Sri Lanka
Ministry of Health

Data Collection Survey on Aging Sector in Sri Lanka Final Report

May 2021

Japan International Cooperation Agency (JICA)

Deloitte Tohmatsu Financial Advisory LLC
Fujita Planning Co., Ltd.

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Abbreviations

Abbreviation	English / Singhalese
ADB	Asian Development Bank
AusAID	Australian Agency for International Development
BOS	Board of Study
CBIC	Community-Based Integrated Care
CBO	Community Based Organization
CCP	Consultant Community Physician
CBR	Community-based Rehabilitation
CHA	Consortium of Humanitarian Agencies
COPD	Chronic Obstructive Pulmonary Disease
DSD	Department of Samurdhi Development
DSS	Department of Social Service
DDG	Deputy Director General
DP	Department of Pensions
DPRD	Disaster Preparedness and Response Division
EC	Elder Committee
EH	Elder Home
EPF	The Employees Provident Fund
ERPO	Elders' Right Promotion Officers
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
ETF	The Employees' Trust Fund
ETU	Emergency Trauma (Treatment) Unit
GDS	Gross Domestic Saving
GP	General Practitioner
GN	Grama Niladari
GNI	Gross National Income
HEO	Health Education Officer
HLC	Healthy Lifestyle Center
IEC	Information, Education and Communication
IHCA	International Health Care Academy
ILO	International Labour Organization
JETRO	Japan External Trade Organization
JICA	Japan International Cooperation Agency
MOH	Medical Officer of Health
MoH	Ministry of Health and Indigenous Medical Services
MoWCASS	Ministry of Women & Child Affairs and Social Security
MSD	Medical Supply Division:

Abbreviation	English / Singhalese
NAITA	National Apprentice and Industrial Training Authority
NCD	Non-communicable diseases
NCE	National Council for Elders
NGO	Non-Governmental Organization
NISD	National Institute of Social Development
NSE	National Secretariat for Elders
NSPD	National Secretariat for Persons with Disabilities
NVQ	National Vocational Qualification
OJT	On-the-Job Training
OMF	Oral and maxillofacial surgeons
PCU	Preliminary Care Unit
PDHS	Provincial Department of Health Services
PGIM	Postgraduate Institute of Medicine
PHDT	Plantation Human Development Trust
PHC	Primary Health Care
PMCU	Primary Health Care Unit
PHCW	Primary Health Care Worker
PHI	Public Health Inspector
PHMW	Public Health Midwife
PHNO	Public Health Nursing Officers
PHNS	Public Health Nursing Sister
PHDT	Plantation Human Development Trust
PHSRC	Private Health Service Regulatory Council
PSPS	The Public Servants Pension Scheme
QOL	Quality of Life
RDHS	Regional Directorate of Health Services
RMSD	Regional Medical Supply Division
SDGs	Sustainable Development Goals
SLAGM	Sri Lanka Association of Geriatric Medicine
SLBFE	Sri Lanka Bureau of Foreign Employment
SLFI	Sri Lanka Foundation Institute
SLPHC	Sri Lanka Population and Housing Census
SLQF	Sri Lanka Qualification Framework
SP	Social Prescribing
SSD	Social Development Division
SSO	Social Service Officers
TOT	Training of Trainers

Abbreviation	English / Singhalese
TVEC	Tertiary and Vocational Education Commission
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
VTA	Vocational Training Authority
WB	World Bank
WHO	World Health Organization
YED	Directorate of Youth, Elderly and Disabled

Summary of all chapters of this survey

- **Chapter 1: Survey Overview**

The purpose of this Survey is to identify current status and challenges of aging sector in Sri Lanka, to sort out status of efforts by Japan and other international support agencies in the sector, to set priorities and propose future JICA assistance measures. Main government institutions surveyed are the Ministry of Women & Child Affairs and Social Security: (MoWCASS), the Ministry of Health and Indigenous Medical Services (MoH)[1]. The survey was conducted from January 16, 2020 to March 15, 2021 in Colombo District, Sri Lanka and surrounding areas.

- **Chapter 2: Analytical Framework for the Aging Sector**

In response to aging of society in Japan, the Basic Act on Measures for the Aging Society was enacted in 1995. Since the enactment of the Long-Term Care Insurance Act in 2000, there has been a rapid increase in a need for measures for the aging of the society[2]. With the population aging rate reaching 21% in 2007, the fastest in the world, various entities such as the national government, provincial governments and the private sector are supporting the aging sector.

Japan has set up a community-based integrated care system as a central concept of its aging policy, drawing on examples from the United Kingdom, Denmark and other countries. In this survey, Japan's community-based integrated care system is used as the analytical framework as Japan is the fastest aging society in the world and it is expexted to serve as a reference for future efforts.

- **Chapter 3: Situation of Aging in Sri Lanka**

Ratio of elderly people (60 years and older) in Sri Lanka (populatiuon aging rate) is 12.4%. Aging in the country is expected to progress fastest in South Asia, and to increase even further. Population aging rates across the 9 states vary from 7.85% to 14.0%, and the circumstances surrounding the elderly differ by state.

Sri Lankan elderly people participate in society in a variety of ways, including working, living, and the engaging in elder committee. Participation in the elder committee, in particular, has strengthened ties with local communities. There is a risk that the elderly people become older, the worse their health condition deteriorates. Thus the number of people who have difficulties in daily life increases due to conditions requiring elderly care, dementia, etc., leaving more people in need of support.

- **Chapter 4: Current Status and Challenges of the Measures for Aging in Sri Lanka**

Based on policies related to the aging of society, multiple organizations such as the National Secretariat for Elders (NSE) under the jurisdiction of the Ministry of Social Welfare and related organizations such as the Directorate of Youth, Elderly and Disabled (YED) of the MoH cooperate to provide necessary services to

[1] These ministries' names are at the time of field survey. After the 2020 August general election, they were renamed due to a reorganization. After the election, both NSE and DSS under MoWCASS were transferred to the State Ministry of Primary Health Care, Epidemics and COVID Disease Control.
[2] In this report, "measures for the aging of society" is defined as measures necessary to cope with issues arising from increasing share of elderly people in total population. It is distinguished from "measures for the elderly".

the elderly and facilities for them. In addition to the central government, provincial governments provide necessary services and facilities to senior citizens, and there is a complementary relationship at field level. Although family care remains the mainstay in Sri Lanka, various factors have increased the need for external services. However, due to the lack of facilities for the elderly and caregivers, the needs of the elderly and their families are not met.

- **Chapter 5: Activities by Related Development Partners**

Outlines and challenges of projects related to the aging of Sri Lanka implemented by Colombo University, Asian Development Bank, International Labour Organization, United Nations Population Fund, World Bank, World Health Organization, HelpAge and Japanese partners are introduced. These projects are often implemented separately by the NSE or the MoH, and coordination between them is not necessarily sufficient.

- **Chapter 6: Analysis of Japanese Companies and Their Technologies**

Given the high marketability of Japan's aging sector, there are companies and technologies that can contribute to Sri Lanka's aging sector. They are, in the medical field, telemedicine and mobile medical care, rehabilitation and follow-up, computerization of medical data for the elderly. In the nursing field, management of nursing facilities, training of nursing personnel, and nursing workload reduction technique etc. are included.

- **Chapter 7: Challenges of the Measures for Aging in Sri Lanka**

This report classifies issues of Sri Lanka's aging policy into three categories: cross-sector, under the jurisdiction of the Ministry of Social Welfare, and under the jurisdiction of the MoH, and outlines each issue.

- **Chapter 8: Comprehensive Analysis and Future Business Proposals**

In this survey, a time-phased roadmap based on previous research on Sri Lanka's aging sector is created. A comprehensive analysis is then conducted to clarify the priorities of the proposed assistance. The direction of cooperation mainly centering on JICA is clarified.

CHAPTER 1 Survey Overview

This chapter presents an overview of the survey conducted by the mission to collect and confirm information on the Democratic Socialist Republic of Sri Lanka and its aging sector.

1.1 Background of the Survey

The Democratic Socialist Republic of Sri Lanka (Sri Lanka) has achieved a steady economic growth, shifting to a upper-middle income country with a total population of approximately 21.7 million, at an average economic growth rate of 5.6% from 2010 to 2018, with a gross national income of US $4,102 per capita.[3]

In addition, Sri Lanka is aging. According to "the Health Report of the Sri Lankan Ministry of Health and Indigenous Medical Services (2017)", the elderly (60 years and older) was 12.4% in 2012 and the figure is now expected to rise further. Due to the decreasing ratio of 0 to 14 years old in the population and the trend of increasing ratio of 60 years and older and the geriatric index, the society is becoming an aging society with fewer children. Furthermore, the population aging rate is expected to rise to 21.9% in 2031 and to 27.4% in 2050.[4]

Table 1.1.1 Population by Age Group, Geriatric Index, and Dependent Population Index

year	0–14 years old	15–59 years old	60 years and older	Geriatric index	Dependent population index
	(A)	(B)	(C)	(C / A) * 100	(A + C) / B * 100
1911	40.9	54.8	4.3	10.5	82.5
1946	37.2	57.4	5.4	14.5	74.2
1971	39.0	54.7	6.3	16.2	82.8
1981	35.2	58.2	6.6	18.8	71.8
2001	26.3	64.5	9.2	35.0	55.0
2012	25.2	62.4	12.4	49.2	60.3
2018	25.2	62.4	12.4	49.2	60.3

The geriatric index is calculated by dividing (C) the population aged 60 or older by (A) the population aged 0-14 and multiplied by 100. The higher this number, the higher the number of people aged 60 or older.

The dependent population index is an index obtained by dividing (A) the population aged 0-14 and (C) the population aged 60 or older by (B) the population aged 15-59 divided by 100. The higher this number, the higher the number of working people in general.

