4.3.2 INITIAL IMPLEMENTATION OF A HEALTHY LIFESTYLE PROGRAMME IN KURUNEGALA

A. BACKGROUND

Provincial Vision:
- A healthier population in the North Western Province (NWP) that contributes to the nation in its social, economic, mental and spiritual development

Goal:
- To reverse the increasing trends in priority NCD-related morbidities, mortalities & disabilities

Mission:
- To adopt feasible, cost-effective policies & strategies for the prevention and management of non-communicable diseases of major importance to public health in the province

Strategic Objectives:
- Capacity enhancement
- Primary prevention and health promotion
- Patient management and rehabilitation
- Surveillance system

NCD accounts for 4 of 10 admissions and more than half of the deaths in Kurunegala government hospitals. At the Base Hospital (BH) Kuliyapitiya, medical clinics attendance has increased from about 25,000 in the year 2000 to 40,000 in 2004. In 2005, the RDHS Kurunegala initiated the "Reduction of Overcrowding in Medical Clinics in Base Hospital Kuliyapitiya due to Chronic Life Style Related Disease Morbidity in Kurunegala District". Four major strategies were adopted: improvement in the knowledge and skills of the health staff on the prevention programme; establishment of a healthy lifestyle programme for and with patients, health staff and the community; improvement in the lifespan of patients diagnosed to have diabetes and hypertension by changing their lifestyle; and cost-effective screening of the community for hypertension and diabetes. With the financial support from the Health Sector Development Project, a training programme was designed to combine both learning of theories and practical exercises. Follow up done three months after the onset of the initial training programme showed optimistic results. A review of the hospital-based programme recommended an expansion to settings outside of the base hospital and development of a surveillance system.

B. OBJECTIVE

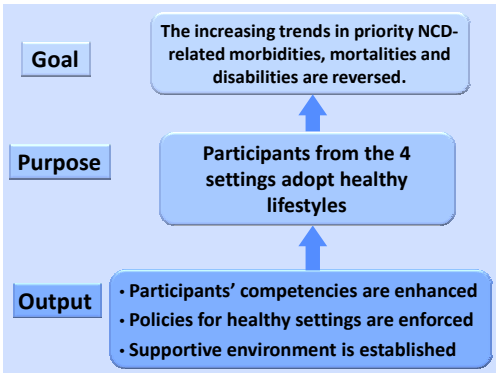

FIGURE 4- 7: HEALTHY LIFESTYLE PROGRAMME DIRECTIONS

During the course of the programme, the participants of the various activities would have adopted a healthy lifestyle (). Four settings in the Kuliyapitiya Division were identified for the initial implementation: health facilities, schools (10 primary and secondary schools), a village and workplaces. The village of Mahimpitiya has a population of 483. Aside from the BH Kuliyapitiya, the participating health institutions were the MOH Office, a district hospital, a rural hospital and 2 central dispensaries. The workplaces

were the participating schools and health institutions as well as an insurance company, a garments factory and a university.

C. Advocacy & Building a Broad Base of Supporters

A Steering Committee was set up to provide the leadership and overall directions for the programme. It has a multi-sectoral membership. All the four settings are represented in the Steering Committee for Healthy Lifestyle, which meets at least once a month.

Several consultative meetings were conducted to identify the needs and priorities of the village and health leaders in the Mahimpitiya GS division. A coordination meeting with the Kurunegala District Education Department was held and a follow-up meeting was conducted in September 2006. A one-day conference was organised to sensitise district leaders and other stakeholders on some basic concepts on NCD and their risk factors **(Figure 4- 8)**. A residential advocacy meeting brought together the provincial decision-makers from all sides of the political spectrum to discuss their roles in NCD prevention and control in August 2007.

Figure 4- 8: Advocacy Meeting in Kurunegala

A logo was developed that depicted the key areas of a healthy lifestyle– physical activity, healthy diet, not using tobacco and not misusing alcohol **(Figure 4- 9)**. Shirts were distributed to community volunteers, leaders and health staff. Several school children participated in a poster-making contest.

