Annexure 1

1. Project Title	Strengthening the Health Financial System of the North Western Province through Cost Accounting
2. Target Areas & Beneficiaries	Tertiary & secondary care hospitals, provincial & district hospital management & policy-makers in the North Western Province, the patients, their families & communities who use hospital services.
3. Focal Point	PDHS / NWP
4. Implementing Agencies	RDHS – Office Kurunegala / Puttalam
5. Duration	Three years (starting fiscal year 2007 August)

6. Project Summary

This project will aim to improve efficient and effective utilisation of the health resource in the North Western Province through introduction of cost accounting to the Provincial Hospitals. The benefits of the actions are expected to reach to the patients, their families and communities who seek available health services in the Province. This project was drawn based on the pilot implementation at the two hospitals in the Kurunegala District in 2006-2007 with collaboration of the JICA EBM Study. This is a step forward to scale up the pilot interventions to the nation-wide implementation.

Activities will be undertaken in the tertiary and secondary care hospitals in the first year and district hospitals in the second year. The total implementation period will be 3 years, starting from 2007. A steering committee as well as coordinators will be appointed to assist administrative and technical needs of the hospitals while starting up the activities. The steering committee will regularly meet and discuss the effective use of health resources based on the cost information gained from the hospitals and it shares with the central Ministry.

In particular, the project focuses on the achievement of the following outputs.

- To setup a functioning cost accounting system in place at all tertiary, secondary care institutions and all District hospitals by the establishment of a mechanism to collect and analyze data.
- To disseminate and share the analyzed information gained from cost accounting for better decision making.
- To establish a coordinating mechanism at RDHS / PDHS level to facilitate, guide and monitor the implementation, which will take place simultaneously.

- To implement a policy in place to run cost accounting system in parallel to currently available accounting system which will ensure the continuity of the project

7. Justification

The Ministry of Healthcare and Nutrition (MOH) has identified the need to reorient their strategies to bring about better accountability and cut down the wastage of the limited resources in the existing health care delivery system. The establishment of a good management information system that could measure costs of services is an essential pre-requisite in this regard. Evidence-based decision making and appropriate resource allocation are of major importance in this context for which improvement of hospital management through cost accounting becomes vital.

Pilot implementation was successful and left valuable lessons behind, which can be explored in the next stage. Methodologies developed through the pilot study are found to be effective in enhancing not only the hospital financial management but also in improving cost consciousness among the patients and health care providers. In this regard, the decision for the provincial-wide implementation as drawn in this action plan is a step forward to build a wider consensus on the cost effectiveness in the health system island wide. The provincial exercise will contribute to that end.

8. General objective

- Vision
  This project aims to contribute to the improved health care delivery system by utilizing resources efficiently and effectively through the introduction of managerial cost accounting in hospitals. In the long run, the strengthened health system will benefit the patients and communities at large
- Specific objective

Objective	Indicators	Means of Verification
To utilize resources effectively and efficiently through cost-accounting system	Availability of cost per patient by unit Availability of information for service cost on diet, cleaning, laundry , transport , security etc., comparison among the hospitals.	Monthly report of cost accounting

9. Output

Output	Indicators	Means of Verification
A coordinating mechanism is established at the RDHS / PDHS level to facilitate, guide and monitor the implementation.	Number of visits to the hospitals Number of training sessions conducted	Record of discussion in the hospitals Record of training sessions
A functional cost accounting system is established to collect integrate and analyze data, in all tertiary, secondary care institutions and all District Hospitals.	Frequency of Working committee meeting Regularly submit monthly report	Minutes of meetings Monthly report of cost accounting
A provincial policy is developed and practiced to run cost accounting system in parallel to accounting system currently available	Number of institutions following the policy	Monthly report of cost accounting
The analysed information are disseminated and shared for a better decision making.	Integrated and analysed report of the hospitals Frequency of Steering committee meeting	Handouts for the meeting Minutes of meetings

10. Schedule of Activities and Budget

Activities	Schedule			Responsible Office	Budget
	Y 1 *	Y 2	Y 3		
1. A coordinating mechanism is established at the RDHS / PDHS level to facilitate, guide and monitor the implementation.					**490,760/=**
1.1 Appoint one coordinating officer for each district and provincial office	+			PDHS/RDHS	**Basic training of staff involved with cost accounting** Refreshments 50 x 160 = 8,000/= Trainer 1000 x 4 x 2 = 8000/= Stationary 500 x 4 = 2000/= Training co-ordinator 400 per day x 8 = 3200/= **Total 21200/=**
1.2 Set up a Development Committee	+				
1.3 Prepare the guidelines and regulations	+	+		HOI/PD/RDHS	**Request line ministry & Provincial ministry to do external evaluation** Refreshments 5000/= Transportation Stationary 1000/= **Total 6000/= per meeting** **Total 6000x5=30,000**
1.4 Make necessary adjustments on the data entry formats etc. to facilitate data collection		+	+	Planning Units of PD/RDHS	
1.5 Conduct regular trainings for the staff	+	+	+	Planning Units of PD/RDHS	**Coordinating visit of the hospitals** PD office to Puttalam 120Km
1.6 Ensure continuous supply of physical resources	+	+	+	HOI/PD/RDHS	

Activities	Schedule			Responsible Office	Budget
	Y 1 *	Y 2	Y 3		
1.7 Conduct Frequent reviews and supervisions of cost accounting system	+	+	+	HOI/RDHS	PD office to Nikaweratiya 60Km PD office to Kuliyapitiya 50Km PD office to Dambadeniya 50Km PD office to Chilaw 80Km PD office to Marawila 80Km Estimate total mileage to visit 880Kmx 12m x 3y=31,680Km Fuel 8Km/litter = 3,960litter **Total Rs.111 x 3,960 = 439,560/=**
1.8 Regularly review cost data to improve accuracy in the hospital	+	+	+	PD/RD Coordinating officers	
1.9 Request the line ministry to do external evaluation	+	+	+	Coordinating officers	
2 A functional cost accounting system to collect, integrate and analyze data, in all tertiary, secondary care institutions and all District Hospitals.					**2,521,500/=**
2.1 Set up and institutionalise a working committee at each hospital	+	+		Head of the institution	**computers –** (80,000/= per computer & accessories) Computer 55,000Laser printer 15,000,Computer table & chair 10,000 Amount 4 BH – 2x 4 = 8 computers 18DH- 1x18=18 computers 1PD&2RDHS office 1x 3= 3 computers Total 29 computers & I printer for each computer **Total 80,000 x 29** **2,320,000** **Stationary** Papers A4 200 x 6 (months) =1200 1200 /400= 3x4(BH)12+18 DH) = 30 30 x 400 =**12,000/**= For 6 Months A3 papers&files= 200 x 30=**6000/=** **Total 18,000/= per 6 months** **108000 for 3 years** **Recurrent cost** 5,000 pre institution (cartridge etc.)
2.2 Identify available Human resources for capacity building & develop their competencies	+	+		working committee	
2.3 Identify physical resources- equipment, instruments, stationeries & establish a Cost Accounting Unit at each hospital	+	+		PDHS,RDHS	
2.4 Collect data and analyse at the hospital ✓ Customize data collection format/s ✓ Distribute formats ✓ Record data ✓ Collect data sheets, ✓ Collect necessary data from RD/ RMSD, ✓ Enter Data to the computer, ✓ Analyse data &prepare reports	+	+	+	Head of CAU	

Activities	Schedule			Responsible Office	Budget
	Y 1 *	Y 2	Y 3		
2.5 Establish internal evaluation system at the hospital	+			Head of the institution	500 x 22 for 6 months **110,000/=** **22 training programmes held within the Hospital** Transport for Resource personnel – 1000/= per session Refreshments 3000/= for one session Handouts (stationary) 250/= per session **Total 4250 x 22 = 93500/=**

3. A provincial policy is developed and practiced to run cost accounting system in parallel to accounting system currently available					**135,000/=**
3.1 Conduct awareness programme among Politicians, Trade unions, Other interested parties	+			PD/RD/Coordinating officer	**Awareness programme among Politicians, Trade unions, Other interested parties** **Estimated cost of 75,000/=** Workshop to develop the policy paper-objectives, strategies Refreshments 5000/= Transportation Stationary 1000/= Total – 6000 per work shop For 10 meetings **Total cost of 60,000/=**
3.2 Conduct workshops to develop a policy paper	+			PD/RD/Coordinating officer	
3.3 Finalise the provincial policy	+			Coordinating officer	
3.4 Secretary of health to present it before the cabinet	+			Coordinating officer	
3.5 Get the approval		+		RD PD HOI	
3.6 Implement Policy		+		PD	