Source: Ministry of Health and Indigenous Medical Services ANNUAL HEALTH BULLETIN 2018, p. 4

From such background, policy planning and expansion of business on welfare and medical treatment to the elderly became an issue. With regard to welfare for the elderly, based on the Protection of the Rights of Elders Act, 2000, the National Secretariat for Elders (NSE) was established under the MoWCASS[5]. Based on the National Policy on the Elderly (2006), the agency has been providing measures[6] for low income

[3] World Bank data as of October 15, 2019. Since 2020, World Bank has classified countries and regions whose GNI (US $) per capita in 2018 is $1,025 or less as low-income countries, $1,026 to $3,995 as low-middle-income countries, $3,996 to $12,375 as upper-middle-income countries, and $12,376 or more as high-income countries.

[4] Professor KA Padmasiri Siddhisena (2014) https://demography.cass.anu.edu.au/events/ageing-population-and-elderly-care-sri-lanka. In 2031, the population aging rate is 21.9%, and in 2050, it is 27.4%. Other projected developments are described in Chapter 3.

[5] After the election in August 2020, NSE was transferred to MoH.

[6] In this report, "measures for the elderely" is defined as measures necessary for the people called elderly (in Japan, those 65

elderly such as supplemental security income, welfare equipment, subsidies to elderly facilities, disseminating IDs for the elderly, promoting the establishment of committee day care for the elderly and developing caregivers for the low-income elderly.

With regard to medical care for the elderly, Sri Lanka is one of the countries that emphasize primary health care (PHC), which enables everyone to access to health and medical services as a right, and public medical care is accessible free of charge.

However, both medical and welfare services for the elderly are not adequately provided in terms of quality and quantity due to lack of budget and human resources required for various plan and project implementations and reviewing policy systems and human resource development is an urgent issue.

1.2 Objectives and Results of the Survey

The purpose of this survey is to identify the current status and challenges of the aging sector in Sri Lanka, to sort out the status of efforts by Japan and other international support agencies in the sector, to set priorities, and to propose future JICA assistance measures. The main ministries surveyed were MoWCASS and MoH. The survey was conducted mainly in Colombo and also in Kandy and Nuwara Eliya Districts.

Based on the results of the survey, the overall measures to be taken by the Sri Lankan government in the aging sector were compiled as a roadmap, classified into short term (starting in 3 years), medium term (starting in 4-6 years) and long term (starting in 7 years) phases. In addition, this paper describes (1) objective and necessity of each cooperation project, and (2) outline of each cooperation project on the roadmap.

Based on this, direction of JICA's cooperation in the aging sector and the details of cooperation were examined and prioritized and proposed. In addition to (1) and (2) above, (3) implementation structure, (4) estimated amount of cooperation and proposed schedule were described for each engagement. The proposal will be discussed and agreed with the Sri Lankan government and JICA on the basis of importance and urgency.

1.3 Outline of the Survey

Table 1.3.1 Outline of the Survey

Japan / Sri Lanka	Work	Time	Item
Japan operations	Pre-work	January 2020	Preparation for survey and compilation of existing information
Sri Lanka operations 1	Field Survey 1	January to February	Reconsideration and agreement with officials of the Ministry of Social Welfare and the MoH Collecting information at the national level Listening to donor activities Report on survey results, etc.
Japan operations	Arrangement after returning home	February	Summary of above results and analysis in Japan Develop and share summary, discuss content Preparation of field survey 2

years old or older / in Sri Lanka, those 60 years old or older). It is distinguished from “measures for the aging of society”.

Japan / Sri Lanka	Work	Time	Item
Sri Lanka operations 2	Field Survey 2	March	Collection of additional information at the national level Field surveys (Kandy Province, Nuwara Eliya Province, *Mainly in the medical field
Japan operations	Arrangement after returning home	April to May	Summary of on-site survey 2
Japan operations	Domestic survey	June to September	Continuation of remote and other surveys
Japan operations	Domestic survey	October	Creating a Draft Final Report
Japan operations	Domestic survey	November 2020 to January 2021	Additional survey
Japan operations	Domestic work	October 2020 to April 2021	Creating Final Report
Japan operations	Domestic work	December to May 2021	Discussion with Sri Lanka side Finalization of the Final Report

Source: JICA Survey Team

1.4 Members

Table 1.4.1 Composition of the Mission

Name	Role	Affiliation	Field survey period
Akira Takagi	Operations Chief / Policies for the elderly comparative institutional analysis	Deloitte Tohmatsu Financial Advisory LLC	2020/1/26-2/8 2020/3/1/-3/8
Kanako Tanigaki	Assistant Supervisors / Medical Care for the Elderly	Fujita Planning Co., Ltd.	2020/2/2-2/8 2020/3/1/-3/19
Michiko Fujimoto	Medical Care for the Elderly 2	Fujita Planning Co., Ltd.	
Shinya Adachi	Welfare for the elderly	Deloitte Tohmatsu Financial Advisory LLC	2020/3/1/-3/8
Shohei Kotani	Welfare for the elderly	Deloitte Tohmatsu Financial Advisory LLC	
Narangoda Kushani	Japanese Business Alliance / Japan Program	Deloitte Tomatsu Venture Support Co., Ltd.	2020/3/3/-3/6
Special thanks for reviewing and finalizing report			
Dr Lakshmi Somatunga	Additional Secretary (Public Health Services)	Ministry of Health	2020/1/12- 2021/5/22
Dr Deepa Saranajeewa	Director (Acting)	Directorate of Youth, Elderly & Disabled	2020/1/12- 2021/5/22
Dr Shiromi Maduwage	Consultant Community Physician	Directorate of Youth, Elderly & Disabled	2020/1/12- 2021/5/22
Mr. M.K.R.U. Krishantha	Deputy Director	National Secretariat for Elders	2020/1/12- 2021/5/22

Source: JICA Survey Team

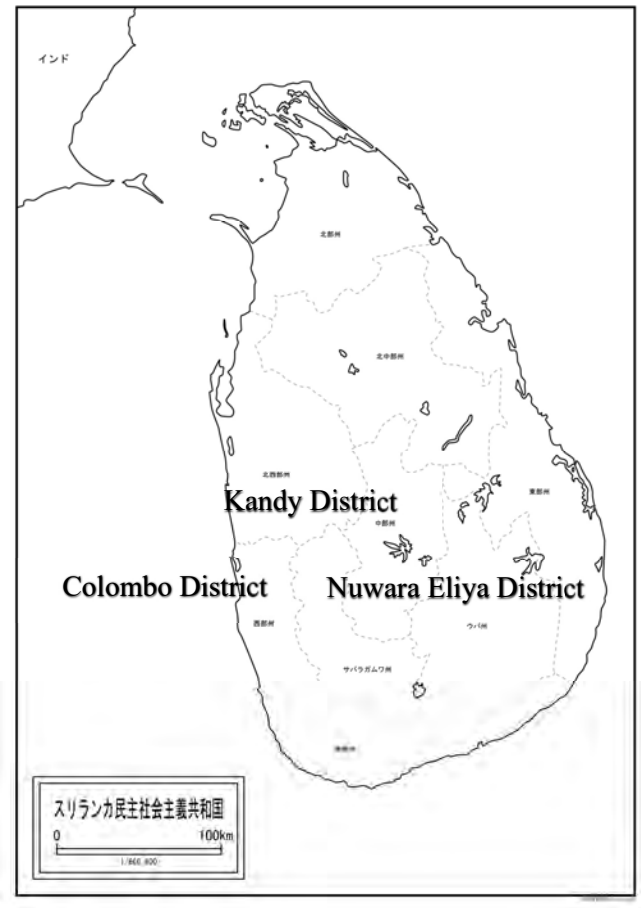
1.5 Implementation Methodology of the Survey

This survey was implemented based on analysis and surveys by the survey team, as well as introduction of other cases and discussions with the Sri Lankan side based on the survey results. This work was carried out through two on-site surveys and domestic surveys.[7]

[7] This survey was influenced by the epidemic of COVID-19 in Sri Lanka and Japan after March 2020 and the survey process was changed from the initial plan.

In the first field survey, as a kick-off, the overall outline of the survey was explained to key stakeholders (Ministry of Social Welfare and Health) in Colombo District, and the overall picture of policies and measures, roles, systems, and implementation status of major government agencies in relation to the aging sector as well as stakeholders, were confirmed.

In the second field survey, based on the information obtained in the first survey, a survey on the aging sector was conducted in Colombo District (Medical care in Kandy and Nuwara Eliya Districts). The workshop scheduled in the latter half of the survey could not be held due to the effect of COVID-19 situation. For this reason, it was neither possible to invite Sri Lankan officials from relevant organizations to Japan nor conduct further field surveys. Instead, as an alternative, a 3-day online seminar was held and this report was prepared through domestic surveys including remote surveys.



Based on a white map of Sri Lanka https://www.freemap.jp/item/asia/srilanks.html

Source: JICA Survey Team

Figure 1.5.1 Field Survey Area

CHAPTER 2 Analytical Framework

This chapter summarizes research framework based on the concept of geriatric care in Europe and Japan, taking into account the aging sector in Japan.