Figure 4- 9: Examples of Communication Materials

D. ASSESSMENT OF BASELINE NCD STATUS

FIGURE 4- 10: BASELINE ASSESSMENT

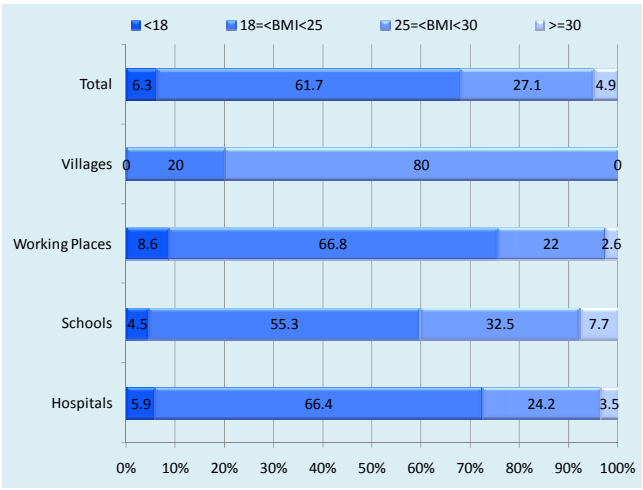

FIGURE 4- 11: RESULTS OF BASELINE ASSESSMENT-BMI (BODY MASS INDEX)

To establish the status of participants in 4 settings at the onset of the programme, an assessment programme was conducted with the use of a questionnaire on their basic demographic profile, history of NCD and risk factors. Physical examination included the measurement of blood pressure **(Figure 4- 10)**, heart rate, weight and height **(Figure 4- 11)**. Fasting blood sugar was also taken.

Out of 1,418 participants, 63% are females, 82% married, 89% Sinhala, 43% completed A level and 51% earns between 10,000 to 20,000 rupees per month. The mean age is 42 years old with a range from 14 to 83. Five percent reported a history of hypertension only, 5.5% of diabetes only and 1% of both conditions. Physical examination revealed that 23% of the participants had at least 140/90 blood pressure and about 7.6% had fasting blood sugar of at least 7 mmol/l. As such, the possible undiagnosed case compared to those diagnosed cases are 5 times more for hypertension and 2 times more for diabetes.

Furthermore, 10% of the participants acknowledged being smokers, 54.2% consumed less than 2 servings of fruits daily and 18.9% consumed less than 3 servings of vegetables daily. Engaging in at least moderate physical activity most days of the week was reported by only 3 of 10 participants.

E. BUILDING CAPACITIES

Several capacity-building programmes were conducted with the overall aim of developing a resource pool in all the four settings – hospitals, schools, village and workplaces. Process documentation as well as pre- and post-tests were carried out.

The programme on diet was held for two days at the MOH Office, Kuliyapitiya. Dr. Shanti Gunawardana, Director, Nutrition Coordination Division, and Ms. Lakmini Thilakawardana, a nutritionist, were invited as facilitators. Most of the sessions were conducted as lecture discussions. The participants were provided with a thorough knowledge on food-based dietary guidelines, the

harmful effects of fast food as well as on the dietary guidelines for different chronic NCD and obesity. They also engaged in group activities where they planned model diets for different groups of people. The feedback from the participants at the end of the programme was very satisfactory.

Training Programmes:
- Diet
- Physical activity
- Reducing the use of tobacco & alcohol; stress management
- Life competencies (Stages 1 to 3)
- Behavioural change communication

The two-day training of trainers on physical activity was facilitated mainly by Dr. Palitha Bandara, who was a JICA trainee on lifestyle related diseases in 2002. It consisted mostly of practical exercise sessions and discussion on the importance of physical activity and its relevance to chronic NCD. Dr. Bandara and co-facilitators from the BH Kuliyapitiya were geared with the necessary attire and equipment. A pre-test questionnaire was given to the participants consisting of 8 questions. Eleven out of 32 participants (34.4%) got more than 50% correct. The post-test revealed that 31 out of 32 (96.9%) got more than 50% correct.

FIGURE 4- 12: A TRAINING PROGRAMME IN KURUNEGALA

The programme on reducing the use of tobacco and alcohol was conducted for two days . Dr. Neil Fernando, consultant psychiatrist, Dr. Manoj Fernando-Executive Director of Mel Medura, Mr. Pubudu Sumanasekara - Executive Director, Alcohol and Drug Information Centre or ADIC, and Mr. Amaranath Thenna from ADIC were the facilitators. The participants were enlightened on the real harm of tobacco and alcohol by way of discussions, interactive sessions, presentations and small group activities. The shrewd strategies employed by the tobacco and alcohol companies to promote their products were widely discussed. A pre-test questionnaire of 7 questions on tobacco and alcohol was given to the participants. Ten out of 17 participants (58.81%) got at least four correct answers. The post-test revealed that all the 17 participants got four or more correct.

The three-day Life Skills Programme (Stage 1) was facilitated by consultant psychiatrist Dr. Neil Fernando, Dr. Nelly Rajaratne (Family Health Bureau), Dr. P.A.D. Premaratne (Medical Officer for NCD from Gampaha), Mrs. Rathna Weththasinghe (Ministry of Education), Dr. Uthpala Amarasinghe and Mr. Suneth Bandara (Health Education Bureau). They introduced the life skills using various interesting anecdotal examples which instantly captured the audience attention. Other learning methods that were employed were small group activities, games and tasks. They made the whole programme both educative and enjoyable. The feedbacks received by the facilitators

bore living evidence to how much the participants found the programme useful.

