohol and smoking control program
	Suicide prevention program
	Nutrition intervention program
	Stress reduction program

(14) **Relevant Agencies to be Co-ordinated:**

Relevant directors of Ministry of Health, MOL, Ministry of Sports and education , Ministry of Local Government, Provincial health ministries,

(15) **Monitoring & Evaluation:**

1. Who? HEB
2. When? Periodic reviews and evaluation workshops
3. What actions to be taken based on results of monitoring & evaluation?

   Further improvements in programme planning, and implementation after evaluation of programme

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Conduction of coordinating body meeting at National level	Review of HLS Program	Monitoring body established
Conduction of Advocacy workshops for HP programme at national level and provincial level	Programme implementation facilitated	Review of advocacy strategies used
Development and printing of training & reading material on healthy lifestyles	Developed & printed training guides and material	Drafts prepared
Purchase of training equipment	LSRD Pervention centre formed	% of centres with equipment
Capacity building of health workers	Health staff competent in LSRD prevention working in the field	Trainers Teams established in all districts
Empowerment of community groups and high risk groups	General population competent in LSRD prevention	Percentage of population covered in

		each MOH area
Conduction of Monitoring and evaluation workshops	quality of program implementation Improved	workshop reports prepared
Research conducted on LSRD's prevention and intervention	Establish program effectiveness	Research reports

(1) **Project Title:**	Programme for improved community involvement in Health Promotion	(2) **Project Number:**	1.7.2.e
		(3) **Project Priority:**	
(4) **Focal Point:**	**Health Education Bureau**	(6) **Starting Fiscal Year:**	
(5) **Implementing Agencies:**	Provincial Directors of Health Deputy Provincial Directors of Health Medical Officers of Health (MOOH) Public Health Inspectors Public Health Midwives	(7) **Project Duration:**	

Project Summary

Planning, Implementation and evaluation of voluntary health worker programme is a major community participatory and extension education technique adopted in health promotion in Sri Lanka. Initially the activity to be implemented in five communities (five villages) in selected areas of public health midwives in each MOH division and subsequently extend the programme to another five communities and implement activity in the fifty villages in each MOH areas within the period of 10 years. Within this 10 years of project period nearly about fourty thousand villages in the country to be covered with the programme.

The following activities are implemented by central Ministry of Halth (MOH) and Provincial Ministries of Health with corporation of international agencies.

1. Implementing policy and implementing guidelines.
2. preparation of updated training plans and materials.
3. orientation of health managers and workers.
4. implementation of activities at community levels .
5. Recording, reporting and evaluation.

(8) Target Areas & Beneficiaries:

General Public , specific population group &

Community members , Primary Health care Workers and care givers.

(9) Justification:

The goal of voluntary health worker Programme in Sri Lanka is to promote active community participation in health through development of extension education and participatory techniques utilizing trained volunteers for activity immplementation.

Health Department has considerable experience in adopting of this strategy for the last three decades. Community members are coming forward to function as voluntary health workers and the policy/administrative support is available. Primary Health care Workers responsible for implementing the activity are willing to undertake the activity. There is strong and broad community acceptance for the strategy.

(10) Important Assumptions/Risks/Conditions:

- Central Ministry of Health and Provincial Ministries of health have accepted the concept of voluntary participation of community members in activity implementation at community settings.

- Health care managers at all levels ((ie National , Provincial < Regional and District) have accepted the importance of training and utilisation of voluntary health workers.
- Primary Health care workers and their supervisors functioning at community levels have gained considerable experience in implementation of the activity as a major community participatory and extension education technique for the last three decades

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To promote active community participation for health promotion at community settings.	Community members volunteering to be active as voluntary health workers.	Records and returns of PHC workers.
	Community members volunteering and attending in programme for Training of voluntary health workers.	Records and returns about training.
	Primary Health Care Workers adopting the Voluntary Health Worker strategy for the promotion of active community participation and extension education.	Reports from Health Managers.
	Volunteers participating in activity implementing.	Progress reports from Primary Health Care PHC workers.
	Acceptance of voluntary health workers by community members and community level Institutions (social acceptance)	Periodical Community Surveys.