2.1 Overview of Japan's Aging Sector

In this report, aging sector is defined as a field related to aging.[8] Regarding the aging sector in Japan, the government has enforced various policies for old people from the age of Ministry of Health and Welfare which is the predecessor of Ministry of Health, Labour and Welfare.[9]

Table 2.1.1 Welfare and Medical Care Policies prior to the Long-Term Care Insurance System

Time	Population aging rate	Status	Major policies
1960s	5.7% (1960)	Beginning of welfare policy for the elderly	1963 Law Concerning the Welfare of the Elderly enacted Establishment of special nursing home for the elderly Legislation for home-visit elderly care
1970s	7.1% (1970)	Increase in medical expenses for the elderly	1973 Introduction of free medical care for the elderly
1980s	9.1% (1980)	Hospitalizations and bedridden elderly people as a social problem	1982 Enactment of the Health and Medical Service Law for the Aged 1989 Creation of a consumption tax Formulation of the Gold Plan
1990s	12.0% (1990)	Promotion of the Gold Plan Preparations for the introduction of the long-term care insurance system	1997 Raising the consumption tax (3 → 5%) Establishment of the Long-Term Care Insurance Act
2000s	17.3% (2000)	Implementation of the Long-Term Care Insurance System	2000 Enforcement of the Long-Term Care Insurance Act

Based on the Ministry of Health, Labour and Welfare (2018) "Current Status and Future Role of the Public Long-Term Care Insurance System"

Source: JICA Survey Team

In response to the aging of the society, the Basic Act on Measures for the Aging Society was enacted in 1995. Since then, the Council for Measures for the Aging Society has been held mainly by the Cabinet Office as a special organization headed by the Prime Minister.[10][11] On February 16, 2018, the 29th Meeting on Measures for the Aging Society was held and a new "Outline of Measures for the Aging Society" was

[8] Though there is no clear definition of the aging sector, the explanation of the private sector by JICA was used as a reference. https://www.jica.go.jp/activities/issues/private_sec/index.html

[9] In 2001, the Ministry of Health and Welfare merged with the Ministry of Labour and became the Ministry of Health, Labour and Welfare.

[10] Under the basic law, the government is required to set an outline of measures for the aging society and submit an annual report to the Diet every year. In addition, the Council for Measures for the Aging Society will prepare a draft outline of measures for the aging society, coordinate among relevant administrative organizations necessary for measures, deliberate important matters concerning measures, and promote the implementation of measures.

[11] On February 16, 2018, the 29 meeting was attended by more than 10 ministers from various ministries and agencies.

decided.[12] Basic idea and main reference indicators are specified based on an idea that "the general tendency to view people aged 65 and over as elderly people is no longer realistic, and the time will come when people aged 70 and beyond will be able to exert their abilities according to their motivation and abilities. An environment where all generations can lead a fulfilling life in response to the social issues that accompany them need to be created." Focusing on the elderly, legal systems exist in various fields such as elderly care, welfare, medical care, abuse, employment, welfare equipment, housing, transportation, and pensions. Various enterprises exist as implementing bodies in the field based on policies, systems and principles related to the elderly.

Table 2.1.2 Japan's Legal System for the Elderly

Field	Year of enforcement	Legal system	Summary
Welfare	1950	Public Assistance Act	Act for Providing Various Types of Support to Guarantee the Right to Live under Article 25 of the Constitution of Japan
	1963	Act on Social Welfare for the Elderly	Act on Measures Necessary for Maintaining Mental and Physical Health of Elderly Persons and Stabilization of Their Lives
	2000	Social Welfare Services Act	A law that specifies the types and entities of social welfare services and promotes them
Elderly care	1997	Long-Term Care Insurance Act	Act for providing long-term care insurance to persons requiring long-term care, etc.
Medical care	2008	Act on Assurance of Medical Care for Elderly People	Law to provide various kinds of support for elderly people to have appropriate access to medical care
Abuse	2006	Act against Elder Abuse	Act for the Prevention of Abuse of Children 65 Years of Age or Older by Their Families and Institutions
Employment	1986	Act on Stabilization of Employment of Elderly Persons	Act for Promoting Stabilization of Employment of Business Operators of Age 55 and Older
Welfare equipment	1993	Act on Promotion of Research and Development and Dissemination of Welfare Tools	Act for Promoting the Independence of Persons with Disabilities and Reducing the Burden on Caregivers
Housing	2001	Act on Securing Stable Housing for Elderly People (Act on Housing for the Elderly)	Law to provide a safe living space for the elderly
Move	2006	Act on Facilitation of Movement of Elderly Persons, Persons with Disabilities and Other Persons (Barrier Free Law)	Act for Promoting Improvements in Convenience and Safety of Elderly Persons, Persons with Disabilities and Other Persons in Moving and Using Facilities
Retirement	1954	Employees' Pension Insurance Law	Act on the Pension Insurance System for Japanese Workers
	1959	National Pension Law	Act on the National Pension Insurance System of Japan

Based on database services (https://www.wam.go.jp/content/wamnet/pcpub/kourei/handbook/system/) such as the Welfare and Medical Service Agency (https://www.mhlw.go.jp/hourei/) and laws and regulations of the Ministry of Health, Labour and Welfare.

Source: JICA Survey Team

[12] The Cabinet Office https://www8.cao.go.jp/kourei/measure/a_3.html

Table 2.1.3 Key Implementing Bodies in the Aging Sector

Entities	Summary
Local government	Support and implement various local projects in cooperation with each business operator
Social welfare institutions	Implement mainly social welfare services in one's community
Medical care corporations (incorporated associations and incorporated foundations)	Implement businesses such as hospitals, clinics and long-term care health facilities
Private companies	Carry out welfare, medical, and other related businesses
NPOs and communities	Implement various activities related to the elderly in the community

Note can be described here.

Source: JICA Survey Team

According to "2019 White Paper on the Aging Society 'Situation of Aging' (2019)" by the Cabinet Office, the population aging rate in Japan based on the data as of October 1, 2018 (proportion of population aged 65 or older to the total population) was 28.1%, and it is expected that the population aging rate will continue to increase in the future.[13] The aging of society is being driven by Japan's declining population aged 64 and under and an increasing population aged 65 and over. The former issue requires system design based on national strategy such as improvement of total fertility rate and accepting foreigners and support system in the field. The latter issue is, in a sense a reward of Japan's well-organized medical and elderly care system, but from the perspective of national and local government finances, it casts an increase in social security costs and other burdens.

Table 2.1.4 Population Ratio of Aged 65 or Older and Years of Doubling by Country

Country	Proportion of population aged 65 or older (arrival year)					Years for doubling
	7%	14%	21%	25%	30%	7% → 14%
Singapore	2004	2021	2029	2034	2042	17
South Korea	2000	2018	2026	2031	2037	18
China	2002	2025	2036	2046	2075	23
Japan	1970	1994	2007	2013	2025	24
Germany	1932	1972	2014	2028	2050	40
United Kingdom	1929	1975	2029	2049	-	46
Russia	1967	2017	2043	2093	-	50
Italy	1927	1988	2013	2025	2034	61
Canada	1945	2010	2026	2050	-	65
Americas	1942	2014	2034	2067	-	72
France	1864	1990	2021	2033	2076	126

Based on the Population Statistics (2020) compiled by the National Institute of Population and Social Security Research

Source: JICA Survey Team

Table 2.1.4 shows the years of attainment by population ratio of persons aged 65 or older by country and the number of years when the population aging rate doubled from 7% to 14% (doubling time). The reason why Japan is attracting attention from all over the world with its aging population is that in 2007, Japan's population aging rate reached 21%, the fastest in the world.[14] Japan's efforts are benchmarked by the

[13] As of October 1, 2018, the total population of our country was 126.44 million. The population aged 65 and over is 35.58 million. "Population aged 65 to 74" was 17.6 million and "Population aged 75 and over" was 17.98 million. In 2065, it is estimated that 1 in 2.6 people is over 65 years old and 1 in 3.9 people is over 75 years old.

[14] Among the major countries, Germany, the UK, Italy and France had a population ratio of 65 years of age or older that was 14% faster than that of Japan, but it took more time than that of Japan to reach 21% due to the policies of each country. Japan has

countries taking steps to cope with aging population.

In addition, the employment rate and healthy life expectancy of elderly people are increasing. According to the Cabinet Office's (2019) 2019 edition of the White Paper on the Aging Society "Trends in Old-age Life," the employment rates of people aged 65-69 and 70-74 in Japan's total population in 2018 increased by 10.4 points and 8.4 points, respectively, compared to those in 10 years ago in 2008. As of 2016, healthy life expectancy was 72.14 years for men and 74.79 years for women, an increase of 1.72 years for men and 1.17 years for women respectively, compared to 2010.[15] Furthermore, compared with 2010, increase in healthy life expectancy in 2016 exceeded that of average life expectancy of 1.43 years for men and 0.84 years for women, indicating an increase in the number of elderly workers and healthy elderly people in Japan.

2.2 Concepts of Elderly Care in Other Countries

Leinchsering (2004) summarized the concept of integrated care in European countries as shown in Table 2.2.1. Although there are differences in depth among countries, in the field of care for the elderly, the main concepts that constitute integrated care, which are currently the mainstream in Japan, are emphasized and implemented in policies and the field. The following sections describe the case of the United Kingdom, which is said to be a pioneer in community care, the case of Denmark, where the introduction of elements of integrated care is progressing and the case of Japan.

Table 2.2.1 Key Concepts of Integrated Care by Countries

Integrated Care Key Concept	Austria	Germany	Denmark	Greece	France	Finland	Italy	Netherlands	United Kingdom
Public health	**	**	**			*	***		**
Managed care	**	**	*		*	*	**	*	***
Horizontal integration	**	**		**	*	*	*	*	*
Vertical integration						**	**		**
Continuous/consistent care	*					***		**	*
Geriatric collaboration / Network	*	*			***		*		
Whole system approach									*
Human-centered approach			***			**		***	**

*** The most important concept followed and implemented by key policies.

** An important concept that is partially implemented.

* A concept that is being discussed or experimented with, for example, a model project.

Source: Leinchsering K. (2004). Developing integrated health and social care services for older persons in Europe. P.6.

Table 2.2.2 Implementation Status of each Component of Integrated Care by Countries

Components of Integrated Care	Austria	Germany	Denmark	Greece	France	Finland	Italy	Netherlands	United Kingdom
Case management /	*	*	***			**	*	**	***

a relatively high doubling time (number of years to double). This is because the doubling time alone is slower than Singapore, South Korea and China.