FIGURE 4- 13: A TRAINING PROGRAMME IN POLONNARUWA

The Stages 2 and 3 of the Life Skills Programme was also for three days and was conducted by the same set of facilitators as for the Stage 1 programme. This programme built on the knowledge that was given during the Stage 1 training. Group activities were used as the main learning method. Field visits facilitated the participants to plan interventions for the different settings. All the facilitators were involved in each of the activity, and a lot of interaction took place. Special attention was given to the development of the participants' skills in public speaking. The participants were given a chance to speak on a given scenario, while being videotaped, and later on they were given a chance to watch for themselves the areas which need improvement. The programme on the whole earned much praise from the participants.

The 5-day basic programme on Behaviour Change Communication (BCC) was handled at the Kuliyapitiya MOH Office by Dr. Kanthi Ariyarathna from the Health Education Bureau. An introduction to BCC was followed by identification of target audiences, main problems, and risk factors of the four settings and preparation of action plans for each, with health massages and means of monitoring and evaluation. Focus group discussions were conducted by the course participants in their respective settings. Dr. Kanthi followed up the basic programme with a two-day course that worked on improving the action plans for the different settings. Afterwards, there was a lengthy and detailed discussion on different communication methods. Several small group activities were organised for the participants to conduct SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis on the different communication methods.

F. REVIEW OF THE HEALTHY LIFESTYLE PROGRAMME

The Healthy Lifestyle (HLS) Programme has been successful in developing a resource pool of trainers. Other highlights of the review that was conducted by MoH officials who were not directly involved with the HLS programme were as follows:

- Majority (87%) have understood most of the topics discussed at the workshops while the rest claimed to have understood only some of the topics;

- An assessment of the participants' retention of key concepts that were discussed during the training programmes yielded a high mean mark of above 70% with only one participant who scored below 50%;
- All participants from the schools and working places have conducted interventions, mostly on healthy diet, in their own settings while 89% from the MOH/Hospitals have done so far; and
- Majority of the HLS Steering Committee members perceived an improvement in the performance of their subordinates who participated in the HLS training programme **(Figure 4-14).**

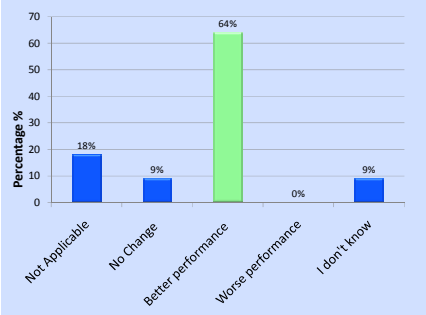

FIGURE 4- 14: PERFORMANCE OF STAFF AFTER PARTICIPATING IN TRAINING PROGRAMMES

Several areas for improvement were also identified. For one, infrastructure and polices favouring a healthy lifestyle proved to be inadequate in most settings. Majority of the participating institutions did not have adequate equipment for physical activities. More than 60% did not have any specific time allocated for it; if the activities are not included in the syllabus and timetable, then the schools would be in a difficult position to provide extra time. Most institutions still have fast food items still being sold at their canteens. Only canteens from two schools and one hospital did not carry such foodstuff anymore. Canteen owners refused inclusion of more fruits and vegetables as it would be a deviation from their existing contracts.

The programme review also interviewed participants who were advised referral because of high blood pressure and/or fasting blood sugar during the baseline assessment. It appears that only 28% of them had met a doctor following the referral. The highest rate of compliance (51%) was seen among the school setting. None from the village setting have complied with the referral. Less than 20% complied from workplaces and MOH/hospitals. Out of those who did not visit a doctor, 74% were unaware that they should meet a doctor, 6% had no time, 8% thought it's not important and 12% gave other reasons.

Many recommendations were proposed to improve the HLS Programme:

- Increase the number of participants from each institution to ensure the programme sustainability within the setting;
- Teachers felt that student leaders, especially from grades 1 to 5, should be trained to pass on the message regarding food habits;
- Baseline assessment and education programme be conducted in schools;
- Redesign the exercise programme to suit to the villagers and invite professional trainers from the Ministry of Sports;

- Flexibility in the programme design in the future because the community trends keep changing with time;
- Avoid lengthy and large group discussions as they are unproductive, and give feedback immediately after discussions;
- Distribute printed study materials in the local language to enhance understanding of the subject matter;
- Additional inputs are needed on mental health and reducing the use of tobacco and alcohol; and
- Use the mass media to effectively educate the public.