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Developed policy and plan for implementation of volunteer health worker programme	Availability of policy document and master plans for implementation at all the identified levels.	Activity implementation review.
2. Implementation of pilot project	Pilot project implementation	Records
3. Programme evaluated.	Impact assessment data.	Post intervention surveys.
4.. Dissemination of project to other districts	No of districts taken up projects	Periodical review

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	NIL

(14) **Relevant Agencies to be Coordinated:**

MOH, HEB,FHB, PDDHS, DPDDHS & MOOH and supervisory staff.

(15) **Monitoring & Evaluation:**

1. Who? MOH, HEB, PDDHS, DPDDHS, MOOH , PHC workers.
2. When? MOH periodical , HEB quarterly, PDDHS quarterly, DPDDHS quarterly, MOOH monthly, PHC workers monthly.
3. What actions to be taken based on results of monitoring & evaluation?

   Modifications and corrective measures as indicated.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Developed policy and plan for implementation of volunteer health worker programme		
1.1 Baseline survey.	Situational analysis and baseline for evaluation.	Baseline established.
1.2.Consultative review and planning meetings at national level.	Guidelines and resources for activity implementations at national level.	Consultation provided guidelines prepared at National Level.
2. Implementation of pilot project		
2.1 Consultative review and planning meetings and provincial level.	Guidelines and resource for activity implementation at provincial levels.	Consultation provided and guidelines perform at Provincial levels.
2.2 Updating Training modules and materials	Updated training modules	Updating process
2.2 Training of voluntary health workers	Knowledge and skills in voluntary health workers.	Training commenced.
2.3Micro projects implementation	community action for health promotion.	Micro projects in progress.
3. Programme evaluated benefits confirmed with evaluation findings		
3.1Consultative review and planning meetings	Annual review and measures for Sustenance based on experience .	Consulted and guidelines prepared in each year.
3.2.Review at MOOH levels.	appropriate corrective measures in time.	Review conducted in all MOOH areas.
3.4 Post intervention survey and dissemination of findings .	Assessment of the impact.	Reports compiled at the end of each 30 months. (2 1/2 years)
4. Dissemination of project to other districts		
4.1 Implementation of project in other district	Project disseminated to other district	Project taken place

CHAPTER 2

PROFILES OF COMMUNITY-EMPOWERMENT AND CLIENT-SATISFACTION

2 PROFILES OF COMMUNITY EMPOWERMENT & CLIENT SATISFACTION

2.1 PROGRAMME FOR IMPROVED COMMUNITY INVOLVEMENT FOR HEALTH DEVELOPMENT

(1) **Project Title:**	Strengthening the Capacity of Key Concerned Government Officials, Community Groups & Political Leaders in Improving Community Involvement in Health Development	(2) **Project Number:**	2.1.1
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	Secretary	(6) **Starting Fiscal Year:**	
(5) **Implementing Agencies:**		(7) **Project Duration:**	

Summary

The project for strengthening the capacity of key concerned government officials aims to achieve a better maintenance of health by the community and responsiveness of the services. The major measures to strengthen the capacity of key concerned government officials are;

1) Raising awareness of the community regarding health needs and services
2) Expansion & /or revitalization of local joint actions for health
3) Review and improvement of the role & performance of hospital committees and health development committees.

(8) **Target Areas & Beneficiaries:**

Members of the National Health Council, Members of Parliament, Members of Provincial Councils, Members of Local Governments & Pradeshiya Sabas.

Members of the NHDC, Key Governments Officials of Health & Health Related Sectors.

Members of the Hospital Development Committees, NGO Leaders, Divisional Secretaries, Grama Niladhari.