[15] According to the Health and Longevity Net, the definition is "Average duration of unrestricted daily activities" and refers to the period during which a person can live healthy and independently perform activities of daily living. https://www.tyojyu.or.jp/net/kenkou-tyoju/tyojyu-shakai/sekai-kenkojumyo.html

Components of Integrated Care	Austria	Germany	Denmark	Greece	France	Finland	Italy	Netherlands	United Kingdom
care management									
Intermediate care	*	*	**			**	*	**	**
Needs assessment by interdisciplinary teams			**		**	**	**	**	***
User-centric services (personal financial resources/long-term care insurance)	***	***	*		**			***	*
Collaboration	*	*	***		*	**	*	**	**
Precautionary approach		*	***	**				**	**
Integrated housing (Housing with care, etc.)	*	*	***	*	*	**	*	**	*
Integration of family care (including respite care and employment)	*	**		*	**	**	*		*
Independent counseling	*	**			*			**	*
Collaborative care conference		*	**		*				**
Management of quality of care/assurance of quality of care	*	**	*		**	**	**	*	**

*** Widely recognized and applied element as a national standard.

** Partially implemented at the regional/district level.

* Experimentally introduced by model projects.

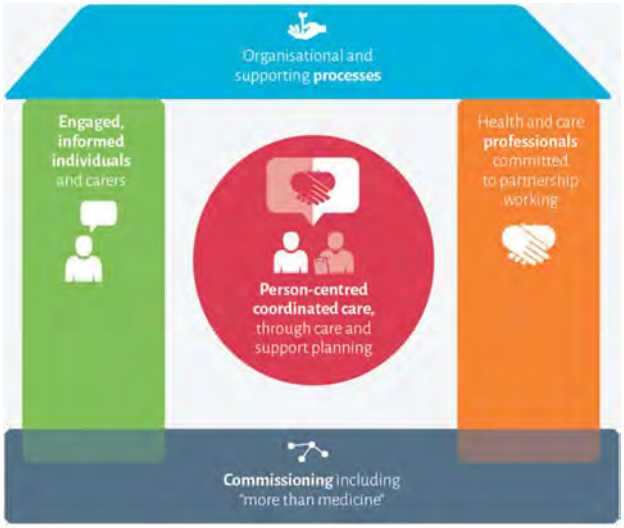
Source: Leinchsering K. (2004). Developing integrated health and social care services for older persons in Europe. P. 12

2.2.1 The United Kingdom

According to Kobayashi and Ichikawa (2015), the approach of community care in the United Kingdom since the late 1960's was the beginning of the approach in which the community (neighbourhood) became the main provider of care, replacing the medical system that was free and universal, but inefficient and of poor quality. According to the Cabinet Office's "2019 White Paper on the Aging Society," "FY 2018 International Comparative Research Report on Cooperation between Various Entities for Supporting the Elderly and Public Support for Promoting Participation of Local Residents" by the International Center for Longevity points out that there is a basic flow for people in the United Kingdom and other European countries where people register with their primary care doctors (General Practitioner: GP), who then refer them to tests, introduce them to specialty doctors for prescribe drugs. Expanding the concept of the flow, UK's "Social Prescribing (SP)" allows GPs to introduce elderly people to local volunteer activities, exercise circles and other activities that promote community participation. SP was recommended in a 2006 report by the British Ministry of Health "Our Health, Our Care" and has spread throughout the United Kingdom.[16] Kumagawa et al. (2016) described UK's "Social Prescribing" as "it means delegating services that prevent deterioration of health of people who already have chronic illnesses and reduce the treatment of costly professionals to partners who provide non-medical support in the community". The report goes on to say that the "Social Prescribing" will also contribute to solving the financial problems of the elderly. In addition,

[16] The details of the social prescription are described in the Secretary of State for Health by Command of Her Majesty (2006) "Our health, our care, our say". a new direction for community services Chapter 5 Support for people with long term needs.

"The House of Care (care focusing on individual elderly person)" has been developed, and various organizations and individuals are providing various kinds of support for elderly people to live in their communities by understanding their thoughts.



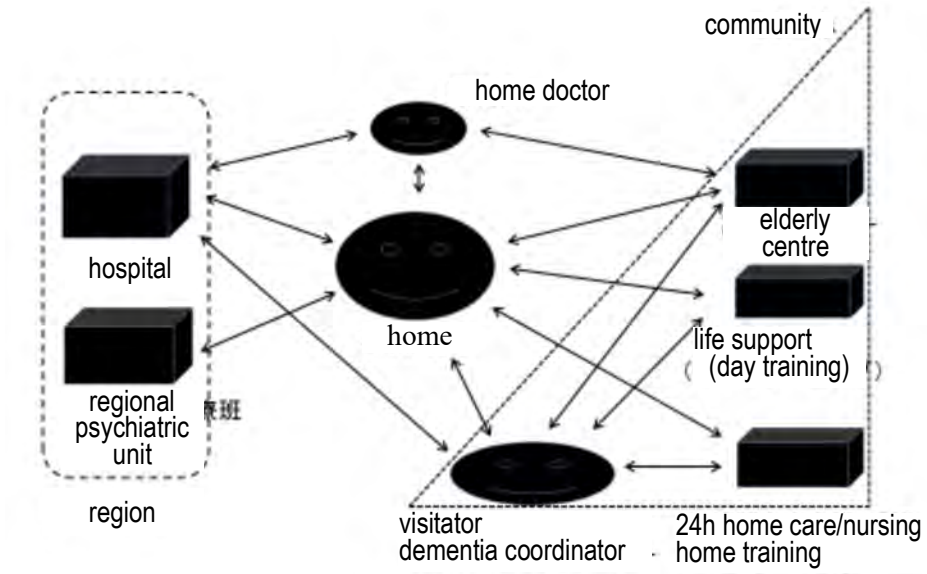
Source: NHS England (2016) Personalized care and support planning handbook: The journey to person centred care p.9

Figure 2.2.1 The House of Care (Elderly Care Focused on Individuals)

2.2.2 Denmark

In Denmark, based on the concept of integrated care, initiatives related to each component are being implemented in policy and the field, resulting in successful ageing measures.[17] Zenimoto (2018) sorted out the administrative units of Denmark into the regions corresponding to Japan's prefectures and the communes corresponding to Japan's municipalities, and drew up a conceptual scheme of the care system of Denmark. The core of Danish care system is that home is the centre of care. Both Ikari (2013) and Kajii (2014) discuss the importance of housing for the elderly policy in Denmark, citing Matsuoka, an expert on Danish welfare for the elderly. Matsuoka (2008) introduced the concept of "Aging in place" rooted in recent Danish policies. "Aging in place," borne out of criticism and lessons of facility-based care, has been attracting attention since the 1990s as a care system which replaces medical institution care.

[17] According to the Danish Population Census (2020), the population aging rate (Percentage of population aged 65 and over) in Denmark exceeded 7% in 1925 and 14% in 1978 (53 years of doubling). However, due to the success of various policies, the target of 21% and 25% are estimated to be achieved in 2024 and 2059, respectively. 30% is not expected.



Source: Zenimoto (2019), A Study on Activities of Elderly People - Through the Activities of Elderly People in Denmark

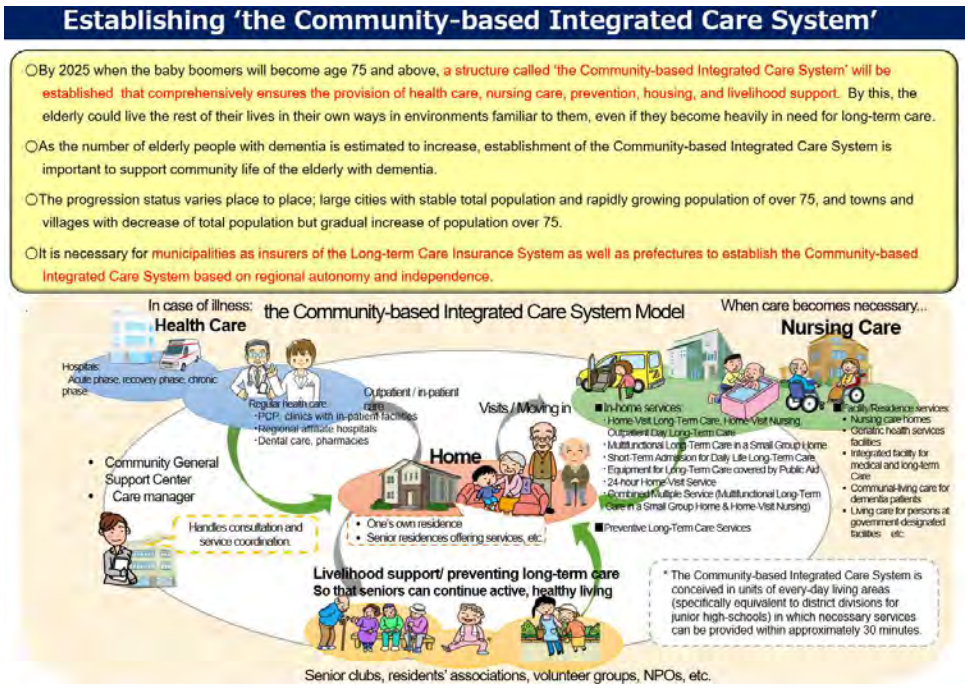
Figure 2.2.2 Elderly Care System in Denmark

Ikari (2013) points out that in Denmark the elderly themselves have influenced policy and opinion through a bottom-up approach. Specifically, with the aim of solving the social problems of increasing welfare costs and lowering the quality of welfare services provided at facilities, the Policy Committee for the Elderly was established under the Diet in 1979 to discuss welfare reform. At the same time, 100 working groups were established in cities, towns and villages all over the country to provide opportunities for the elderly themselves to discuss their future in their old age. The essential needs of the elderly extracted in those discussions are the basis of the three principles of welfare for the elderly. According to Seki (2008), in Denmark both the central and local governments practice the three principles of welfare for the elderly in the field of "self-determination" "continuity of life" and "utilization of one's own abilities."