The main obstacle faced by the trainers was the difficulty in changing the attitudes of people from their settings.

4.3.3 INITIAL IMPLEMENTATION OF A CHRONIC NCD SURVEILLANCE SYSTEM IN POLONNARUWA DISTRICT

A. BACKGROUND

Surveillance is the systematic collection, analysis and interpretation of health data and the timely dissemination of this data to policymakers and others.

In Sri Lanka, epidemiological data is collected routinely through various mechanisms. The Registrar General's Department provides data on births and deaths. Notifiable diseases are reported routinely from hospitals to the Epidemiology Unit, which was organised in 1959 to be responsible for all disease surveillance activities. The Medical Statistician's data includes information on indoor morbidity and mortality. However, morbidity data on NCD and other diseases are not routinely received from the out-patient departments of both government and private sector institutions and on indoor patients treated in the private sector hospitals. The existing routine information system counts admissions only and not the incidence of diseases. It can hardly generate information for defining prevention priorities or monitoring progress of interventions as it does not measure risk factors. Lastly, publication of the national statistics on morbidity and mortality has at least a two-year lag.

Several initiatives were undertaken to strengthen the existing information system. In October 2005, the PDHS Anuradhapura and the Epidemiological Unit designed a plan for reporting chronic kidney disease, which is one of the leading causes of mortality in the province ranking either first or second during the past years. A multi-disease surveillance was set up in the tsunami-affected districts with the aim of increasing the precision of notification of diseases and timely production of the IMMR.

B. OBJECTIVE

In 2006, the MoH and the RDHS Polonnaruwa decided to pilot a mechanism of generating, managing and using information on selected chronic NCD in all MOH areas and 3 hospitals, namely,

General Hospital Polonnaruwa, Base Hospital Medirigiriya and District Hospital Hingurakgoda. Polonnaruwa was chosen as the site for the initial implementation because of existing initiatives to improve the information systems in the curative and public health sectors as well as in the management of drugs. The new surveillance system for chronic NCD will bring many benefits. It can offer to uncover novel means of primordial and primary prevention to the preventive sector and means of secondary and tertiary prevention to the curative sector. For the health planners and administrators, it can offer to measure the trends and burden of disease, provide guidance for resource allocation and policy formulation.

C. STRATEGIES

The three major strategies to set up the surveillance system were as follows:

- Formulation of a minimum data set (MDS) for chronic NCD through consultation with actual and potential information users, particularly the authorities tasked with NCD prevention and control responsibilities;
- Design of system, forms, registers and a Patient Data Record; and
- Orientation of all staff and training of those who will be directly involved.

A Minimum Data Set is a core set of data elements agreed for mandatory collection and reporting. It ensures that correct indicators are monitored by the stakeholders in a standardized manner that will allow comparison of data.

Forms and Registers:

- Hospital Chronic NCD Notification Form (Form 1)
- Field Investigation Form for Patients with Chronic NCD (Form 2)
- Hospital Chronic NCD Notification Register
- MOH Chronic NCD Notification Register
- PHI Chronic NCD Notification Register

Because they are the leading causes of hospitalisation, leading causes of mortality, and diseases of public health interest, the following were selected as priorities - cardiovascular diseases, diabetes mellitus, mental health and cancer. Among the MDS domains, the ones that are currently routinely collected includes: health outcomes such as morbidity & mortality; service coverage/utilization (e.g. hospital beds & consultants); and some non-modifiable factors like age and gender. The MDS domains that are not yet routinely collected are the risk factors and the underlying determinants.

Aside from the forms and registers, the Patient Data Record (PDR) was developed to replace the old clinic book, which is often an exercise book. It gives comprehensive details about the patient's history, examination, investigations that have been done, management plan at discharge, drugs prescribed and follow up notes since the first clinic visit. It is intended to be used also during

readmissions and for patient referral. It contains essential information about care and prevention of chronic NCD. So the PDR fulfils the requirements previously filled by the diagnosis card, clinic book, and drugs card. It benefits the patients and makes things easier for medical officers.

D. REVIEW OF THE CHRONIC NCD SURVEILLANCE

The introduction of the chronic NCD surveillance system was received favourably (Figure 4- 15). 18% have claimed it to have an extremely positive effect on the job performance of hospital staff, MOH and PHI/SPHI. 71% have claimed a positive effect. Almost all of the staff (95%) wanted the programme to continue, 2% to stop and 3% have no opinion.