(9) **Justification:**

The determinants for behavioural and lifestyle changes are multi-factorial. They are multi faceted and are densely interwoven with the social fabric that has been enriched by ideals, norms, and values and believes of people. The effort to achieve a positive behavioural change in selected population risk groups needs to be shared by civil, non-governmental and other governmental organizations as well. In selected areas, the programme will work with relevant government departments aiming to achieve healthy public policies and interventions in all

sectors. Similarly community groups and other non—governmental organizations will also be encouraged to participate in these activities.

(10) **Important Assumptions/Risks/Conditions:**

N.I.L.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To achieve a better maintenance of health by the community & responsiveness of the services.	Average out-patient visits per person per year	Hospital statistics community surveys
	Average in-patient visits per person per year	Hospital statistics community surveys

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
1. Strengthening the Capacity of Key Concerned Government Officials, Community Groups & Political Leaders in Improving Community Involvement in health Development.		
2. Raising awareness of the community regarding health needs & services.		
3. Expansion & / or revitalisation of local joint actions for health.		
4. Review and improvement of the role & performance of Hospital Committees and Health Development Committees.		

(13) **Related Projects:**

Project No.	Project Title
1.7.1	Development of national Policy & Plan on Health Promotion as well as Strengthening of Coordinating Mechanisms.
1.7.2	Establishment of Implementation mechanisms for health promotion programme.
2.1.4	Review & Improvement of the role & performance of Hospital Committees and Health Development Committees.

(14) **Relevant Agencies to be Coordinated:**

N.I.L.

(15) **Monitoring & Evaluation:**

N.I.L.

(1) **Project Title:**	Programme for improved community involvement	(2) **Project Number:**	2.1.2.
		(3) **Project Priority:**	Anchor Project
(4) **Focal Point:**	DDG/PHS	(6) **Starting Fiscal Year:**	2004
(5) **Implementing Agencies:**	Health Education Bureau	(7) **Project Duration:**	10 years. with intention to extend.

Project Summary

Strengthening of the community through identified mechanisms could be the key to their active involvement in health activities for their benefit.
To develop a suitable environment to achieve the above objective a proper process to disseminate information through both modern & traditional medium is needed.
It also needs to stimulate the health workers for this purpose by updating their knowledge & skills.
The use of media to disseminate the information to public too will need highest priority
Establishment of "Health Circles" at community level, Work place level, Estate level, Religious places level, school level etc.
Formation of Media, Clubs at community level with active participation of youth, to respond to media programme.
Development & publication of journals, newsletter, brochures etc. for health workers, youth clubs, volunteer health clubs, journalists etc.
Development of Traditional Media programme such as puppet shows etc.
Conduction of competitions among various categories of public.
eg: School children, youth, housewives etc.
Development of Exhibition panels and conduction of exhibitions at various settings.
Conduction of research studies on community involvement & the usefulness of the various strategies made to important the community involvement.
Establishment of a training mechanism and award scheme for media personnel

(8) **Target Areas & Beneficiaries:**

Community leaders, school principles, teachers, students, youth clubs members, Health Workers, Traditional media experts, Editors, Directors, Sub-editors, Working journalists & media practitioners, media trainers, media consultants, Programme Producers and Presenters Reporters, Feature writers and trainee journalists both. Print and Electronic media at national and provincial level.

(9) **Justification:**

Active participation of the well informed community in health activities will help to maximum utiilization of health facilities and Services to the prevention activities.

The contribution of health workers, NGO, youth & other community leaders is an vital component to active success.

At the same time Mass media is a strong ally in health promotion, as a partner in both advocacy and IEC. The popularity of media could make health messages reach the public even in most remote and different areas of the country, in a shortest possible time.

(10) **Important Assumptions/Risks/Conditions:**

Assumptions :

Community Leaders and media will response positively to the messages provided by experts in the health and disseminate the messages .directed to the public and will act as catalysts in behaviour change.