2.2.3 Japan

Since the enactment of the Long-Term Care Insurance Act in 2000, central concept of Japan's policy for the elderly has been community-based integrated care, and the system to realize this concept is the community-based integrated care system. Framework of the system has been created by referring to cases of other countries, including the UK and Denmark. Ministry of Health, Labour and Welfare defines the community-based integrated care system as "integrated support and service provision system that enables elderly people to continue living in their habitual areas as much as possible with the aim of maintaining their dignity and supporting their independent lives." The Government of Japan has been supporting municipalities to establish community-based integrated care system by 2025 that suits local autonomy, independence and characteristics of each community through formulation and implementation of Long-Term Care Insurance Business Plan every 3 years.[18]

[18] The Ministry of Health, Labour and Welfare (MHLW) has been disseminating information on the Web and other media that will serve as a reference for the development of integrated community care system models and integrated community care systems by advanced local governments, and is working to raise public awareness.



Source: Ministry of Health, Labour and Welfare (https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/chiiki-houkatsu/index.html)

Figure 2.2.3 Conceptual Diagram of Community-Based Integrated Care System

In developing a municipal community-based integrated care system, Regional Comprehensive Support Center plays an important role.[19] According to the Ministry of Health, Labour and Welfare, the main function of the centre is preventive care support as well as integrated care support such as (1) preventive care management, (2) comprehensive consultation support, (3) rights protection, and (4) integrated and continuous care management support. Centres are implementing these activities by building a cross-institutional cooperation network. According to the Japanese Council of In-Home Care Support Center, establishment of such centre is promoted in daily living area (approximately 1 centre per 20,000-30,000 population). As of April 2018, there are 5,079 centres nationwide and every municipality has at least one centre. The number of centres has been increasing slightly every year.[20]

Hoshi (2015) cited the following 3 reasons for promoting community-based integrated care: (1) stringent Long-Term Care Insurance finance, (2) diversification of elderly care needs and (3) financial difficulties of local governments. He argued that if elderly care prevention is properly implemented, government finances will be stabilized even if the number of elderly people increases. Yokouchi and Shitamatsu (2019) discussed the necessity of active involvement of private business in addition to local residents (community

[19] The basis for the establishment of community general support centres shall be Article 115 paragraph 46 paragraph 1 of the Long-Term Care Insurance Act. According to the Health, Labour and Welfare Ministry, "A facility established by the municipality, with public health nurses, certified social workers, and chief long-term care support specialists, etc., for the purpose of providing necessary assistance for the maintenance of residents' health and the stabilization of their lives through a team approach of three occupations, and thereby providing comprehensive support for the improvement of their health and medical care and the promotion of their welfare." (https://www.mhlw.go.jp/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/chiiki-houkatsu/dl/link2.pdf)

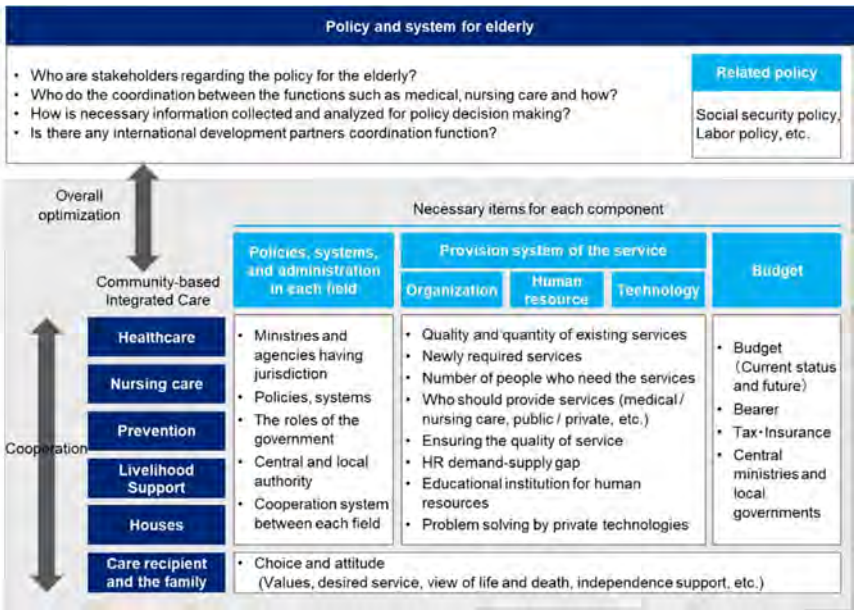
[20] A similar centre is the Home Care Support Center. In 2005, up to 8,668 centres were established nationwide, but after the introduction of the long-term care insurance system, many of them were transferred to community general support centres through the establishment of community general support centres. (http://www.zaikaikyo.gr.jp/about/index.html)

associations and volunteers), public administration, social welfare corporations, NPOs, etc. in a community-based integrated care system and a community symbiotic society expanded from the same concept. Examples of community-based integrated care system are shown on an attachment to this report.

2.3 Research Framework

For three reasons, community-based integrated care is envisaged as one of the ideal forms of elderly care in Sri Lanka. First, elderly care facility is scarce in Sri Lanka and many aged people are based at their homes. Second, unlike the case in Japan, approach to elderly people varies a lot due to lack of Long-Term Care Insurance System and mechanism to assess care needs. The last is aging ratio differs by province and locations. Policies and systems related to the aging sector need to be aimed at overall optimization, taking social security and labour policies into account as well as other various factors. A survey framework was prepared with the following important survey points with reference to the community-based integrated care in Japan.

- Current state of the aging sector elements: medical care, elderly care, prevention, livelihood support, housing, social participation, etc.
- Cross-sectoral approach to ageing: policies, planning, partnerships, coordination, etc.
- Implementation status and changes in systems of service providers for an aging society
- Social mechanisms for promoting health with the aim of extending healthy life expectancy: health education, health check-ups, nutrition education, etc.
- Creating a mechanism to promote social participation of the elderly
- Budget planning, allocation methods and roles and responsibilities among government agencies for realization measures for aging
- Assessing the needs of the aging sector from the viewpoint of the elderly and their families



Source: JICA Survey Team

Figure 2.3.1 Survey Framework

CHAPTER 3 Aging in Sri Lanka

In this chapter, the aging situation in Sri Lanka is analysed by theme.

3.1 Overview of the Aging Society

The 2012 "Sri Lanka Population and Housing Census" shows that among the total population of 20,359,439, the elderly (60 years and older) accounted for 12.4% (population aging rate).[21] Table 3.1.1 shows population aging rate in 2022 and its growth rate (both projected figures), indicating that Sri Lanka is expected to have more aging population compared to other South Asian countries. Furthermore, in 2041, the population aging rate is predicted to double to 24.8% (compared to 2012) (De Silva (2007)). Some researchers claim that in the next few years Sri Lanka will have the biggest elderly population in the world as a developing country.[22]

Table 3.1.1 Population Aged 60 and Older in South Asian Countries

Country	Population aging rate (2012)	Population aging rate (2022) <prospect>	Rate of elongation <prospect>
Sri Lanka	12.4%	16.3%	31.5%
India	8.5%	10.7%	12.6%
Bhutan	8.4%	9.8%	11.7%
Bangladesh	7.3%	9.5%	13.0%
Nepal	6.8%	8.1%	11.9%
Pakistan	6.3%	7.6%	12.1%
Afghanistan	4.1%	4.5%	11.0%

E. L. Sunethra J. Perera et al. Ageing Population in Sri Lanka: Emerging Issues, Needs, and Policy Implications (2017) p. 17, growth rate calculated by JICA Survey Team.

Source: JICA Survey Team

E. L. Sunethra J. Perera et al. (2017) also showed proportion of Sri Lankan population aged 60 or older by province. The national population aging rate is 12.4%, but it varies from 7.85% to 14.0% by province, suggesting that the circumstances surrounding the elderly differ from province to province.[23] This regional difference is thought to be a result of working class migration over the last 3 decades of turbulence between the central government and the Liberation Tigers of Tamil Eelam. The Northern and Eastern Provinces were under the control of the Liberation Tigers of Tamil Eelam and those labour generations in those provinces migrated to North Western Provinces, then they became old there.

[21] Many countries, including major countries, define people aged 65 or older as elderly, but as Horii et al. (2018) have summarized, some Asian countries define people aged 60 or older as elderly. The Asian Development Bank (Asian Development Bank: ADB) (2019) states that the retirement age for public institutions is 60, the age for receiving pensions is 50 for women, and the age for men is 55 for Sri Lanka's elderly population of 60 years or older.

[22] Dr N.N.J.. Contributed by Nawaratne October 30, 2018, Daily Miller Online.