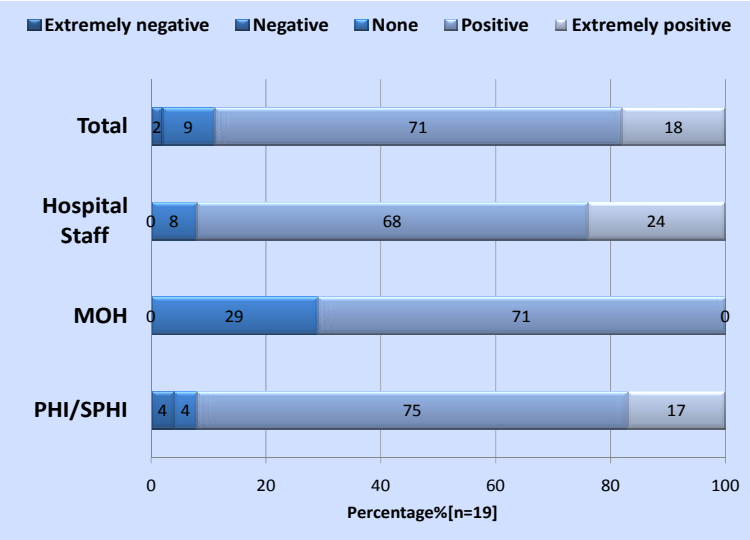

FIGURE 4- 15: EFFECT ON JOB PERFORMANCE, POLONNARUWA

The information flow was according to the planed design. The forms and registers were believed to be useful particularly if they were properly completed and analysed. Filling them up was not difficult and often took less than 5 minutes or sometimes between 5-10 minutes only. Most of the targeted cases (75%) for notification were registered immediately; others that could not were those mainly without confirmed diagnosis or those discharged on holidays and weekends.

Complimentary feedback was received also from the patients who were included in the chronic NCD surveillance. Almost all (95%) had received advice on the importance of healthy diet, exercise, refraining from smoking and alcohol use, clinic follow up, compliance with their treatment plan and prevention of complications. Majority had (74%) understood the advice well. However, only 47% were following all and 32% were following much of the advices. Nonetheless, all the patients would like to be visited again at their homes. Most of them (86%) claimed that setting up a Patients Society was a good idea and that they would like to be a member of

it. Another 12% agreed to it being a good idea but were uncertain of becoming a member.

The programme reviews generated the following key recommendations:

- Define the involvement of other MOH staff, other local health institutions, private sector and community volunteers;
- Conduct awareness and training programme for the health staff, volunteers and communities;
- Improve the facilities for diagnosis and monitoring;
- Institute regular reviews preferably into existing mechanisms;
- Maintain a follow-up register which is to be kept at the hospital and checked up regularly; if a failure of follow-up visit is detected, it should be informed to the MOH to investigate.
- Streamline the referral and back-referral system;
- Review the system for follow up – one option is for routine follow up to be conducted in local health institutions, once the diagnosis is confirmed and treatment plan is issued by the visiting physician;
- Assess the strategy for home visits – may be limited to following up of clinic defaulters, compliance to treatment plan and adoption of healthy lifestyles;
- Update incentives (e.g. travel allowance); and
- Plan and implement effective programmes for NCD prevention.

4.4 THE ROADMAP

Recognising the experience gained during the initial implementation of a healthy lifestyle programme and a chronic NCD surveillance system, and considering the favourable reviews, the RDHS Kurunegala and RDHS Polonnaruwa decided to continue their initiatives. They formulated their district action plans with inputs from eachother; cross-learning was promoted through field visits and inter-district planning workshops. They benefited from the support extended by officials from the central MoH and other stakeholders.

4.4.1 PROFILE OF THE ACTION PLAN

- **Project Title:**
  - Promoting Healthy Lifestyle in Kurunegala District
  - NCD Surveillance and Prevention in Polonnaruwa District
- **Project Duration:** 5 years
- **Focal Point:** Regional Directors of Health Services (RDHS)
- **Implementing Agencies:** RDHS Offices in Kurunegala and Polonnaruwa
- **Target Areas and Beneficiaries:** Entire population in Kurunegala and Polonnaruwa districts

4.4.2 JUSTIFICATION

Recognizing the epidemiological, nutritional, demographic and other socio-economic-political changes, the MoH prioritised the delivery of comprehensive health services that reduce the disease burden and promote health as one of its Health Master Plan strategic objectives. The global strategy to respond to the mounting problem of NCD defines 3 major elements – surveillance, prevention and patient management.