4. The analysed information are disseminated and shared for a better decision making.					**72,000/=**
4.1 Establish a steering committee in the provincial level		+	+	PD/RDHS	**Meeting Cost** Refreshments 5000/= Transportation Stationary 1000/= **Total 6000/=** Meetings every three months Total cost for 3 years = 6000x 12 = 72000/=
4.2 Review and compare the cost data				PD/RDHS	
4.3 Undertake disease-management costing, using the cost data obtained form the hospitals	+			PD/RDHS	
4.4 Make decisions to divert resources to more needy places in the hospital		+	+	PD/RDHS	
4.5 Forward suggestions to financial authorities		+	+	PD/RDHS	

- **Budget** **3,219,260/=**
- **Miscellaneous (10% of budget)** **321,926/=**
- **Total Budget** **3,541,186/=**

Y1 = year 1

11. Important Assumptions/Pre-Conditions/Risks

- Assumptions/Pre-Conditions
  a. External resource and technical advice continue for a reasonable time of period.
  b. The Provincial policy/circular gets effective without a delay
  c. Operations of the project are not affected by the transferring of key personnel at the PDHS and RDHS offices.

12. Related Projects/Programmes

The Health Master Plan (2007) identified four projects under the strategic programme area of financing, resource allocation and utilisation.

- **4.1.1-**Development of a health finance policy for national, provincial & district levels.
- **4.1.2-**Development & implementation of a plan to reorient procedures & formats towards performance-based planning & budgeting.
- **4.1.3-**Strengthening & reorganising the DDG Finance Office and DDG Planning for health service delivery & inter-sectoral health activities/issues within the context of health economic reality and with full accountability

13. Monitoring & Evaluation:

1. At the institutional level: Hospital Working Committee to check the validity and accuracy of the cost data.
2. At the regional level: Development Committee coordinated by the Coordinating Officer of the RDHS office to share the progress of activities among the hospitals.

At the provincial level: Steering Committee headed by the Provincial Director of Health Services to discuss budgeting and resource allocation based on cost analysis.

Annexure 2

1. Proposed Project Title	Organizational Development for the Quality Management Program (QMP) (To be finalized after review and receiving comments of stakeholders)
2. Target Areas & Beneficiaries	Public hospitals at the tertiary, secondary, primary and peripheral levels, health care receivers at public hospitals in Sri Lanka.
3. Focal Point	DDG/MS
4. Implementing Agencies	Director, Quality Secretariat
5. Duration	To be decided

6. Project Summary

This project aims to develop structure and organization that facilitates the National Quality Management Programme (QMP) that would facilitate the institutionalization of quality management including 5S practices in health institutions.

The strategic framework of this project is based on the recently drafted National Policy on Hospital Quality and Safety, with specific focus on organizational development. Improved productivity and quality of health services will be an ultimate aim of the Quality Management Programme, and organizational development contributes to management improvement and identifies factors that influence clinical quality and safety.

This project introduces 5S, a management tool originated in Japan, to inculcate a systematic approach to productivity, quality and safety improvement. In 2004, the Quality Secretariat was established to replicate this useful tool at the other public hospitals. The Ministry of Health has implemented 5S in a few selected hospitals. To date, some hospitals have become role models for others. However, replication is still limited mainly because the initiatives rely on individuals, and a systematic support network is lacking. Most technical resources (trainers, opportunities for learning) predominantly concentrate and stay in and around Colombo.

This Action Plan, therefore, advocates establishment of a coordination body at the Provincial and District Levels. The establishment of a Quality Department in the existing planning unit of the Provincial Development of Health Services (PDHS) is a foremost priority for this project. Once a pool of trainers and model hospitals are created within the province/District, the Quality Secretariat could take up a more strategic role as a central support unit for guiding, training in quality management, evaluation of the programme, and advocating quality and safety issues in the clinical dimensions.

At the ground level, the health service institutions including MOH offices will establish a Quality Management Unit (QMU) and Work Improvement Teams (WIT) in their respective institutions. The responsibilities at each level will be defined and quality management cycles will be practiced at the hospitals. Regular and continuous training is a key driver to improve employee participation. Under this project, the hospitals receive training from locally available resources that can be the staff of other hospitals in the same locality.

To link the outputs of this project to the clinical quality initiatives, the related projects are also identified. They will benefit the development of the structure and mechanisms to be constructed at the Central and Regional levels under the Quality Management Programme.

7. Justification:

Implementation of a responsive health care system has been a long felt need in Sri Lanka. A growing demand for a better quality of hospital services is prevalent across the country. Overcrowding at the OPD and long waiting time for registration and at the drug counter are so common in the secondary and tertiary level hospitals in Sri Lanka.

Absence of rigid rules and regulations for hospitals on the standards of hygiene, maintenance of facilities, waste disposal, and sewage system adversely affect quality and safety of public hospital services. Deficiencies in maintenance of equipment and training of staff in the use of equipment have caused breakdowns. The mechanism for maintenance of medical equipment has to be strengthened.

Clinical performance is affected in a disarrayed work environment. The Castle Street Hospital for Women and many other public hospitals in Sri Lanka have proven this point after introducing organizational development through a simple and low-budget management tool. The technique helps to identify management issues that need improvement.

With the successful implementation of this project, it is envisioned that the public hospitals in Sri Lanka will develop **organizational capacities** to plan, act and sustain provisions of promotive, preventive, diagnostic and rehabilitative services with high quality and safety standards.

8. Objective

Objective	Process Indicators	Means of Verification
Develop a structure and mechanism at the central and provincial/district levels for the nation-wide implementation of the National Quality Management Programme (QMP)	% of Provinces/Districts with Quality Management Departments established	
	Quality Secretariat cadres approved and appointed	

9. Output

	Output	Indicators	Means of Verification
1	A mechanism to support the implementation of the Quality Management Programme established at the central level	Availability of comprehensive plans for Quality Management Programme implementation at the various levels.	
		Number of permanent Medical Officers and administrative staff appointed to QMP at MOH and QS	
		Operational budget available to support the Provinces/ Districts/Teaching Hospitals	
		Operational plans for training, field visits, technical support, programmes updated	
		% of Teaching Hospitals with established QM departments	
2	A structure developed and capacities of the Provincial/ District Offices strengthened for coordinating QMP with the Quality Secretariat and the quality management units of regional hospitals	Number of provincial/district QM departments established	
		Number of Trainers trained within the District	
		% of hospitals in the Province/District that have established quality management system	
		Number of model hospitals achieving quality standards	
3	Information system established to monitor changes	Monitoring criteria and number of standards available	
		Number of hospitals/ RDHS offices sending monitoring records regularly	
4	An auditing system established for National Health Excellence Awards	Number of hospitals audited	
		Number of hospitals that implemented auditor's recommendations	
		Number of hospitals receiving appreciation/ awards	

10. Schedule of Activities

Activities
1. Establish a mechanism to support the implementation of the Quality Management Programme at the Central Level
1.1 Proceed with appointment of required cadres at Quality Secretariat.
1.2 Appoint a working group to develop a Quality Secretariat medium term plan

Activities
1.3 Conduct consultative meetings to develop a comprehensive plan for National Quality Management Programme implementation
1.4 Establish an Advisory Committee comprising of representatives of colleges, SLMA, DDG/MS of the MOH, etc to represent clinical quality matters in QMP
1.5 Develop TOT curriculum to train district-based trainers
1.6 Develop and publish a manual on QMP in health sector
1.7 Support Teaching Hospitals across the country in implementation of the QAP
1.8 Develop performance criteria to measure quality and safety in the health care institutions
1.9 Monitor progress and impact of the QAP

2. Develop a structure and strengthen capacities at the Provincial/District level to coordinate the QAP
2.1 Establish Quality Department in all Provinces and selected Districts and Teaching Hospitals
2.2 Develop the functions and responsibilities of Quality Management Departments.
2.3 Develop provincial implementation plans and Teaching Hospital Plans of the National Quality Management Programme.
2.3 Establish teams who can plan and conduct Training for Trainers (TOT) at the Province/District Level.
2.4 Support the hospitals/MOH offices in developing Quality Management Units
2.5 Support hospitals in establishing 5S methodology as one of initial activities in QMP
2.6 Support hospitals in establishing Quality Management cycles including setting and supervising the standards
2.7 Establish model hospitals at each District
3. Establish information system to monitor changes
3.1 Develop a system for hospitals to regularly collect hospital statistics to enable routinely measure and utilise performance data
3.1 Develop a mechanism for RDHS to monitor progress to ensure the equitable services in all areas within the District
3.2 Develop a mechanism for PDHS to monitor the quality improvements in the priority areas
3.3 Develop an information flow from provinces, districts and Teaching Hospitals to Quality Secretariat and a feedback system.
3.4 Develop a method for use of monitoring data for planning support programmes and reward schemes.
3.5 Establish linkages with the international circle to participate in exchange of experiences of the quality programmes and organise forums.