Risk:

Community leaders and Media might refuse to accept certain messages, due to prejudice. Media may - sensationalise certain messages, for their benefit. Community leaders might not be adequately sensitized to accept the messages.

Conditions:

Guidance and Advice to Community Leaders, health workers, media should be conducted in collaboration with accepted leaders and senior media personnel. Health Care providers and owners of media institutions after sensitising about the importance should corporate with HEB.

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ Community will participate more activity and effectively in promoting health, identifying and preventing health problems, and utilize available resources to the maximum.	No. of country programmes and activities. No. of health circles, media clubs established. No. of publications produced, exhibitions conducted, research conducted.	Available data/Research. No. of clubs found. No. of activities conducted.
■ Media will disseminate more health messages relevant to important and current health topics/issues.	Listnership or Viewership or Circulation of various media.	Available data./Market Research Data.
	The allocation of media Space/Time for health related messages.	Summary of media, time and space allocation.
	Client satisfaction in community.	Questionnaire survey. Sample survey.

(12) **Project Output/Product:**

Output	Indicators	Means of Verification	Supportive Officers
1. Health workers will provide relevant information and guidelines to community after empowered with	Accessibility to up dated knowledge to health workers. No. of meeting the	No. of copies of health publication distributed among the health workers. Reports received.	DPD MOH HEO

Output	Indicators	Means of Verification	Supportive Officers
updated knowledge.	health workers conduct with the community leaders.		
2. Health Circles are established at community level and other settings with the guidance of Health Workers.	No. of Health circles found and the no. of members enrolled.	Reports received.	DPD MOH HEO
3.Health journals/ newsletters are published targeting various target audiences (eg: Health Workers, School Health Clubs, Volunteer Health Workers, media etc)periodically.	No. of journals/ Newsletters published periodically. Evaluation of knowledge gained through in built contests.	Contents published in the publications.	
4. Media clubs are formed at community/workplace . School settings to respond to the media programme.	No. of clubs found & membership. No. of responses forwarded by the clubs.	Reports submitted. No. of responses from community levels.	DPD MOH
5. Traditional media programmes (eg: puppet shows, street dramas.) are developed and performed.	Development of Traditional media activities with embodied health messages.	No. of media activities performed.	Traditional media on DPD, HEOO, MOH
6. Various competitions are conducted (Art, Poster, Essays, Poetry, Sing, Dancing etc.) for various target audiences.	Conduction of competition Selection of winner/ prizes distribution.	No. of competitions conducted.	PD PPD MOH HEOO
7. Exhibition panels are developed and exhibitions are conducted.	No. of exhibition panel developed. No. of Exhibition conducted.	No. of viewers for the exhibition.	HEO Exhibition experts.
8. Regular Research and Surveys are conducted.	Research topics are identified. Research are conducted on identified messages.	No. of Research conducted. Research results.	Research committee.
9. Consultative media forum established with senior media personnel and media	Establishment of media forum and quality of messages, disseminated.	Minutes/Records of the meetings.	Officers of Ministry of Health,, Senior Media Personnel

Output	Indicators	Means of Verification	Supportive Officers
representatives.			
10.Media Research to provide evidence based and to measure the impact of media on health issues.	Research undertaken	Research reports.	Research consultants.
11. Current and appropriate health messages are disseminated through media	No. of health articles published and programmes broadcast or telecast.	Newspaper clipping. Recordings of Radio/TV Programmes.	Officers of Ministry of Health,, Senior Media Personnel Training directors from media institutions.
12. Capcity building for media personnel on health literacy , and health advocacy	Programmes conducted and number of journalists trained.	Reports submitted. Attendance sheets pre-Post tests.	Officers of Ministry of Health,, Senior Media Personnel Training directors from media institutions.
13. Publication of a quarterly newsletter to update the knowledge of journalists.	Newsletters published.	No. of News letters published and distributed.	Media Consultants, Health Experts.