Global Strategy:
- Surveillance – decisions/actions based on information on disease, risk factors & determinants
- Prevention – reduction of risk factors, health promotion
- Patient Management – curative and palliative services, rehabilitation

Consistent with the global strategy, the MoH is conducting an island-wide survey on risk factors and strengthening the existing information system for both the curative and public health sectors. It has taken various initiatives in promoting health of population in general and priority subgroups (e.g. mothers, children, youth, elderly and people with disability) and reducing risk factors such as tobacco, unhealthy diet, physical inactivity and inability to cope with persistently high levels of stress. The Parliament and other government agencies, professional bodies, trade unions, academia and research institutions, non-governmental organisations, external development partners, media and other stakeholders have also done their part. Partnerships between the government and its partners have produced clinical guidelines for enhancing the quality of patient care and

the cost-effectiveness of screening programmes as well as policy documents such as those on nutrition, health promotion and chronic NCD.

The RDHS Kurunegala is one of the local health authorities that picked up the challenge of NCD through its Health Lifestyles Programme (HLS). Starting in the Base Hospital Kuliyapitiya, then expanding to a network of hospitals, MOH offices, schools, workplaces and a village, the HLS has been received favourably. Meanwhile, the RDHS Polonnaruwa started a passive surveillance system to generate information for the prevention and management of cardio-vascular diseases and diabetes initially and other priority NCDs later on. Reviews of the initial implementation of both the HLS programme and the surveillance system revealed a highly favourable feedback. With heightened stakeholders' interest and the lessons learned during the past months, both districts of Kurunegala and Polonnaruwa decided to embark on a comprehensive programme that will incorporate, integrate and implement the three elements of the global strategy and will carry them out district-wide.

4.4.3 OBJECTIVES, OUTPUTS AND ACTIVITIES

Both the RDHS Kurunegala and Polonnaruwa share the national vision of a healthier population that contributes to a sustainable and equitable socio-economic, mental and spiritual development.

Within the next five years, their objective is to arrest the increasing trends in NCD morbidity, complications and premature mortality. This year the World Health Assembly adopted an annual 1% reduction in mortality.

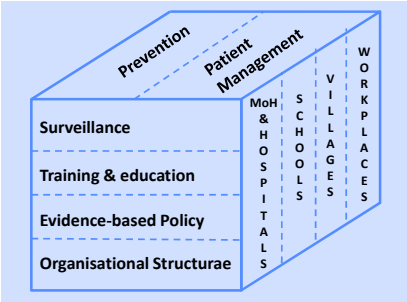

FIGURE 4- 16: KEY OUTPUTS IN HEALTHY SETTINGS

The outputs **(Figure 4- 16)** may be categorised into those that are aimed at strengthening systems and organisational structures. The system for the delivery of health services (both prevention and patient management) and mobilising health actions will be undertaken in settings that can give strategic advantage such as schools and workplaces on top of the traditional venues like the health institutions and villages. Doable and durable systems for surveillance, training and policy development are some of the key cross-cutting management issues. Another principle output will be on institutionalising organisational structures.

A. OUTPUT 1 (PREVENTION): ENHANCED SYSTEM FOR PREVENTING RISK FACTORS, AND PROMOTING HEALTH AND WELL-BEING

Kurunegala will expand its ongoing HLS programme. By the end of the 5th year, healthy settings approach will be practiced in the district particularly in all health institutions, 50% of the schools and at least 5 workplaces per MOH division. Also, at least 5% of those who are 40-60 year old would have adopted HLS, too. A new Health Promotion Resource Centre will be established at the RDHS with its infrastructure as well as administrative and logistical support. The

RDHS and Medical Officer NCD will coordinate several activities in each setting: advocacy campaigns; formation and maintenance of committees; formulation of action plans; awareness programmes; training of trainers; production of behavioural change communication materials on HLS; assessment of supportive environmental factors; monitoring of enforcement of policies; and making recommendations. They will establish joint ventures with the other sectors to provide facilities for sports activities and for healthy food habits to be practiced. The MOH and local health institutions will be responsible for developing model health promoting centre or health promoting family clinic.

Meanwhile, Polonnaruwa plans to start its prevention activities. It will register all families and develop a record system at the MOH, set up health promotion society at PHM level, and advocate at district level. The MOH staff will heighten the general public's awareness particularly those in government and private institutions. The PHM will conduct health promoting family clinic quarterly.

B. Output 2 (Management): Improved System for Early Detection and Prompt Treatment as well as Provision of Acute and Long Term Care, including Rehabilitation

The health authorities in Polonnaruwa and Kurunegala are committed to improving the quality of care for those suffering from chronic NCD and complications. Within the local health institutions, they will foster the availability and use of standard clinical management guidelines or protocols, support the medical audit system and strengthen the hospital health promotion unit. They will promote community rehabilitation programmes that will be managed and operated by trained volunteers. In Kurunegala, they will improve the Physiotherapy Units at the Base Hospital Kuliyapitiya and Base Hospital Nikaweratiya. In Polonnaruwa, the Jayanthipura Hospital will be designated as the rehabilitation centre. Joint ventures with the indigenous medicine will be explored such as in the long-term management of disabilities. To ensure cases are diagnosed early, is treated promptly and continuously minimising complications and premature deaths, a referral system will be set up with the participation of all levels of hospitals, MOH and communities.