Activities
4. Develop an auditing system for National Health Excellence Awards
4.1 Review existing auditing formats and develop the one relevant to the health sector
4.2 Develop incentive schemes –e.g. Fellowship- to recognise and reward the best performing hospitals
4.3 Monitor the progress of implementation of audit recommendations.

11. Assumptions/Pre-conditions /Risks (Refer pages A 2-10 to A 2-12)

12. Related Projects/Programmes (Refer pages A 2-10 to A 2-12)

13. Relevant Agencies to be Coordinated: (Refer pages A 2-10 to A 2-12)

14. Monitoring & Evaluation: (Refer pages A 2-10 to A 2-12)

1. Proposed Project Title	Implementation of National Clinical Guidelines in the MoH Hospitals (To be finalised after review and receiving comments of stakeholders)
2. Target Areas & Beneficiaries	Clinical care provided in the MoH health institutions providing in ward care particularly in the specialist manned hospitals, care seeking population at the MoH hospitals at Teaching, Provincial General, District General, Base Hospitals, and District Hospitals, the care providers, the health administration
3. Focal Point	DDG/MS
4. Implementing Agencies	Director, Quality Secretariat supported by the Advisory Committee on Clinical Quality (to be appointed)
5. Duration	To be decided

6. Project Summary

The national policy on Hospital Quality and Safety identifies of clinical practice as the third policy area aimed at promoting evidence-based as well as ethically accepted clinical practice. The first of the four strategies proposed is “minimize variation by developing evidence-based clinical protocols and guidelines on clinical procedures”. The second strategy suggested is “to develop a mechanism for professional oversight and peer review and audit of clinical practices”.

This project intends to followup on the above policy directions by effective use of the recently launched National Clinical Guidelines, and develop additional guidelines as and when necessary and launch a process of implementing hose guidelines in the clinical practice of all hospitals.

Initially the hospitals where specialists are available will be targeted and there after with the intention of extending to other hospitals. These guidelines were developed with the assumptions that the expected facilities are available in all the hospitals of the country banking on the experience of the experts who developed them.

However, this assumption needs to be verified and where gaps are identified in the facilities needed to implement them and filled. This ensures efficient implementation and gain the confidence of the health care providers specially the medical professionals.

7. Justification:

Sri Lanka has been proud of the health indicators reflecting the clinical care in the health institutions, such as low levels of maternity mortality, infant mortality rates. This has been due to the clinical excellence reached through

the commitments of the care providers who have set clinical standards in their individual capacity.

As new frontiers open out in the different specialties of Medicine need for incorporating the new information in to the clinical practice in the MoH hospitals without undue strain on the available resources becomes very important. At the same time efficient and timely utilization of resources in the provision of care which must be provided expeditiously saving precious minutes in emergency situations too is of utmost importance.

All these objectives could be achieved by the use of Clinical Guidelines in the health care institutions. Well documented instance of reduction of venous thrombosis in the UK after clinical guidelines were implemented is well known. Long felt need of clinical Guidelines has been fulfilled recently in the MoH hospital by the development of Guidelines on 93 Clinical conditions. These will reach the hospitals within the next one month.

It is very important to sensitize the care providers not only about the content but also on the advantages of using them. This will project will ensure the use of these guidelines not only by advocacy but also by identifying the gaps in the necessary resources and providing a satisfactory environment to implement the guidelines.

8. Objective

With the implementation of this project, it is envisaged that MOH hospital would provide improved care with respect to the 93 clinical conditions for which the guidelines have been developed.

Objective	Indicators	Means of Verification
To improve the clinical care provided with respect to the 93 clinical conditions by the efficient implementation of the clinical guidelines.	1. Improvement in outcomes of clinical conditions 2. Performance of clinical services to the desired levels against targets.	

9. Output

	Output	Process Indicators	Means of Verification
1	Setting up a stage (strengthening the health system) to use the guidelines efficiently	List of requirements needed to implement available	
		List of deficiencies in the institutions	
		Operational plans to fill in these gaps available	
2	Capacity building of the health	Number of hospitals/units taking part in	

	care providers in order to implement the said guidelines	implementation	
		Number of care providers taking part in the discussion sessions for each guidelines	
3	Systems to monitor and evaluate compliance with the guidelines and assess the impact	Monitoring and evaluation criteria available	
		Rate of compliance based on the criteria	
		Evaluation guidelines available	
		Number of hospitals evaluated	

10. Schedule of Activities and Budget (to be decided later)

11. Assumptions/Pre-conditions/ Risks (Refer pages A 2-10 to A 2-12)

12. Related Projects/Programmes (Refer pages A 2-10 to A 2-12)

13. Relevant Agencies to be Coordinated: (Refer pages A 2-10 to A 2-12)

14. Monitoring & Evaluation: (Refer pages A 2-10 to A 2-12)

1. Proposed Project Title	Establishment of a Risk Management System to ensure patient and staff safety in the MoH health Institutions (To be finalised after review and receiving comments of stakeholders)
2. Target Areas & Beneficiaries	The Teaching Hospital level and later the other hospitals at other levels, the provincial-wide implementation. Health care providers and recipients, and their families.
3. Focal Point	DDG/MS
4. Implementing Agencies	Director, Quality Secretariat supported by the Advisory Committee on Clinical Quality (to be appointed)
5. Duration	To be decided

6. Project Summary

This project is based on the recently developed National Policy on Hospital Quality and Safety. The policy identifies Risk Management and Safety as the fourth policy area to be addressed in order to achieve the goal of risk identification, analysis and control, which would ensure a positive climate towards patient and staff safety in the MOH hospitals.

This project is intended to achieve improvement in integrated patient and staff safety as the ultimate goal. Its primary target is to minimize preventable adverse events and to encourage a systematic approach in examining contributory factors that lead to these events.

The project is planned to initially establish Risk Management Units (RMU) at two levels: Central and Regional, but as the system develops, setting up a Provincial level Unit is to be considered.

7. Justification

The term Risk Management is applied to a number of diverse disciplines. For the health care providers, it could be considered as a form of quality assurance. Clinical risk management is an approach to improve the quality of care and ensure safe delivery of health care by placing special emphasis on identifying circumstances that put patients at risk of harm, and acting to prevent or control those risks.

A similar approach targeting the staff safety too is important in countries like Sri Lanka. Therefore, an integrated approach is suggested. It is difficult to estimate the frequency of adverse events happening to patients in Sri Lanka as there is no record of such events maintained. Individual events are managed as and when they occur to the best of the ability of those involved.

However, by the media reports of such events and the increasing number of legal interventions the numbers of adverse events must be considerable although it is not surprising, considering the work load of the MOH hospitals. However it is timely that a system to identify, document, and evaluate these adverse events is established in order to take preventive action.

8. Objective

With the implementation of this project, it is envisaged that MoH hospital would have less adverse events concerning clinical care and staff safety.

Objective	Indicators	Means of Verification
To Improve the clinical care and staff safety by minimising adverse events	Percentage of reduction of adverse events in successive years.	Data collected by Central RMU

9. Output

	Output	Process Indicators	Means of Verification
1	Establishment of Central Risk Management Unit (RMU)	Availability of policies and procedures to oversee risk management	
		One Medical Officer per RMU	
		Operational budget to support local RMU	
		Number of operational plans for assisting local RMUs available	
2	Establishment of 4 local RMUs	Risk Management teams identified Number established	
3	Mechanism to implement Risk Management and staff safety : Incident management system	Number of tools and methodologies to identify and manage risks	
		Hand books produced	
		Number of risk mitigation strategies in place	
		Number of sentinel events reported per month	
		Number of high risk incidents and near misses investigated	
		Annual analytical reports	

10. Schedule of activities and Budget (To be decided later)

11. Assumptions/Pre-conditions or Risks

- Assumptions/Preconditions
  1. Policy on Hospital Quality and Safety is approved and institutionalised in the Ministerial system.