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
UNFPA	IEC Programme for Reproductive Health
UNFPA	Seminars for Media Personnel
W.H.O.	Seminar for Media Personnel

(14) **Relevant Agencies to be Coordinated:**

MOH, HEB, other health sectors/Programme nd campaign personnel.

PD, DPD and other relevant officials and personnel from provinces and districts.

(15) **Monitoring & Evaluation:**

1. Who? HEB

2. When? Reports, Programmes submitted; Simultaneously with the pogramme and end of the activity.

3. What actions to be taken based on results of monitoring & evaluation?

Further strengthen the media activities, with necessary amendments.

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. "Health Circles" are established at community/estate/school/work place/religious place levels.	Community leaders activity participate in prevention/Health Session utilization activities.	Community leaders activities participated for the programmes.
2. Publications on health (journals/newsletters) are developed and published.	Health journals/Newsletters are developed, published and circulated among various target groups.	Newsletters/ Journals have better circulation and requests from various target groups increased.
3. Conduction of Traditional media activities puppet shows/Dramas/street dramas/musical shows etc.	Traditional media activities with embodied health messages are developed and performed.	Traditional media embodied with media programmes are accepted and request perform.
4. Conduction of competitions (Art, Essay, Drama, Quiz , Posters, Songs, Poster, Quarterly, Debates etc.) periodically.	Various contests among selected target audiences are conducted periodicals.	knowledge improved on health subjects.
5. Media Clubs are formed	Media clubs are formed at various setting to respond to media programmes conducted.	Listnership increased.
6.Exhibitions panels are developed, produced and exhibitions are conducted at various settings.	Exhibitions themes are selected and panels developed Exhibitions are conducted at various settings.	Exhibitions conducted.
7.Consultative media forum established	Advise of Snir. Media Personnel were obtained for planning media programme.	
7.1 Establishment of National level media forum with senior level media personnel.	Synergistic effect achieved through both Media and Health to disseminate appropriate health messages to public.	Better identification of media needs and health needs.
8..Media Research to provide evidence based and impact evaluation		
8.1 Conducting media research studies.	.assessment of needs for effective use of media	Better insight to the media out come.
8.2 Evaluative studies	Impact of media in changing knowledge, attitudes, behaviours are measured	
9. Conduction of awareness programmes.	.	.
9.1 identifying Priority and Important topics for media personnel	Identified priority activities / topics for media.	List of tropics / activities
9.2 Conduction of awareness programmes on selected topics	Improved awareness as priority health needs and efficient dissemination	Public receive more correct, appropriate & current messages
10.Capcity building for media personnel on health literacy , and health advocacy		
10.1 Improved awareness through	Awareness raised on relevant	Participation in the seminars/

Activities	Expected Results	Process Indicators
awareness programmes. Conducted for media personnel and awareness raised	issues	activities
10.2Development of a curriculum.	It will pay a uniform way for a training of journalists.	Training programme will be more successful.
10.3 Training of young journalists.	Development of a generation of journalists who are better equipped to report/write on health.	Public are blessed with efficient and & current health information.
10.4 Awards for the best journalist	Best journalist was honoured.	Journalists will be more enthusiastic and partnership improved.
10.5 Site visits by journalists.	Journalist will observe achievements/ deficiency /needs of health promotion and health care activities at various settings.	Better reporting of important topics.
11 Publication of a quarterly newsletter		
11.1Newsletter for journalists.	Help to update the knowledge of media.	Media updated with latest development.