For better compliance of clinical guidelines and for the referral system to be functional, there will be improvements also in the following areas: patient education; patient record management; availability of personnel, equipment, drugs and consumables.

C. OUTPUT 3 (SURVEILLANCE): COMPREHENSIVE USER-FRIENDLY SYSTEM FOR SURVEILLANCE GENERATES INFORMATION ON NCD AND RISK FACTORS

The surveillance system in Polonnaruwa will be expanded to all healthcare institutions. A data analysis centre will be established at the RDHS. A survey of risk factors will be carried out. In Kurunegala, a committee will be appointed to oversee the technical and operational issues related to the surveillance system. The forms, registers and records used in Polonnaruwa will be reviewed and the staff trained prior to a stepwise approach in implementing the surveillance system in Kurunegala district.

D. OUTPUT 4 (TRAINING): CONTINUING DEVELOPMENT PROGRAMME FOR HUMAN RESOURCES FOR NCD ESTABLISHED

An overall strategy for developing the human resources for NCD within the districts of Kurunegala and Polonnaruwa will be formulated with technical support from the national and provincial agencies. Existing training programmes, curricula and materials will be reviewed and adapted to the needs of the target groups and to suit local context. A programme for continuing professional development will be incorporated into the priorities of institutions with a mandate for training.

E. OUTPUT 5 (POLICIES): A SYSTEM TO GENERATE EVIDENCE FOR POLICY DEVELOPMENT ESTABLISHED

The RDHS Polonnaruwa and Kurunegala will make the most use of the data and information that will be generated by the chronic NCD surveillance system. They will conduct reviews and special investigations to monitor the implementation or enforcement of approved policies. They will promote operational research on health promotion. The results of all the monitoring and evaluation activities will be transmitted to national and local policy-makers. They will be used to advocate for the enhancement of existing or the formulation of new policies for better NCD prevention and management.

F. OUTPUT 6 (STRUCTURES): ORGANISATIONAL STRUCTURES CONTINUE TO FUNCTION FOR COORDINATION, IMPLEMENTATION AND MONITORING AND EVALUATION

Existing organisational structures will be utilised as much as possible; should a need arises, new ones will be set up. Their membership and management will continue to reflect the genuine spirit of partnership. To effectively fulfil their responsibilities, the members will participate in capacity building programmes on NCD as well as on increasing productivity of meetings, advocacy, community mobilisation, coordination, planning, implementation, monitoring and evaluation.

4.5 POLICY CONSIDERATIONS

4.5.1 EXISTING POLICIES REFERRING TO NCD

> Policy – a high-level overall plan defining the general goals and acceptable procedures to guide and determine present and future decisions

The government of Sri Lanka has documents that refer to non-communicable diseases and their risk factors (Table 4- 2). For example, the Mental Health Policy was drafted with the vision of establishing a comprehensive community-based service on prevention of mental illness, promotion of mental well being, and rehabilitation of people with illness and maximization of their normal lives.

TABLE 4- 2: SOME DOCUMENTS THAT REFER TO NCD

	POLICY	YEAR
1.	Food Act – Act 30	1980
2.	Report from the Presidential Task Force on Health Policy	1992
3.	National Health Policy Statement	1996
4.	Report from the Presidential Task Force on Health Policy	1997
5.	Mental Health Policy	2005
6.	National Nutrition Policy	Draft
7.	National Authority on Tobacco and Alcohol (NATA) – Act 27	2006
8.	National Medicinal Drug Policy	2006
9.	Private Medical Institutions Act	2006
10.	National Health Laboratory policy	Draft
11.	National Policy for Prevention and Control of NCD	Draft
12.	National Health Promotion Policy	Draft

Recognising the need for limiting the production, marketing and use of tobacco and alcohol, the Parliament recently passed the National Authority on Tobacco and Alcohol (NATA) Act No. 27 of 2006. While tasked with assessment and monitoring responsibilities, the NATA is also charged with curtailing people's access to tobacco and alcohol products.

The introduction of some government policies antedated the realization of the growing NCD burden but nonetheless contributed to NCD prevention. The adoption of the Food Act in 1980 is a case in point. Back then, the objective was simply to prohibit manufacturing, importing or selling of commodities that are unfit for human consumption as well as to prohibit manufacturing, preserving, packing and storing for sale of any food under unsanitary conditions.