2. The Quality Secretariat retains its official mandate that allows implementation of the quality improvement activities.
3. External sources continue to provide technical and financial support to the hospitals during the implementation.
4. Possibility of mobilising political and com
5. munity support to sustain the activities
6. A committed leader figure is always available.
7. The interventions undertaken will help to change mindset of employees
8. Government will have in place at least the minimum requirements for a successful QMP.
9. Clinicians support is available

- Risks
  1. Members of strong labour unions consider the changes as a threat
  2. Unscheduled transfers of dedicated managers before full establishment of the quality programme
  3. Use of the same strategy when applied in different locations could give different results.
  4. A non-flexible programme that does not adapt to changing situations.
  5. Non-provision of minimum resources to run the programme
  6. Inadequate cooperation from clinical staff
  7. Difficulty of some managers and clinicians to devote some time for these activities.
  8. Interruption in training due to unforeseen circumstances

12. Related Projects/Programmes

The Health Master Plan (HMP) identified three projects under the strategic objectives number 1 to implement a National Quality Assurance Programme to enhance the quality of service delivery (1.3).

In addition to the project of Total Quality Management of Hospital Service, there are two other related projects as follows;

1.3.1. Improved Quality of Patient Care Services

1.3.2. Development of Emergency Services Network for injuries, accidents and Disasters

13. Relevant Agencies to be Coordinated:

1. PDHS
2. RDHS
3. MDPU, MOH
4. ALMA, Professional Colleges, Medical Schools
5. SLIDA
6. NPS
7. SLSI
8. JASTECA

14. Monitoring & Evaluation:

- Institutional Level
  Information will be collected monthly and be reviewed quarterly at RDHS and PDHS quality Management Departments. A feedback will be sent to the institutions after the review.
- Provincial/District Level
  Monitoring visits will be made by the Provincial and District Quality Management Teams to the institutions on a regular basis
  The monitoring information will be discussed at the monthly meetings of PDHS and RDHS with the heads of institutions. Further actions will link this monitoring of the quality programme to the activities of the proposed M&E cell to be established in all Planning Units.
  Similarly, the progress of the activities related to directly to organizational functions of Provincial and District Quality Management Departments will be monitored separately and progress report be discussed at their monthly meetings.
- Central Level
  Quality Secretariat will monitor overall progress of the project activities. Reports will be presented to the Health Development Committee meetings at the MOH on a quarterly basis with a view to finding solutions to identified problems in the implementation.
  A semi annual report will be published by the Quality Secretariat describing the progress of quality plans, focusing on implementation of activities, major achievements, problems faced and solutions found.
  Data on clinical audits of the hospitals will be collected for analysis by the Quality Secretariat and its clinical advisory committee and a report will be published annually.
  A mid term evaluation is carried out by the Quality Secretariat, which describes the achievements against the plan, lessons learned and adjustments made to the project. The report will be submitted to the HMP Steering Committee to receive policy directions.

Annexure 3

1. Project Title	NCD Surveillance and Prevention in Polonnaruwa District
2. Target Areas & Beneficiaries	Entire Population of Polonnaruwa district
3. Focal Point	Regional Director of Health Services (RDHS) Polonnaruwa
4. Implementing Agencies	RDHS Office in Polonnaruwa
5. Duration	Five years (from 2008)

6. Project Summary

During the past months, the RDHS Polonnaruwa initiated a surveillance system for selected chronic NCD in 3 hospitals and all MOH areas. This 5-year action plan will advance the surveillance system to cover the entire district as well as to manage and use information on cardio-vascular diseases, diabetes and other chronic NCD and risk factors. It will also establish cost-effective prevention interventions that will reduce risks, promote health and well-being. It will enhance the existing mechanisms of improving patient care. It will set up a rehabilitation programme. It will build the capacities of staff and other stakeholders. It will develop systems for referral, back-referral and generating/using evidences for actions. It will ensure that structures for multi-sectoral coordination remain functional. All these will be aimed at reducing the prevalence and complications of NCD.

7. Justification

The top three causes of mortality are related to chronic non-communicable diseases (NCD) in Polonnaruwa district. Although they are not the leading causes of hospitalization, NCDs take up a large proportion of bed occupancy and account for more than 90% of medical clinic attendance. In Polonnaruwa district, the available information is not sufficient to guide the decisions and actions of the administrators, curative and preventive sectors. To generate information for action, a surveillance system is necessary and one was initially implemented during the past year. Based on this experience, the RDHS Polonnaruwa decided to make the surveillance system more advanced so that it will not only generate the information but also it will be able to manage and use such for people's health.

During the next five years, a continuing professional development programme will be necessary to improve the standards of a spectrum of health services for better patient management from early detection, to provision of acute and long-term care. A facility- and community-

based rehabilitation programme will be introduced as there is none. In partnership with networks of stakeholders in various settings, cost-effective prevention strategies will be initiated to reduce risks, promote health and well-being. Towards this end, training and public education programmes will be conducted. In the expansion of the surveillance system, improvement of patient management and introduction of prevention interventions, there will be a need to review, amend or adopt new organizational or technical policies based on evidence.

8. Objective

The RDHS Polonnaruwa would like to reduce the prevalence and complications of major NCDs by adopting effective prevention strategies and adhering to standard clinical management procedures. It shares the national vision of a healthier population that contributes to the national socio-economic, mental and spiritual development.

9. Output

	Output	Indicators	Means of Verification
1	Comprehensive prevention programme established that includes the reduction of risk factors, a user-friendly screening mechanism for early detection of high-risk groups, promotion of healthy food habits and lifestyles	Long-term reduction in the prevalence of NCD & associated complications	IMMR & NCD Notification Register
2	System for better patient management, including prevention of complications, strengthened	Reduction of increasing trend of complications	PDR , MOH data base
3	Rehabilitation programme established	Rehabilitation of patients started	Records at Rehabilitation centre
4	Comprehensive user-friendly surveillance system expanded district-wide covering cardio-vascular diseases, diabetes, other priority NCD and risk factors	Prevalence and other data available for interventions	Records at the RDHS office
5.	A functional multi–sectoral coordination structures and mechanisms at divisional, district & provincial levels	Coordination structures are available for implementation	Minutes and Reports of coordination structures
6.	System set up for training the key partners of the program	Availability of programme schedule	No. of sessions & output from participants
7.	System established for policy enforcement as well as for generating evidence to amend existing or formulate new ones	Policies enforced, amended or newly formulated	Circulars of the district; Minutes of meetings; & reports of evaluation

10. Activities: Schedule and Budget

Activities	Schedule					Responsible Office	Budget
	Y 1 *	Y 2	Y 3	Y 4	Y 5		
1. Comprehensive prevention programme established that includes the reduction of risk factors, a user-friendly screening mechanism for early detection of high-risk groups, promotion of healthy food habits and lifestyles							
1.1 Registration of families at MOH level	+						0.2M
1.2. Development of record system to carry out proper information to the community at MOH level	+	+	+	+	+		0.5M
1.3 Development of health promotion club/society at PHM level	+	+	+	+	+		No cost
1.4 Conduct of health promoting family clinic quarterly by PHM range	+						0.5M
1.5 Development of MO NCD unit/procurement of health education materials	+						10M
1.6 Conduction of regular Advocacy programmes at district level	+				+		0.06M
1.7 Conduction of awareness programs at MOH level to enhance government and private sector institutions	+	+	+	+			0.4M

Activities	Y 1 *	Y 2	Y 3	Y 4	Y 5	Responsible Office	Budget
2. System for better patient management, including prevention of complications, strengthened							
2.1 Identification of human resources and consumables/ drugs	+	+					No cost
2.2 Development of referral and back referral at district level and educate health care workers regarding this referral system	+						0.035M
2.3 Development of computer based clinic registration system	+	+	+				3.9M
2.4 Conduct program for improvement of drug dispensing system	+						0.75M
2.5 Health education of patients regarding the diseases, drugs etc.	+						1.5M

Activities	Schedule					Responsible Office	Budget
	Y 1 *	Y 2	Y 3	Y 4	Y 5		
3. Rehabilitation programme established							
3.1 Appointment of one Occupational Therapist to the district		+					No cost
3.2 Development of Jayanthipura Hospital as a Rehabilitation		+	+				39M