(1) Project Title:	Expansion and/or Revitalisation on Local Joint Actions for Health	(2) **Project Number:**	2.1.3
		(3) **Project Priority:**	Anchor Project
(4) Focal Point:	DDG/P	(6) **Starting Fiscal Year:**	
(5) Implementing Agencies:		(7) **Project Duration:**	

(1) Project Title:	Review & Improvement of the Role & Performance of Hospital Committees & Health (Hospital) Development Committees	(2) **Project Number:**	2.1.4
		(3) **Project Priority:**	
(4) Focal Point:		(6) **Starting Fiscal Year:**	
(5) Implementing Agencies:	MoHN&W/SAS, DDGMS Provincial Health Ministry Heads of respective hospitals	(7) **Project Duration:**	03 Years

Project Summary

The present hospital community system have to be amended to suit the present needs of the hospital set up. The functions and the role of the hospital community should change accordingly. Therefore the MoH has decided to take legislative steps to amend the act. To ensure the wide participation MoH expect to get the views and ideas from the public too with the introduction of new system series of training programmes may arrange to educate the members. The main objective of the exercise is to upgrade the qualify of the hospital community system to cater the present needs

(8) **Target Areas & Beneficiaries:**

Hospital under line ministry & provincial council

(9) **Justification:**

Existing act has to amend & upgrade to suit the present requirement. Need to do have better participation & better contribution from the hospital committees to develop the hospitals

(10) **Important Assumptions/Risks/Conditions:**

Abuse of powers by few/some committee members

Appointments of unsuitable members to the committee

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ Development & upgrading the quality of the hospital committees assuring	Number of meetings held	Through reporting system
	Number of participation	
	Number of proposals	

quality service to the customers. ■ Meet the above objective change the existing act & development of a plan.	Number of proposals implemented	

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Preparation of a TOR for hospital committees development	Establishment of a system	Reporting system
Conducting orientation programmes for the hospital committee members to gain knowledge on hospital development through public participation	Organizing and conducting programme	Reporting by hospitals

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
	N.I.L.

(14) **Relevant Agencies to be Coordinated:**

Ministry of HN&W/Provincial Health Ministries

(15) **Monitoring & Evaluation:**

1. Who? Central MoH/Prov MoH/Respective Hospitals
2. When? Monthly, Quarterly, Annually
3. What actions to be taken based on results of monitoring & evaluation?
    i. Taking remedial actions to correct
    ii. Settings up proper guidelines
    iii. Training where necessary

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
1. Preparation of a situation report of the present hospital committee system	Accquire the knowledge about the system	
1.1 Establishment of a review committee	A team work will help tp reach the objective	
1.2 Reviewing the existing documents	SWOT Analysis	
1.3 Do a survey (sampling public)	Get the ideas from the public	

Activities	Expected Results	Process Indicators
1.4 Writing a report	Documentation of findings	
2. Prepare amendments to the act	To meet the present needs	
2.1 Preparation of a draft based on the above review	Get the necessary legal approved	
2.2 Consultative meeting with the stakeholder	Proper functioning and make the members knowledgeable	
2.3 Approval for the BG		
2.4 Preparation of a cabinet paper		
2.5 Obtaining the cabinet approval		
2.6 Pass the resolution ink parliament		
2.7 Discussing relevant circulars		
3. Preparation of a TOR		
3.1 Based on 1 above and the parliament act develop a criteria for the selection of members		

2.2 PROGRAMME FOR PROMOTION AND PROTECTION OF HUMAN RIGHTS WITH RELEVANCE TO HEALTH

(1) **Project Title:**	Establishing a System of Improving People's Access to Regularly Updated information on All Public and Private facilities	(2) **Project Number:** 2.2.1 (3) **Project Priority:**
(4) **Focal Point:**	DDG/P	(6) **Starting Fiscal Year: 2004**
(5) **Implementing Agencies:**		(7) **Project Duration:** 05 yrs

(1) **Project Title:**	Development of a Health Charter, Necessary Legislation and Implementation Plans to Protect Communities, households and Individuals	(2) **Project Number:** 2.2.2 (3) **Project Priority:**
(4) **Focal Point:**	Secretary	(6) **Starting Fiscal Year: 2004**
(5) **Implementing Agencies:**		(7) **Project Duration:** 05 yrs