[23] Regional disparities also exist in Japan. As of 2017, the highest percentage of elderly people was 35.6% in Akita Prefecture and the lowest was 21.0% in Okinawa Prefecture. (https://www8.cao.go.jp/kourei/whitepaper/w-2018/html/zenbun/s1_1_4.html)

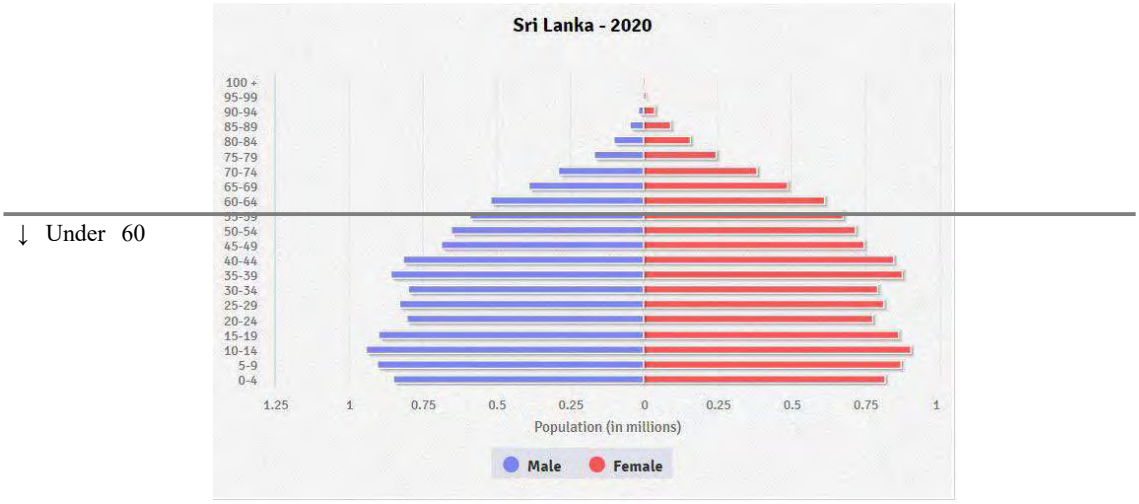
Table 3.1.2 Populatin of Aged 60 and Older Throughout Sri Lanka (2012)

Province	Population	Population over 60 years old	Percentage of population aged 60 or older	Population aging rate (%)
Sri Lanka (Total)	20,359,439	2,520,673	100	12.4
Western	5,851,130	785,251	31.2	13.4
Central	2,571,557	329,126	13.1	12.8
Southern	2,477,285	347,004	13.8	14.0
Northern	1,061,315	125,500	5.0	11.8
Eastern	1,555,510	122,065	4.8	7.85
Northwest	2,380,861	290,153	11.5	12.2
North Central	1,266,663	118,757	4.7	9.38
Uva	1,266,463	137,095	5.4	10.8
Sabaragamwa	1,928,655	265,622	10.5	13.8

E. L. Sunethra J. Refer to Perera et al. (2017) pp. 26 -27. The population aging rate was prepared by JICA Survey Team.

Source: JICA Survey Team

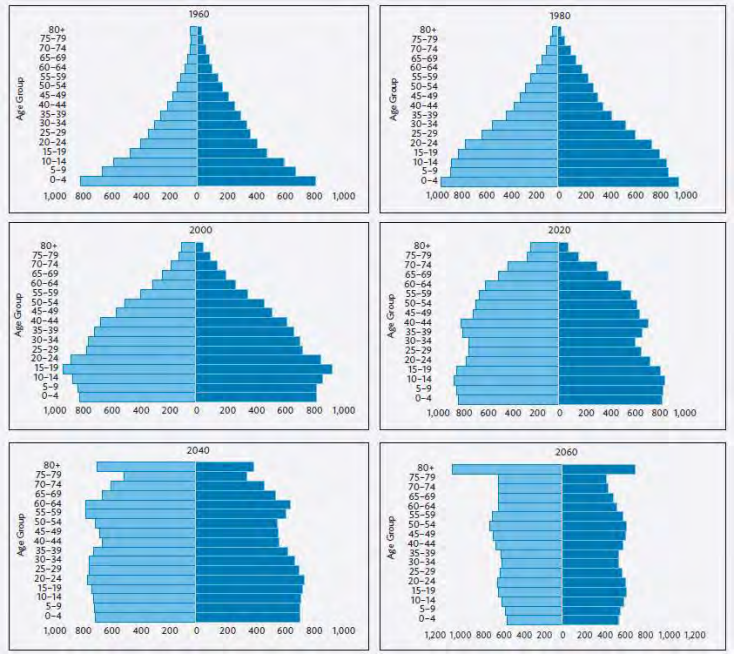
3.2 Demographics of the Elderly



Source: Source: CIA The World Factbook 'Sri Lanka' (https://www.cia.gov/library/publications/the-world-factbook/geos/ce.html)

Figure 3.2.1 How to Make-up Figure Caption

According to the population pyramid of Sri Lanka, as of 2020, the majority of the population was under age 60, indicating that aging of society has not progressed significantly. However, the average life expectancy in the 2011 to 2013 survey conducted by the Sri Lankan Government Statistics Office is 72.0 years for men and 78.6 years for women, and many people under 60 years old are expected to live until their 70s. Moreover, ADB predicts aging of the population, and indeed the population pyramid of Sri Lanka in 2020 is close to the prediction. Aging of the population is likely to continue in the future as described in ADB papers.



Source: ADB (2019), p. 3

Figure 3.2.2 Changes in the Population Pyramid (1960-2060)

As Tamura (2015) pointed out, Sri Lankan birth rate is declining due to low mortality rate of new-borns and infants, long average life expectancy, permeation of birth control and popularization of higher education. Professor Lakshman Dissanayake's (2012) calculated total fertility rate over time (forecast) indicating a trend toward a declining birth rate in the future.

Table 3.2.1 Total Fertility Rate in Sri Lanka (Forecast)

Time	Low-level estimate	Median estimate	High-level estimation
2012-2017	2.14	2.37	2.56
2017-2022	2.03	2.26	2.45
2022-2027	1.88	2.10	2.35
2027-2032	1.73	1.91	2.25
2032-2037	1.56	1.73	2.14

Source: Prof. Lakshman Dissanayake (2012) p. 12

3.3 Social Characteristics of the Elderly

Opportunities for the elderly to have contact with society are diverse. Saito and others (2015) classified such opportunities as work, outings, participation in groups and gatherings, interaction with friends and acquaintances, and hobbies. The elderly participate in society in each situation. In addition, according to documents of the 47th Long-Term Care Insurance Subcommittee in Japan, a subcommittee under Social Security Council in 2013 reported that risk of falls, dementia and depression tended to be lower in communities with higher participation in sports, volunteer, and hobby groups.

The following sections provide an overview of the situation of the elderly in Sri Lankan by social characteristic theme (economy, employment, living environment, and social participation).

3.3.1 Poverty of the Elderly

The 2009-2010 Sri Lanka Poverty Survey measured domestic poverty on the basis of a per capita monthly expenditure of Rs. 3,028. Table 3.3.1 shows an analysis of the survey by age group. The proportion of the poor is high in young and middle-aged people. The table below does not reveal the fact that elderly people aged 60 or older are particularly poor. However, as 10 years have passed since the survey, the population that was young and middle-aged at the time of the survey is now a reserve group of elderly people. Therefore, the number of the impoverished among the reserve group of elderly people and elderly people may be increased than the number in Table 3.3.1.

Table 3.3.1 Poverty in Sri Lanka by Age Group (as of 2009)

Age group	Population	Percentage of total (%)	Non-poor population	Non-poor percentage (%)	Poor people population	Poor people percentage (%)
Under 24 years old	8,417,370	41.4	7,509,643	40.5	907,727	50.2
25~44	5,743,869	28.2	5,273,577	28.5	470,292	26.0
45~59	3,679,603	18.1	3.439,531	18.6	240,072	13.3
60 years and older	2,492,164	12.3	2,303,941	12.4	188,223	10.4
Unknown	4,755	0.0	4,608	0.0	147	0.0
Total	20,337,761	100.0	18,531,300	100.0	1,806,461	100.0

Source: Department of Census and Statistics Ministry of Finance and Planning Sri Lanka Poverty Review A study on Household Income and Expenditure Survey - 2009/10 p.6JICA Survey Team

Figure 3.3.1 shows the domestic savings rate in Sri Lanka. Since 2000, the savings rate has been less than 30%, and it is conceivable that there is a certain proportion of Sri Lankan elderly and reserve elderly people who do not have savings.

Based on Asian Development Bank (2019) Key Indicators for Asia and the Pacific 2019 Source: JICA Survey Team

Figure 3.3.1 Changes in Gross Domestic Saving Rate[24]

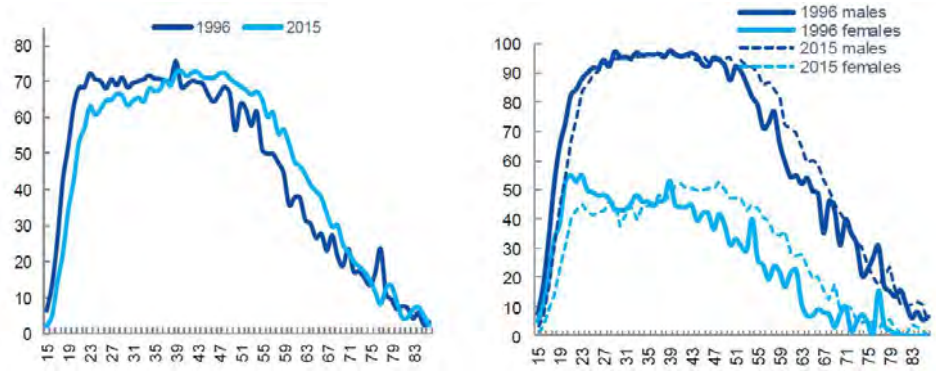
In particular, for the elderly who belong to the poor, regular income from pensions and employment it is important in order to maintain a certain standard of living. On the other hand, there are many elderly people who are not eligible for pension or who have pension but the amont is too small. In response, the MoWCASS's Samurdi Division[25], which deals with poverty issues, and the NSE, which handles elderly

[24] Gross Domestic Saving as a percentage of GDP
[25] Samurdhi is Singhalese meaning promotion of human resource development

issues, provide financial support for low-income elderly people. Support for improving the livelihoods of the elderly is also being provided by Berendina, an international non-governmental organization (NGO), and at several nursing care facilities.[26]

3.3.2 Employment

According to the World Bank (2019), there is a gender gap in the elderly's employment and a decline in the employment rate with advancing age. Although the gender gap narrowed between 1996 and 2015, the employment rate of women is still significantly lower than that of men. The employment rate of elderly people, especially those aged 70 and over, is less than 30% for both men and women.