	Y 1 *	Y 2	Y 3	Y 4	Y 5	Responsible Office	Budget
4. Comprehensive user-friendly surveillance system expanded district-wide covering cardio-vascular diseases, diabetes, other priority NCD and risk factors							
4.1 Printing and distribution of standard notification form for inward and outdoor patients of government hospitals and private health care institutions	+						0.61M
4.2 Development of data analysis centre in RDHS office	+	+			+		0.49M
4.3 Development of risk analysis survey		+	+	+			1.5M
4.4 Dissemination and promotion of the use of information	+	+	+	+	+		0.5M

	Y 1 *	Y 2	Y 3	Y 4	Y 5	Responsible Office	Budget
5. A functional multi–sectoral coordination structures and mechanisms at divisional, district & provincial levels							
5.1 Identification of key stakeholders for committee	+	+					0.2M
5.2 Development of multi-sectoral coordination committee		+	+				0.4M

	Y 1 *	Y 2	Y 3	Y 4	Y 5	Responsible Office	Budget
6. System set up for training the key partners of the program							
6.1 Identification of human resources who needs training	+	+					No cost
6.2 Review of existing training programs and develop new curricula and training programs	+	+	+				3.016M
6.3 Development of necessary investigative facilities		+	+		+		17.3M
6.4 Development of district training plan and carry out the training programs		+	+	+			0.2M

Activities	Schedule					Responsible Office	Budget
	Y 1 *	Y 2	Y 3	Y 4	Y 5		
7. System established for policy enforcement as well as for generating evidence to amend existing or formulate new ones							
7.1 Research for evidences	+	+	+	+	+		1M
7.2 Follow up and monitoring	+	+	+	+	+		2.5M
7.3 Conduct advocacy programs for officials using the evidences gathered from the surveillance system and review methodologies			+	+			1M
Total							**85.561 M**

11. Important Assumptions/Pre-conditions/Risks

Human and physical resources are available to carry out the activities because at present the available cadre is not enough to respond to the disease burden.

The policies on chronic NCD and on health promotion are adopted. The Risk Factors Survey using the STEPS approach will be regularly conducted.

12. Related Projects/Programs

The NCD Surveillance and Prevention in Polonnaruwa District is related to many ongoing programmes and projects. It will benefit from the Health Sector Development Project, which includes components on district planning, NCD, improving mortality data and quality of care, among other things. It is related to a research on chronic renal failure and another programme of a non-governmental organisation called Sarvodaya. It supports the following Health Master Plan Project Profiles:

- 1.4.1.a Integrated NCD Control
- 1.4.1.c Renal Diseases
- 1.4.1.f Mental Health
- 1.4.1.g Cancer Control Programme
- 1.4.2.l Strengthening of Disease Surveillance & Management
- 1.5.2 Health of Elders
- 1.5.8 School Health
- 1.6.2 Establishment of a Mechanism to Implement the National Nutrition Programme
- 1.7.2.a Establishment of Implementation Mechanisms for the Health Promotion Programme
- 1.7.2.b Capacity Building in Health Education & Promotion
- 1.7.2.c Health Promoting Setting Approach

- 1.7.2.d Establishment of Implementation Mechanism for Health Promotion Programme
- 1.7.2.e Programme for Improved Community Involvement in Health Promotion
- 5.4.2 Strengthening of the Provincial Health Information System

13. Relevant Agencies to be Coordinated

Prevention and patient management of the life-style related diseases cannot be successful without the active participation of relevant stakeholders other than the MoH. For example, chronic renal failure is a huge problem that needs to be coordinated with the National Water Board. Likewise, partnership with local government authorities is essential for the development of health-promoting policies. The Maheweli Authority, other government and non-government organizations will play significant role in mobilising community health actions.

14. Monitoring & Evaluation

Process monitoring and outcome evaluation will be carried out during the course of the 5-year implementation to determine the progress of activities as well as the achievement of outputs and objectives. The indicators reflected in this action plan will be monitored. The results will be used also for reviewing policies intended to support behavioural changes in various settings.

Monitoring and evaluation activities of NCD and risk factors will be incorporated into the existing mechanisms. For example, during the MOH monthly meetings and the RDHS quarterly meetings, the reports generated through the surveillance system will be discussed and recommendations proposed so that actions can be taken for better prevention or patient management. Officials from the PDHS will be invited to provide inputs on a regular basis. An annual review will be organised during which national ministry officials and other stakeholders will serve as external evaluators. Evidences will be collected from the surveillance system, questionnaires, focus group discussions and in-depth interviews.

Annexure 4

1. Project Title	Promoting Healthy Life Style in Kurunegala District
2. Target Areas & Beneficiaries	Total population in Kurunegala district
3. Focal Point	Regional Director of Health Services (RDHS), Kurunegala
4. Implementing Agencies	RDHS office, Kurunegala
5. Duration	Five years (from 2008)

6. Project Summary

Ischemic heart disease is the leading cause of hospital mortality (12.5%) in Sri Lanka and it contributed to 11% of hospital deaths in Kurunegala district. Medical clinics in major hospitals in the district are overcrowded with patients having chronic non-communicable diseases mainly hypertension, diabetes and cardio-vascular diseases showing a gradual increase for the past several years. Annually about 450,000-475,000 clinic attendances are reported from all curative care institutions in the district.

Pilot study conducted in one Medical Officer of Health division in Kurunegala district (Kuliyapitiya) during 2006 with the aim of community prevention of major chronic NCDs through promoting healthy life style among the population in 4 settings has created community interest in adopting the healthy life style. In considering the long-term benefits of such a programme as well as the importance of intervention at secondary and tertiary levels of care for the patients, a more comprehensive approach to lifestyle-related diseases (LSRD) prevention is addressed in this action plan that includes for the purpose of generating reliable information for action.

7. Justification

Kurunegala district in the North Western Province (NWP) represents the larger of the two districts in the province with a land area of 7.4% of the country and population of 1.4 million, who are predominantly rural and greying as 9.7% of them are elderly (2001). NCD contributed to 41% of hospital admissions and 54% hospital mortality (2004). District-level risk factor data for chronic NCD are not available except for hospital morbidity and mortality statistics. District mortality statistics reflect the predominance of chronic NCD. Ischemic heart disease alone accounted for 11% of hospital deaths in Kurunegala district while it was the leading cause of hospital mortality in the country (12.6% in 2003). Medical clinics in major hospitals in the district are overcrowded with patients having chronic NCD mainly hypertension, diabetes and cardio-vascular diseases. Annually about 450,000-475,000 clinic attendances are reported from all curative care institutions. The statistics are increasing for the past several years.

A pilot study was initiated in one Medical Officer of Health division in Kurunegala (Kuliyapitiya) in late 2006 with a long-term goal of reversing the increasing trends, a medium-term purpose of the participants adopting a healthy lifestyle and a health promoting setting approach in schools, hospital/MOH, workplaces and a village. It highlighted the need and generated the demand for such a programme; more importantly, it indicated the community interest and potential actions. Considering its long-term benefits as well as the importance of interventions at secondary and tertiary levels of patient care, a more comprehensive approach to LSRD prevention is addressed in this action plan that includes a surveillance system for the purpose of generating reliable information for action. Stepwise evidence-based interventions will be carried out with more research-oriented action.

8. Objectives

The RDHS Kurunegala formulated this action plan with the long-term national and provincial vision in mind – a healthier population that contributes to a sustainable and equitable socio-economic, mental and spiritual development.

By 2012, the purpose is to arrest the projected increasing trends in the chronic NCD-related morbidities, complications and mortalities (particularly among those in the 40-60 age group) in Kurunegala district. This will be achieved through the establishment of a surveillance system by 2008, enhancement of the comprehensive primary prevention programme and improvement of mechanisms for early detection, acute and long-term care.