(1) **Project Title:**	Establishment of the Ombudsman System within the Central & Provincial MoH to Promote & Protect Health Rights	(2) **Project Number:** 2.2.3 (3) **Project Priority:**
(4) **Focal Point:**	DDG(MS)	(6) **Starting Fiscal Year: 2004**
(5) **Implementing Agencies:**	MOH PMOH	(7) **Project Duration:** 05 yrs

Promotion and protection of human rights related to health of individuals and the community are important aspects in an efficient health care system. Such rights should not only be promoted but also violation of them should be prevented. Human right of the providers as well as the recipients have to be taken into consideration together. There are areas of conflicts pertaining to the human rights of recipients (patient/community) and the providers (employed/workers). In the instance of violation of health related human rights, what ever the cause may be, a relief to victims is essentials and important. In such situations Ombudsman system has a major role to play and could bring about solutions to problems and relief to grieved parties. However, to establish an Ombudsman system, identification of health related human rights, problems encounted, possible solutions to problems, necessary legislation and regulation and infrastructure and manpower are the key issues. For sustainable system of promotion and protection of health related human rights the health care providers must be convinced and make them to understand and respect the rights of individuals & community. There must also be measures to deter violation of rights and a method of compensation to the victims in the instances of violations.

(8) **Target Areas & Beneficiaries:**

Community – Patients, and their next of kin, stake holders in health sector.

(9) **Justification:**

Create a forum/establishment for patients or their next of kin to bring up their grievances and to obtain a relief.

(10) **Important Assumptions/Risks/Conditions:**

- Corporation of the stake holders is required. If such corporation is not forth coming implementation may not be feasible
- Implementation may become difficult due to possible objection by trade unions
- Lack of Legislation required for proper and effective implementation
- Conflicting areas. Rights of worker us recuperate

(11) **Project Objective:**

Objective	Indicators	Means of Verification
■ To promote and protect human rights of individuals and community relevant to health by establishing an ombudsmen system with in MOH & PMOH	Health related rights of patients	Human right organization and Charters.
	Possible instances of violation of such rights in Institutional and community Levels	Periodical survey
	Solutions to violation of such rights	Consultative meeting with human right organizations & Questionnaires surveys from patients and health care workers

(12) **Project Output/Product:**

Output	Indicators	Means of Verification
Formulation of a patient charter in relation to health related human rights	Establishment of guide lines for Health care providers.	Report from human right Organization and from complaints by individuals regarding violations
	Establishment of system of Training for providers regarding Important and of health related human rights	Reports from administration disciplinary bodies and Training institutions
Identification and establishment of a workable system with in the structure to prevent human light violations	Legislations and regulations to prevent and deter violation	1. Legal draftsmen 2. Human right groups and organization 3. Disciplinary bodies
Establishment of a system to bring relief to victims of	Legislation Regulations	1. Legal draftsmen 2. Regulations (Public

human rights violation	Compensation	administration) 3.Reports from community/ medial and human right organisation

(13) **Related Projects** *(include ongoing projects & projects under the Health Master Plan)***:**

Project No.	Project Title
?	To create a workers charter for health care providers
?	To create an arbitration system of problem solving for employees.

(14) **Relevant Agencies to be Coordinated:**

- ✳ Human right organizations
- ✳ Legal draftsmen
- ✳ Attorney General's department
- ✳ Trade unions

(15) **Monitoring & Evaluation:**

1. Who? Central MOH, Provincial MOH, Other disciplinary bodies
2. When? Periodical surveys, ad-hoc surveys and from reports
3. What actions to be taken based on results of monitoring & evaluation?
   - b. Regulation
   - c. circulars
   - d. guidelines
   - e. disciplinary inquires
   - f. penalty for violation
   - g. training/rehabilitation
   - h. compensation scheme for victims
   - i. other methods of relief

(16) **Major Activities:**

Activities	Expected Results	Process Indicators
Establishment of and export	Preparation of a	Regulations
Committee (Task-force)	report	Legislations
		Administration
		Logistics