Source: World Bank (2019), p.36

Figure 3.3.2 Employment by Age Group (left) by Age and Gender Group (right)

In Sri Lanka, HelpAge Sri Lanka, an international NGO, is helping the elderly to find work. HelpAge provides microfinance support to the elderly through senior citizens' organizations to promote entrepreneurship. In 2018, HelpAge provided 27 senior citizens' organizations and 260 elderly people in the Galle area of Galle District and the Welligama areas of Matara District with loans of Rs. 10,000 per person, mainly handicraft industry, to help them start businesses.[27]

3.3.3 Living Environment

According to the 2012 "Sri Lanka Population and Housing Census," only 1% of the elderly nationwide (24,535 people) live in facilities for the elderly or related facilities, and the majority of 2,496,038 people live at home. According to a survey conducted by Nishimura (2006) in Colombo City, 87% of elderly people lived with their children, but according to SSD (2016), the average household size in Sri Lanka decreased from 5.2 people in 1981 to 3.9 people in 2012, suggesting that the number of elderly people living with children is decreasing in Sri Lanka.

The means of going out for the elderly include walking, bicycle, private car, elder home facility vehicle, two-wheel taxi, four-wheel taxi, bus, train, plane, etc. It is realistic for elderly people to go out on foot or

[26] Currently, DS (Berendina Development Services Company), MIC (Berendina Small Investment Company), and BEC (Berendina Employment Center) are spun off as the Berendina Group. The elderly is one of the objects of DS. Barendina Website (https://www.berendina.org/index.php)
[27] HelpAge Sri Lanka Annual Report 2017/18, page 19-20

in a facility vehicle because of their physical reasons, financial reasons, and range of possible activities.

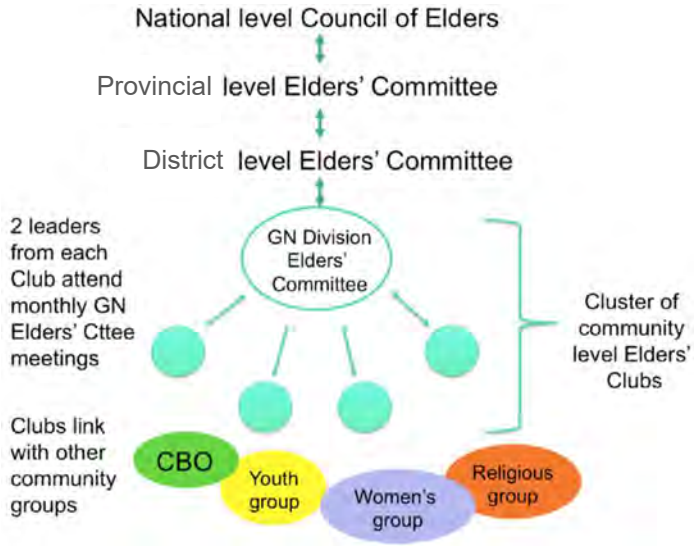
The housing of the elderly can be organized as follows.

Table 3.3.2 Housing for the Elderly

Category	Wealth class	Features	Examples
Home (purchase)	Wealthy class	Sometimes there are caregivers[28]	-
Home (rental)	Middle class to wealthy class	Sometimes there are caregivers	-
Facilities for the elderly	Middle class to wealthy class	Expensive	Cinnamon Care Village 60 plus Jude Elder Care Home Western Healthcare (pvt) LTD
	Intermediate layer	Medium value	Suwasaviya Elders Care Home
	Poor and middle class	Free to low cost *There are facilities for women only.	Nona Memorial Elder Home Moratuwa Social Service Society Elders Home *Irine Thilakarathne Ladies Elder Home and Sri Lanka Dhara Society
Group facility	Poor and middle class	Low cost	Adyathmika Methsevana Peaceful Home
Facilities for the disabled	Poor and middle class	Free to low cost	Senehasa Elder Home-Homagama
Dementia facility	Poor and middle class	Free to low cost	Lanka Alchemier's Foundation
Religious institution	Poor people	Free	-
No facility	Poor people	Free	-

Source: JICA Survey Team

3.3.4 Social Participation



Source: SSD (2016) Long-term Care of Older Persons in Sri Lanka p.33, modified by JICA Survey Team

Figure 3.3.3 Community Gatherings around Elders' Committee

[28] Caregiver is a general term used in Sri Lanka for the people who provide care services. A full picture of caregiver is yet to be clear. In this survey's field visit, no certified caregiver was reached. There were some caregivers who started working right after school without college diploma. Therefore, their academic backgrounds are either junior high or senior high graduate. No facility was found where male caregivers outnumber those of female in the survey. Thus, the majority if caregiver seems to be female.

Elderly people have many points of contact with the local community, such as taking care of their grandchildren at home, working, visiting temples, and participating in elder' committees. Among them, the elders' committee plays a large role in social participation.[29] According to Suvinda S Singappuli, former director of NSE, there are 9 elders' committees at Province level, 25 District level, 331 at county level and 11,500 municipality level.[30] Activities of elders' committee include travel, participation in events, parties and temple visits. In addition to the elders' committee, there are community gatherings where the elderly participate at their own will.

Religion is deeply practiced in Sri Lanka, and Dana (offerings of foods etc) is a way for the Sinhalese elderly to participate in local communities.[31] Nakamura (2011) defined it as "In Sinhala society in Sri Lanka, Dana refers to the daily food offerings from lay followers to monks and the food served to villagers at funerals and apotrapaism. Dana is a concept and practice found more widely in South Asia". It was confirmed that Dana had taken root in the field in multiple facilities for the elderly visited by the survey team. There are close connections, such as meetings of the elders' committee being held at the temple and the chief priest commenting as an advisor in the meetings.

3.3.5 Long-Term Care Needs & Dementia

In Sri Lanka, there is no such a system as in Japan to certify the state of needed care and exact number of people who need care is not known. However, Sri Lankan concept of disability is very similar to the care needs in Japan and it can be used as a reference. According to the 2012 "Sri Lanka Population and Housing Census", the number of persons aged 60 or older with one or more disabilities is estimated to be 866,608, and it can be said that these persons can be said are potential or actual persons requiring long-term care.

Table 3.3.3 Description of Physical and Mental Disabilities in Sri Lanka

#	Name of disability	Supplementary explanation
1	Visual disabilities	Difficulty in seeing, including with eyeglasses
2	Hearing disabilities	Difficulty in hearing, including the use of hearing aids
3	Walking disabilities	Difficulty in walking to the neighborhood or going up and down 12 stairs
4	Cognitive disabilities	Difficulty in remembering and focusing on things
5	Disabilities in daily life	Difficulty in daily activities such as changing clothes and doing laundry
6	Communication disabilities	Difficulty in communicating for physical or mental reasons

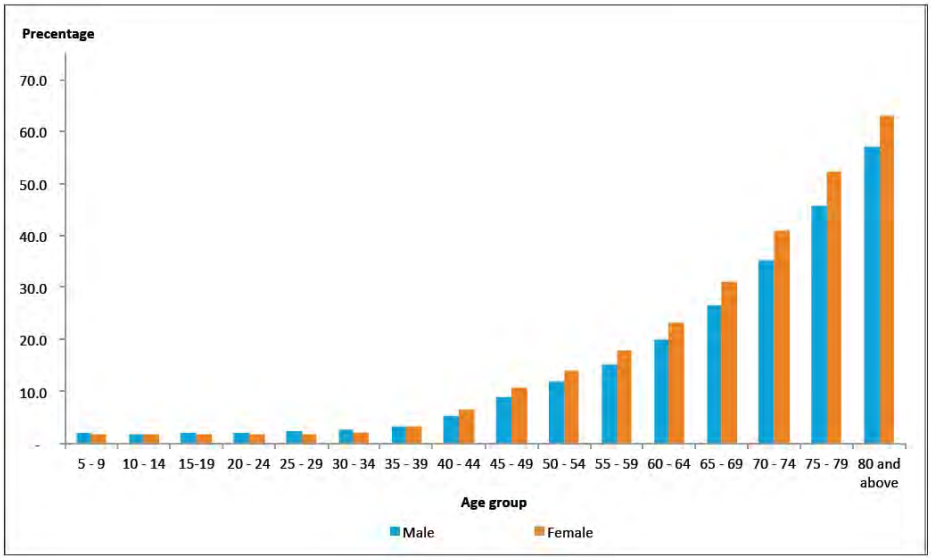
Based on SSD (2016) Long-term Care of Older Persons in Sri Lanka p.47. These are descriptions of disabilities were used in the Census of Population and Housing in 2012.

Source: JICA Survey Team

According to the 2012 "Main Census Results on Population and Housing", 1,616,924 people (8.7% of the total population) have one or more disabilities, and the highest proportion of those with one or more

[29] Those who wish to enroll can enroll before they become old. From interviews, it was confirmed that people aged 60 or younger were enrolled.
[30] https://www.unescap.org/sites/default/files/Sri%20Lanka_1.pdf and H.R. Anulawathie Menike (2015).
[31] According to the Ministry of Foreign Affairs of Japan (2020), the race was Sinhalese (74.9%), Tamils (15.3%), and Sri Lankan Moors (9.3%).

disabilities was for visual disabilities, followed by walking disabilities, hearing disabilities, cognitive disabilities, disabilities in daily life, and communication disabilities.[32] The older they age, the more risk they in physical and mental health. As shown in Figure 3.3.4, one in three people over the age of 70 have some form of disabilities.



Source: Census of Population and Hearing 2012 - Key Findings p.60

Figure 3.3.4 People with Disabilities by Age and Gender

In relation to cognitive disability, dementia is increasing in Sri Lanka as well. The prevalence of dementia is estimated at 3.8% in Sri Lanka, according to the Gerontology Association of Sri Lanka (2018). Dr. Dineszani, in the Sri Lankan newspaper The Sunday Morning, May 29, 2019, has written an article predicting that the number of dementia patients in 2015 is 147,000 dementia patients and the number will nearly be doubled in 2030 to 267,000, and in 2050 to 463,000.[33] Wealthy elderly people with dementia can use private specialized clinics (like the dementia clinic at Nawaloka Hospital,), but many elderly people with dementia live in facilities that do not have family care or specialists.[34] The Lanka Alchemier's Foundation (NGO) is an awareness and educational institution for dementia. It provides education on dementia (for example, a campaign for the world Alzheimer's Day on September 21 every year.), free counseling for people with dementia and their families, and educational programs for caregivers, social workers, and nurses.