Objective	Indicators	Means of Verification
1. To develop comprehensive primary prevention by adopting to risk factor reduction & healthy lifestyle by 2012	Risk factor prevalence; Healthy lifestyle indicators; and Motivated & educated community towards prevention of NCD & promotion of health	Survey
2. Early detection, improved patient care and rehabilitation for chronic NCDs by 2012	Morbidity; Mortality; Rate of Complications due to target diseases; Quality of life of patients and reduced burden to their families	IMMR, Hospital records, survey
3. To develop a comprehensive user friendly NCD surveillance system combined with risk factor surveillance by 2008	Availability of electronic surveillance system for chronic NCD	Surveillance data

9. Output

	Output	Indicators	Means of Verification
1.	**To develop comprehensive primary prevention by adopting to risk factor reduction & healthy lifestyle by 2012**		
1.1	Health promotion centre established at RDHS office	No. of HR developed Exercise training programmes conducted NCD news letter No. screened No. of new NCD research conducted	
1.2	50% of schools in the district practiced health promoting setting policy	% of schools implementing health promoting setting policy % of schools implementing School canteen policy	
1.3	All health institutions in the district practiced health promoting setting policy	% Institutions with active HP Units % staff screened for LSRD % of institutions practising LSRD prevention policy	
1.4	At least 5 work places in each MOH division practiced health promoting setting policy	% of work places implementing HP policy % staff screened for LSRD	
1.5	At least 5% of the population (40-60 years) adopted HLS	Risk Factor prevalence	
1.6	Research on health promotion Institutionalized for more evidence based decision making	No. of relevant researches conducted	Survey
2.	**Early detection, improved patient care and rehabilitation for chronic NCDs by 2012**		
2.1	All curative care institutions practice standard management for chronic NCDs	% of institutions practising standard management for chronic NCD	
2.2	30% reduction of complications of chronic NCDs from the new inpatients registered	% of patients (new inpatients registered) admitted with Complication % of inpatients registered with accepted target values with regard to selected NCDs- control of blood sugar, cholesterol and pressure	
2.3	Efficient back referral system established	% of health institutions capable of handling back referrals to their institutions.	

	Output	Indicators	Means of Verification
2.4	Community based rehabilitation system established.	Community care package available or not. Number of volunteers trained.	
3.	**To develop a comprehensive user-friendly NCD surveillance system combined with risk factor surveillance by 2008**		
3.1	Resources for NCD surveillance identified and developed within the existing health system	% of funds allocated; % of human resources from different categories trained; and formats printed	
3.2	Review & revise hospital recording system for chronic NCDs	% of hospitals using revised format	
3.3	Monitoring and evaluation system in place	% institutions sending returns to RE; % of review meetings held	

10. Activities: Schedule and Budget

Activities	Schedule					Responsible Office	Budget
	Y 1	**Y 2**	**Y 3**	**Y 4**	**Y 5**		
1.1 Health promotion centre established at RDHS office							
1.1.1 Health Promotion Resource centre established at RDHS office Kurunegala (sports centre, auditorium, LSRD information & training centre, research centre, NCD focal point, Screening clinic)	+	+	+				30 M
1.1.2 Mobile vehicle for community screening on NCD (40 – 60y)			+				8 M
1.1.3 Vehicle for NCD focal point		+	+				85 M
1.1.4 HR developed with local & foreign training	+ +	+	+	+ +	+		20 M

Activities	Schedule					Responsible Office	Budget
	Y 1	**Y 2**	**Y 3**	**Y 4**	**Y 5**		
1.2 50% of schools in the district practiced health promoting setting policy							
1.2.1 Advocacy meeting for educational authority	+		+				0.1 M

Activities	Schedule					Respon sible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
1.2.2 Formulate a committee to prepare an action plan (Zonal & Regional Education Directors, selected principals, school instructors-home science &PT, MOH, representative from a technical advisory committee, SPHI)	+						
1.2.3 Prepare the action plan & Monitoring & Evaluation mechanism	+	+	+	+	+		0.05 M
1.2.4 Identify responsible person for coordination from MOH & zonal Educational offices.	+						
1.2.5 Conduct awareness programme for principals & the teachers and parents of schools on HLS (50 x 20 , 250 x 1000, 150 x 1000)	+	+	+	+	+		0.4 M
1.2.6 Conduct awareness programme for prefect & school health promote club members of selected school on HLS	+	+	+	+	+		
1.2.7 Conduct awareness programme for all the students in the selected school through SHPC	+	+	+	+	+		
1.2.8 TOT to teachers on Health promotion & HLS (25 programmes, each 10 days)	+	+	+				3.5 M
1.2.9 Development of HLS package & IEC materials for school setting	+	+					2 M
1.2.10 Develop a check list to assess the existing supportive environmental factors	+	+	+				
1.2.11 Regular monitoring of implementation of the policy & making recommendations	+	+	+	+	+		

Activities	Schedule					Respon sible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
1.3 All Health Institutions in the district practiced health promoting setting policy							
1.3.1 Formulate a committee to prepare an action plan & carry out monitoring of policy implementation (Head of institutions, relevant officers, MOH, representative from a technical advisory committee)	+		+				
1.3.2 Prepare the action plan & Monitoring & Evaluation mechanism through participatory process with the committee	+	+	+	+	+		0.05M
1.3.3 Identify responsible person from MOH & from each Hospital	+						

Activities	Schedule					Responsible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
1.3.4 Prepare a checklist for supportive environment & assess the existing situation	+						
1.3.5 Introduce HLS to Health Staff	+						
1.3.6 Establish a functional Health Promotion Unit in each hospital	+						40 M
1.3.7 Develop TOT programs for Health staff	+						
1.3.8 Conduct TOT programs for health staff	+	+					1 M
1.3.9 Awareness programs for patients, visitors, relatives by Health Promotion Unit	+	+	+	+	+		
1.3.10 Prepare & implement monitoring tools	+						0.2M
1.3.11 Prepare a checklist for supportive environment & to assess the existing situation	+	+	+	+	+		
1.3.12 Model Health Promoting Centre develop for each MOH division	+	+	+	+	+		40M

	Y 1	Y 2	Y 3	Y 4	Y 5		
1.4 At least 5 work places in each MOH division practiced health promoting setting policy							
1.4.1 Advocacy to politicians, management & other relevant sectors	+		+				0.8M
1.4.2 Formulate a committee to prepare an action plan & to Identify the components of the policy (Head of relevant work place & Relevant officers, Ref. Labour department, MOH, SPHI, representative from a technical advisory committee & Ministry on occupational Health)	+						
1.4.3 Prepare the action plan, Monitoring & Evaluation mechanism	+	+	+	+	+		
1.4.4 Identify responsible person from MOH, Labour department & work place	+						
1.4.5 Develop HLS package for work place setting	+						0.01M
1.4.6 Introduce HLS to staff	+	+	+	+			
1.4.7 Capacity building & training of trainers (TOTs) for relevant Staff	+	+					1 M
1.4.8 Situational analysis at each workplace on supportive environment, Problem identification & prioritization	+	+	+	+			
1.4.9 Implementation of the plan	+	+	+	+	+		
1.4.8 Follow up & review	+	+	+	+	+		0.5M

Activities	Schedule					Respon sible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
1.5 At least 5% of the population (40-60 years) adopted HLS							
1.5.1 Awareness to Public Health & peripheral institutional staff	+	+	+	+	+		0.4M
1.5.2 Screening activity in Health Institutions	+	+	+	+	+		2M
1.5.3 Data collection, processing & analysis	+	+	+	+	+		1M
1.5.4 Referrals & follow up	+	+	+	+	+		
1.5.5 Conduct LSRD prevention programmes for community	+	+	+	+	+		1M
1.5.6 Review & recommendations	+	+	+	+	+		0.5M
1.5.7 Health promotion club/society established & functioning at PHM level	+	+	+	+	+		1M
1.5.8 Health promoting family clinic established & functioning in each MOH division & Health institutions	+	+	+	+	+		5M

Activities	Schedule					Respon sible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
1.6 Research on Health promotion Institutionalized for more evidence based decision making							
1.6.1 Creative joint ventures are established with Ayurvedic sector (Long term care and rehabilitation unit for disables due to target NCDs such as DM,HT, IHD)	+	+	+				40M
1.6.2 Creative ventures are established with sports sector	+	+	+				
1.6.3 Creative ventures are established with Agricultural & Veterinary sectors	+	+	+				
1.6.4 Other relevant research	+	+	+	+	+		2M

Activities	Schedule					Respon sible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
2.1 All curative care institutions practice standard management for chronic NCDs							
2.1.1 Standard management protocols available at the curative care institutions	+	+	+	+	+		
2.1.2 Identify necessary resources for each institution (Investigation, Drugs, Manpower etc.) check list							
2.1.3 Medical audit			+				

Activities	Schedule					Responsible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
2.2 30% reduction of complications of chronic NCDs from the new inpatients registered							
2.2.1 Recording system developed to identify complicated patients	+						
2.2.2 Introduce HLS to patients through hospital health promotion unit	+	+	+	+	+		