In 1992, a Presidential Task Force was set up to formulate a national policy on health. It recommended measures for NCD prevention and control: an integrated epidemiological surveillance system for priority NCDs; an intensive health education campaign on risk factors; establishment of physical-cultural and sports activities; and setting up of cardiology units in teaching hospitals. In 1996, the National Health Policy (NHP) was

published. It recognised the increasing number of NCDs such as cardio-vascular diseases, smoking and unhealthy diet. It prioritised the reduction of NCD-related mortality, morbidity and disability. The following year in 1997, another Presidential Task Force was established to develop and recommend action plans for the implementation of the NHP.

4.5.2 FORMULATION OF A NATIONAL POLICY FOR NCD PREVENTION AND CONTROL

The MoH has drafted a comprehensive national policy on NCD. It has organised a series of consultations with stakeholders from the government and other sectors. The vision enshrined in the policy is to foster and guide further sustainable and equitable developments of Sri Lanka and to improve the wellbeing and quality of life of the people by reducing the impact of NCDs and their risk factors on health, economic growth and social development. The mission is to implement measures that are integrated, efficient, effective and accessible by involving different stakeholders from the Government, private sector and the community in order to reduce morbidity, disability and premature mortality. The emphasis of the national NCD policy is on promoting health and wellbeing; prevention of NCD, provision of acute and long term care for people with NCD; rehabilitating people and maximizing their quality of life when illness does occur.

Priority Areas:
- Legislation, regulatory and inter-sectoral measures
- Organisation and delivery of services
- Human resources development
- Community participation and empowerment
- National health information system
- Research and development

4.5.3 FORMULATION OF A HEALTH PROMOTION POLICY

The draft National Health Promotion (NHP) Policy was based on several national and international declarations: Ottawa Charter, subsequent global health promotion conferences and the Bangkok Charter for health promotion; WHO guiding principle for health promotion and WHO South-East Asia Region's Regional framework for health promotion; and Sri Lanka Health Master Plan (2007-2016). The vision of the NHP Policy is "Sri Lanka, a health promoting nation where all the citizens actively participate in health promotion activities continuously for a healthy life expectancy". Its objectives are:

- To strengthen leaderships for health promotion at all levels through advocacy;
- To create nationwide health promotion actions by mobilizing and empowering communities toward active participation in comprehensive health promotion throughout the life course in the settings of people's everyday lives.

- To partner and build alliances with public, private, non-governmental and international organizations and civil society to create and support sustainable health promotion actions;
- To re-orient health service system by incorporating health promotion into all healthcare services;
- To improve health promotion management to enhance and support multi-sectoral comprehensive health promotion at all levels;
- To build capacity for health promotion;
- To improve financing and resources allocation and utilization system for effective and sustainable health promotion; and
- To promote evidence- based health promotion practice.

4.5.4 FOR CONSIDERATION

In addition to the National Policy for the Prevention and Control of NCD and the National Health Promotion Policy, other policy documents may also be drawn up. Acts of Parliament may be enacted or Cabinet decisions may be formulated on the following: a) tax credit or relief for health and healthy products and higher tax for unhealthy ones; b) medical check-up for workers as part of an early detection and prompt treatment programme; c) budgetary allocation for the construction and maintenance of health-promoting facilities like areas for physical activities; d) revision of curriculum to provide appropriate education to medical and paramedical students; and e) collaboration with indigenous medicine practitioners/institutions and with health-related sectors.

The MoH will take the leadership in formulating an action plan that will be based on the NCD policy. In addition, it may need to take measures to shift the health system so that it will be more responsive to the changing milieu. In particular, it may need to redefine the roles and responsibilities of the MoH offices, line ministry and provincial health institutions, and communities. It may revise the policy on drug procurement and distribution to ensure essential medicines are available during medical clinics even in primary care facilities. It will act towards institutionalising chronic NCD surveillance, referral and back-referral systems. Within its premises, it will promote the healthy settings approach; it may issue a healthy canteen policy and provide a supportive environment (e.g. physical activity areas within hospitals). Aside from issuing circulars on the aforementioned priorities, the MoH will be expected to develop or coordinate the formulation of technical documents such as training manuals on NCD and special topics (e.g. advocacy, community mobilisation). The MoH is pilot-testing in two provinces the use of the recently published clinical guidelines that also deal with chronic NCDs such as cardio-vascular diseases (e.g. hypertension, angina and myocardial infarction), stroke, diabetes mellitus, chronic kidney disease, tumours and cancers.

The Parliament Acts, Cabinet Decisions and MoH Circulars will, in one way or the other, facilitate the implementation of the action plans in Kurunegala and Polonnaruwa.