Activities	Schedule					Responsible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
2.3 Efficient back referral system established							
2.3.1 Awareness to Heads of Institutions on HLS & Referral system	+	+		+			0.2M
2.3.2 Develop a check list to Identify resources	+						
2.3.3 Provide necessary HR, equip, and other logistics for each institution	+	+	+	+	+		5M
2.3.4 Monitor the progress							

Activities	Schedule					Responsible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
2.4 Community based rehabilitation system established							
2.4.1 Develop community care (rehabilitation) package	+						
2.4.2 Identify resources (HR, other infra structures)	+	+		+			
2.4.3 Training of Volunteers (200 x 50 x 60)	+	+	+	+	+		0.6 M
2.4.4 Implement rehabilitation							
2.4.5 Improve the Physiotherapy unit at B.H.Kuliyapitiya (HR, Equipments)	+		+		+		5 M
2.4.6 Establish a Physiotherapy unit at B.H. Nikaweratiya	+	+					10 M
2.4. 5 Review and recommendations	+	+	+	+			0.1 M

Activities	Schedule					Responsible Office	Budget
	Y 1	Y 2	Y 3	Y 4	Y 5		
3.1 Resources for NCD surveillance identified and developed within the existing health system							
3.1.1 Committee appointed	+						
3.1.2 Formats developed	+	+	+				0.2 M
3.1.3 Training of staff	+	+	+	+			0.3 M
3.1.4 Implementation	+	+	+	+	+		
3.1.5 Monitoring & Evaluation	+	+	+	+	+		0.1 M
3.1.6 Necessary modifications	+	+	+	+	+		0.05 M
3.1.7 Dissemination & promotion of the use information	+	+	+	+	+		0.5 M
Total							**227.56 M**

11. Important Assumptions/Pre-conditions/Risks:

- Political support
- Support from all relevant sectors
- Human and financial resources
- Availability of guidelines and protocols at health care institutions
- Adoption of a national policy on chronic NCD & health promotion
- The Risk Factors Survey using the Steps approach will be regularly conducted.
- Risks - change in priorities of regional and provincial management

12. Related Projects/Programs

The action plan for "Promoting Healthy Lifestyle in Kurunegala District" will benefit from ongoing programmes such as the Health Sector Development Project, which has components on district planning, NCD etc. The plan supports the following Health Master Plan Project Profiles:

- 1.4.1.a Integrated NCD Control
- 1.4.1.c Renal Diseases
- 1.4.1.f Mental Health
- 1.4.1.g Cancer Control Programme
- 1.4.2.l Strengthening of Disease Surveillance & Management
- 1.5.2 Health of Elders
- 1.5.8 School Health
- 1.6.2 Establishment of a Mechanism to Implement the National Nutrition Programme
- 1.7.2.a Establishment of Implementation Mechanisms for the Health Promotion Programme
- 1.7.2.b Capacity Building in Health Education & Promotion

- 1.7.2.c Health Promoting Setting Approach
- 1.7.2.d Establishment of Implementation Mechanism for Health Promotion Programme
- 1.7.2.e Programme for Improved Community Involvement in Health Promotion
- 5.4.2 Strengthening of the Provincial Health Information System

13. Relevant Agencies to be Coordinated:

- Education Department
- Labour Department
- Social services
- Local Government Authorities
- Agricultural & veterinary sector
- Ayurvedic sector
- Sports and youth sector
- Non-government organization (e.g. Red Cross Society, Plan International, Sarvodaya, Devesarana Development Centre and World Vision, Kantha Sanwardane Padanama)

14. Monitoring & Evaluation:

- Coordinating committee will be formed for each setting and they will prepare the action plan and the monitoring and evaluation plan
- Monthly monitoring meetings at MOH level
- Quarterly district level meetings with all sectors
- Biannual evaluation with national level authorities
- Data collection system for NCD surveillance developed within the action plan. The generated information for identified indicators will be monitored.
- External evaluation by donor agencies/other relevant organizations

Annexure 5

1. Project Title	Improving Trauma Care in Sri Lanka
2. Target Areas & Beneficiaries	Patients, staff and residents of service areas of selected health institutions will directly benefit from activities related to safety promotion, establishment of emergency medical services and improvement of the quality of hospital care; stakeholders who are outside the selected health institutions will also gain from the national guidelines, protocols and other policy instruments
3. Focal Point	Head - Trauma Secretariat of the Ministry of Healthcare and Nutrition
4. Implementing Agencies	Trauma Secretariat, Trauma System Development Committee and other participating health institutions
5. Duration	Two years (from 2008)

6. Project Summary

The MoH and other stakeholders have been responding to the increasing trauma burden. Recently, it set up the Trauma Secretariat (TS) and the Trauma Systems Development Committee (TSDC). Several initiatives have been undertaken already through the TSDC subcommittees and the pilot hospitals (i.e. Colombo South Teaching Hospital, General Hospital Kalutara, Base Hospital Horana and Base Hospital Panadura). During the next two years, the objective is to strengthen all the components of the trauma system. This means that safe community programmes are initiated by a local coalition of stakeholders, system for emergency medical services is made more accessible to urban, rural and estate communities, system for improvement of quality of trauma care is established, an action plan for enhancing the rehabilitation of trauma victims is formulated, the trauma surveillance system is expanded to at least 7 other trauma centres and a policy on trauma system development is adopted. Central to achieving the objective is a fully operational Trauma Directorate and TSDC.

7. Justification

Trauma and other injuries have been the leading cause of hospitalisation since 1995 in Sri Lanka. In 2003, 1 of 6 admissions and 1 of 9 deaths in government hospitals were due to injuries. Road traffic injuries account for a major fraction of all injuries while home accidents are responsible for a majority involving the children. The total cost of accidents in 2002 is estimated to be 14 billion rupees.

The MoH has prioritised trauma and other injuries. It has encouraged the establishment of Emergency Treatment Units and Primary Care Units. The

Health Secretary chairs and the NCD Director serves as the secretary to the National Committee for the Prevention of Injury. A Policy for the Prevention of Injuries has been drafted and an injury information system pilot-tested at the National Hospital Sri Lanka (NHSL). In 2007, the MoH set up the Trauma Secretariat (TS) to provide the leadership and oversee the development of a trauma system. It set up the Trauma System Development Committee (TSDC), a multi-sectoral advisory body. To date, some of the major achievements of the TS, TSDC and their partners are in the following areas:

- Safety Promotion – during the UN Road Safety Week, communication materials were developed with WHO and JICA support, and campaigns were organised at the NHSL and the pilot hospitals to heighten awareness of the staff, patients and residents of the service areas;
- Pre-hospital Care - a curriculum and a structured training programmes for different levels of emergency medical service (EMS) personnel have been developed with the help of the Medical Teams International, Sarvodaya and other members of the TSDC Subcommittee, the rules and regulations for EMS ambulance drafted and the EMS in the city of Colombo and Hikkaduwa supported;
- Hospital Care – drafts on trauma centre designation and a trauma guidelines have been prepared while three training programmes on the Primary Trauma Care course have been conducted in pilot hospitals by the Colleges of Anaesthesiologists and Surgeons under the sponsorship of AmeriCares; and
- Surveillance – a trauma surveillance system has been initiated in three pilot hospitals.

Other stakeholders have also played significant roles. For example, the Parliament passed a law on the use of helmet and seatbelt. The Safe Bottle Lamp Foundation has contributed to the reduction of bottle lamp burns and deaths by marketing safe lamps as well as educating people on first aid and ways of extinguishing flames. Pre-hospital care pilot projects are successfully operating representing multiple approaches (Community Based, Hospital Based, Private, and Government Based). In Colombo, the Colombo Municipal Council's Fire Brigade, in collaboration with the Colleges of Anesthesiologists and Surgeons, has establish an operational model ambulance service with four ambulances providing 24 hour free emergency services for trauma patients. The College of Surgeons, the College of Anaesthesiologists and the Accident and Orthopaedic Service of the NHSL have been in the forefront of building the capacities of doctors and paramedical staff in the care of trauma victims. Moreover, while the Police Department has been maintaining a database on road traffic accidents, the PGIM has conducted a number of research works.

During the next two years, the surveillance of trauma will also be carried out in at least 7 other trauma centres to generate information about and carry out interventions for other areas of the country. The safe community approach will be adopted for a coalition of stakeholders to define their priorities and undertake appropriate actions. Whereas Colombo, Galle and a few major areas already have access to emergency medical services, other

communities like those in the rural areas need to have one also. Trauma centres need to be identified, equipped and their staff trained to deliver better quality care. The Trauma Centre Designation Criteria and clinical guidelines and protocols will have to be reviewed, approved and disseminated so that they will be used as basis for training, certification and provision of logistical support. There remains a gap in the rehabilitation of trauma victims as well. A national policy for the development of the trauma system will have to be formulated based on local evidence and international experience. Finally, the institutionalization of the Trauma Secretariat into a Trauma Directorate with a fulltime Director and supporting staff will facilitate the development and advocacy of policies, ensure the sustainability of the MoH initiatives and programmes on trauma and will be a concrete manifestation of the government's commitment to reducing the growing trauma burden. A directorate for trauma will have a permanent mandate in building and maintaining partnerships that are essential in optimizing the use of resources from various stakeholders.

8. Objective

The Trauma Secretariat and TSDC adopted a vision of providing timely, appropriate, quality and cost-effective medical care to trauma victims by a coordinated, sustainable trauma system with improved preparedness. During the next two years, they aspire to strengthen all the components of the trauma system.

9. Output

	Output	Indicators	Means of Verification
1	TS/TD and TSDC are fully operational	TS/TD fully responsible for development of trauma system/trauma care in SL.	Minutes of TSDC Meetings
2	Policy on trauma system development formulated, adopted and disseminated	Stakeholders participation in the formulation of the policy	Attendance sheet
3	Safe community programs initiated by a local coalition of stakeholders	No of pilot models available for local network to work	Reports generated by the software of injury surveillance
4	Emergency Medical Services System made more accessible to the population in selected urban, rural and estate communities	No of people have access to 24/7 EMS system	Progress report of subcommittee
5	A system for improving the quality of trauma care established particularly in selected hospitals	Hospital designation system established, Clinical protocols and Guide lines available and training programs are conducted	Records and minutes of subcommittee
6	An action plan for enhancing the rehabilitation of trauma victims formulated through a participatory process.	Subcommittee is working towards the development of Rehabilitation pilot programs	Progress reports and minutes of subcommittees
7	A trauma surveillance system developed in selected trauma centres	Evidence are generated and utilization of data	Minutes of subcommittee

10. Activities: Schedule and Budget

Activities	Schedule		Responsible Office	Budget
	Y1 *	Y2 **		
1. TS/TD and TSDC are fully operational				
1.1 MoH to issue a circular empowering the TS/TD to oversee all the aspects of trauma care including policy making power.	+		TS/TD	
1.2 Allocate human resources and necessary infrastructure to TS/TD	+		TS/TD/MoH	
1.3 Organize meetings/advocacy programs with key stakeholders in trauma care	+		TS/TD/TSDC	0.2M
1.4 Conduct a feasibility study on the "Trauma Resource centre" (which includes library facilities, Internet facilities, training centre etc…)		+	TS/TD/TSDC	0.2M
1.5 Supervise/Monitor and evaluate every aspect of trauma care	+	+	TS/TD/TSDC	0.25M
1.6 Transform TS to TD	+	+	TS/TSDC/MoH	

	Y1	Y2	Responsible Office	Budget
2 **Policy on trauma system development formulated, adopted and disseminated**				
2.1 Discussion among working group for policy development	+	+	TS,TD/TSDC	0.05M
2.2 Policy dialogue among key stakeholders	+	+	TS,TD/TSDC	0.5M
2.3 Submission of policy document for approval		+	TS,TD/TSDC	0.1M

	Y1	Y2	Responsible Office	Budget
3. Safe community programs initiated by a local coalition of stakeholders				
3.1 Develop a subcommittee to oversee Safety Promotion as part of the	+		TS/TD	0.05M
3.2 Develop local networks	+		Safety Promotion and Injury Prevention Sub committee	0.15M
3.3 Develop a subcommittee work-plan	+	+	Sub-committee	0.1M
3.4 Implement the pilot program		+	Sub-committee, TS/TD	0.25M
3.5 Review the pilot program and develop a strategic plan		+	Sub-committee, TS/TD	0.1M

Activities	Schedule		Responsible Office	Budget
	Y1	Y2		
4. Emergency Medical Services System made more accessible to the population in selected urban, rural and estate communities				
4.1 A functioning Pre-Hospital care subcommittee of the TSDC is institutionalized within the MoH to manage, direct, certify and provide oversight for out of hospital emergency medical care, personal certification and training, and ambulance	+		Pre-Hospital Care Sub-committee	
4.2 Develop self-sustaining mechanisms for operations, personnel training, quality assurance and education according to accepted international best practice standards for the Sri Lanka Pre-Hospital Care System	+	+	Pre-Hospital Care Sub-committee	
4.3 Implement an Emergency Medical Services in selected areas	+	+	Pre-Hospital Care Sub-committee/TS	

	Y1	Y2	Responsible Office	Budget
5. A system for improving the quality of trauma care established particularly in selected hospitals				
5.1 Develop and finalize the Sri Lanka Trauma Centre Designation criteria	+	+	Trauma System Component Sub-committee/TS/ TD	0.5M
5.2 Develop and finalize the Clinical Protocols and Guidelines for Managementr of Trauma Victims	+	+	Clinical Protocols and Guidelines Sub-committee	
5.3 Provide infra-structure and equipment facilities according to approved SL Trauma Centre Designation Criteria	+	+	TS/TD/TSDC/ MoH	
5.4 Develop trauma care programs for doctors and nurses A)Continuation of the PTC program B)Continuation of the ATRIMS program C)Introduction of the NTMC program D)Introduction of the DSTC program E)Introduction of training program for nurses	+	+	Training Sub-committee	 1.4M 0.6M 1.2M 15.25M 1.5M
5.5 Conduct "Trauma Quality Improvement Program" for trauma care canters in SL.	+	+	TS/TSDC	0.5M

Activities	Schedule		Responsible Office	Budget
6. An action plan for enhancing the rehabilitation of trauma victims formulated through a participatory process				
6.1 Develop a Sub-committee to oversee Rehabilitation of trauma victims	+		TS/TSDC	0.02M
6.2 Develop local networks	+	+	Sub-committee/TS	0.05M
6.3 Develop a Sub-committee work-plan	+	+	Sub-committee	0.05M
6.4 Implement the pilot program		+	Sub-committee/TSDC	0.5M
6.5 Review the pilot program and develop a strategic plan		+	TS/Sub-committee	0.1M

	Y1	Y2	Responsible Office	Budget
7. A trauma surveillance system developed in selected trauma centres				
7.1 Introduce Trauma surveillance in NHSL, Kandy Teaching Hospital, Karapitiya Teaching Hospital Anuradhapura Teaching Hospital, and Ampara General Hospital, then in Lady Ridgeway Hospital for Children and Jaffna Teaching Hospital	+			
7.2 Training of staff	+	+	Sub-committee	0.1M
7.3 Provision of necessary software and hardware	+	+	TS/TD	0.5M
7.4 Report generation and local utilization of data	+	+	Sub-committee/Relevant health institutions	0.03M
7.5 Automation of the Judicial Medical Officer data	+	+	TS,TD/TSDC	1M
Total				**25.25M**

Y1=year 1, Y2**= year 2*

11. Important Assumptions/Pre-conditions/Risks

- Assumptions/Pre-conditions
  - *a.* The Trauma Secretariat and the all the subcommittees are recognized by all stakeholders.
  - *b.* External sources continue to provide technical and financial support during the design and implementation phase of the project.
  - *c.* Government of Sri Lanka introduces legislation that support the development and long-term legal functionality of a nationally organized and administered Pre-Hospital System.
  - d. Communication corporations provide free access for citizens to call the 110 emergency number, and call centres are available to answer the calls.

12. Related Projects/Programmes

The project on “Improving Trauma Care in Sri Lanka” supports at least two Health Master Plan Project Profiles: a) 1.1.6 Emergency Preparedness & Response and b) 1.3.2 Development of Emergency Services Network for Injuries, Accidents, Poisoning & Disasters.

13. Relevant Agencies to be Coordinated

National Committee for the Prevention of Injuries

14. Monitoring & Evaluation

The Trauma Secretariat, TSDC and participating institutions will monitor and evaluate the various components of this project with the use of the indicators reflected in this action plan. They will use the reports generated by the trauma surveillance. Annually, a review will also be conducted through focus group discussion, in-depth interviews and other appropriate techniques.