3.4 Health of Elderly People

(1) Country profile of health indicators in Sri Lanka

This chapter profiles various vital health indicators in Sri Lanka, including non-communicable diseases (NCD) and oral health disease burden. Figure 3.4.1 shows a summary of health indicators of Sri Lanka that

[32] The total number of persons with disabilities is five years old or older.
[33] The Sunday Morning Website http://www.themorning.lk/let-us-not-forget-dementia/
[34] Nawaloka Hospital Website http://www.nawaloka.com/dementia-clinic

are targeted in the Sustainable Development Goals (SDGs), average scores of the indicators in the Southeast Asia Region (SEAR) countries categorized by the World Health Organization (WHO), and those of upper-middle income countries and lower-middle income countries as defined by the World Bank.[35] As shows in Chapter 1-1, Sri Lanka became an upper-middle income country in 2019 due to recent economic growth, however, became lower-middle income country in July 2020 since Gross National Income (GNI) decreased. Health indicators of Sri Lanka recorded lower morbidity and mortality ratios with improved coverage of health services in comparison with those in other SEAR countries. Therefore, the recent efforts of this country led to significant improvement in the field of maternal and child health and communicable diseases reached an average standard in line with other upper-middle income countries in the world. On the other hand, it is necessary to target the issues of NCDs, injuries, and mental health issues caused by the high suicide rate that are also seen in other upper-middle income countries.

Table 3.4.1 SDGs Health Indicators of Sri Lanka, SEAR, and Upper-middle Income Countries

SDGs targeted indicator			Sri Lanka	SEAR	Upper-middle income countries	Lower-middle income countries
Health Indicators	**Unit**	**Year**				
Maternal health						
Maternal mortality ratio	Per 100,000 live births	2015	30	164	55	253
Child health						
Under-5 mortality rate	Per 1,000 live births	2017	9	36	14	49
Neonatal mortality rate	Per 1,000 live births	2017	6	21	26	49
DPT3 immunization coverage	Among 1 year-old (%)	2017	99	88	94	82
MCV2 immunization coverage	By the nationally recommended age (%)	2017	99	77	88	63
Communicable diseases						
New HIV infections	Per 1000 uninfected population	2017	<0.01	0.08	0.24	0.23
Tuberculosis incidence	Per 100,000 population	2017	64	226	58	223
Malaria incidence	Per 1,000 population at risk	2017	0.0	7.0	2.5	42.8
HBV prevalence	Under five years of age (%)	2017	0.64	0.26	0.30	0.72
NCD[36]						
Probability of dying from the 4th major NCD*	Between age 30 years and exact age 70 years (%)	2016	17.4	23.1	17.7	23.3
Suicide mortality rate	Per 100,000 population	2016	14.6	13.2	10.0	10.6
Alcohol consumption	Among 15 years of age and older, litre of pure alcohol (litre)	2016	4.3	4.5	7.0	4.7
Age standardized prevalence of tobacco smoking	Among 15 years of age and older (%)	2016	13.7	16.9	23.1	17.2
Injuries						
Road traffic mortality rate	Per 100,000 population	2016	14.9	20.7	19.2	
Environmental risks						
Air pollution mortality rate	Per 100,000 population	2016	79.8	165.8	131.7	
WASH mortality rate	Per 100,000 population	2016	1.2	15.4	1.1	18.6
Poisoning mortality rate	Per 100,000 population	2016	0.4	1.8	1.1	1.8
UHC and Health systems						
UHC service coverage index	-	2015	62	55	74	54

* Cardiovascular diseases, cerebrovascular disease, diabetes, chronic respiratory diseases.

Source: World Health Statistics, WHO (2019)

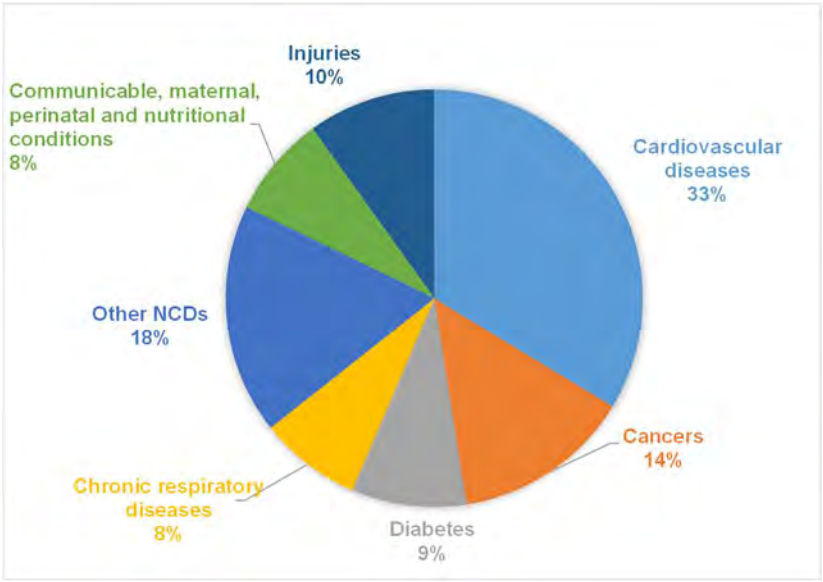
According to the Country Profile of NCD published from WHO in 2018, there were 143,000 total deaths

[35] The World Bank's income classification criteria for 2021 was changed and classified according to GNI per capita (2019) as follows. Lower-middle income, less than 1,035 US dollars; upper-middle income, 1,036-4,045 US dollars; high-middle income, 4,046-12,535 US dollars; and high income, more than 12,536 US dollars.
(https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups)

[36] Cardiovascular illness, cerebrovascular disease, diabetes and chronic breathing problem.

in Sri Lanka and a majority of the cases (83%) died of NCDs. As displayed in Figure 3.4.1, which shows causes of death in 2018, the leading cause of death was cardiovascular disease, which accounted for one-third of total deaths.

In addition, there was a huge gap in premature mortality between males (22%) and females (13%). These findings imply that there is a need to focus on cardiovascular diseases that target male populations.



Source: WHO, NCD Country Profile 2018

Figure 3.4.1 Causes of Deaths in Sri Lanka

Table 3.4.2 shows the top causes of death by age group. As in other age groups, NCDs such as heart and cerebrovascular diseases and bacterial diseases are among the top causes of death in the elderly. The number of deaths due to respiratory diseases and hypertension is higher than that of other age groups and accounts for about 60% of all deaths. Conversely, the number of deaths from malignant neoplasms is relatively small, accounting for 27% of the total, perhaps suggesting that they contribute to more deaths in the younger generation. Undiagnosed deaths account for 7% of the total, ranking 8th both in all age groups and for the elderly specifically; it has been confirmed that a certain number of people of all ages die without an opportunity for diagnosis or treatment.

Table 3.4.2 Top Causes of Death by Age Groups

Rank	Disease	Deaths						Deaths (%)					
		17-49	50-69	70+	17+70+	Un-known	Total	17-49	50-69	70+	17+70+	Un-known	Total
1	Ischemic heart diseases	457	3,082	3,852	7,391(1)	13	7,396	6.2	42	52	100	0.18	14.0
2	Respiratory diseases	254	1,599	2,958	4,811(4)	7	4,893	5.2	33	60	98	0.14	9.2
3	bacterial diseases	592	2,147	2,485	5,224(3)	13	5,382	11.0	40	46	97	0.24	10.2
4	Pneumonia	333	1,220	2,068	3,621(7)	9	3,833	8.7	32	54	94	0.23	7.2
5	Other heart diseases	368	1,440	2,007	3,815(6)	5	3,881	9.5	37	52	98	0.13	7.3
6	Cerebrovascu	351	1,587	1,972	3,910(5)	23	3,917	9.0	41	50	100	0.59	7.4

Rank	Disease	Deaths						Deaths (%)					
		17-49	50-69	70+	17+70+	Un-known	Total	17-49	50-69	70+	17+70+	Un-known	Total
	lar disease												
7	Neoplasms	918	3,175	1,580	5,673(2)	1	5,788	15.9	55	27	98	0.02	10.9
8	No diagnosis	690	1,503	1,384	3,577(8)	48	3,753	18.4	40	37	95	1.28	7.1
9	Urinary diseases	336	1,431	1,050	2,817(9)	6	2,835	11.9	50	37	99	0.21	5.4
10	Digestive disorders	407	1,341	723	2,471(10)	7	2,503	16.3	54	29	99	0.28	4.7
11	Trauma	630	673	447	1,750(11)	97	1,833	34.4	37	24	95	5.29	3.5
12	Hypertension	40	234	362	636(14)	1	636	6.3	37	57	100	0.16	1.2
13	Abnormal clinical findings	98	256	354	708(12)	5	751	13.0	34	47	94	0.67	1.4
14	Diabetes	66	360	279	705(13)	1	708	9.3	51	39	100	0.14	1.3
15	Neurological diseases	117	242	232	591(15)	1	680	17.2	36	34	87	0.15	1.3

Non-communicable diseases are shaded in yellow.

Source: JICA Survey Team based on the data by Medical Statistics Unit, the MoH

Table 3.4.3 shows the leading causes of hospital deaths by district in 2017.

Table 3.4.3 Leading Causes of Hospital Deaths by District (2017)

	Sri Lanka	Western Province			Central Province			Southern Province			Northern Province					Eastern Province			North Western Province		North Central Province		Uva Province		Sabara-gamuwa Province	
		Colombo	Gampaha	Kalutara	Kandy	Matale	Nuwara Eliya	Galle	Matara	Hambantota	Jaffna	Vavuniya	Mannar	Kilinochchi	Mullaitivu	Batticaloa	Ampara	Trincomalee	Kurunegala	Puttalam	Anuradhapur	Polonnaruwa	Badulla	Monaragala	Ratnapura	Kegalle
Ischemic heart diseases	1	2	1	1	3	1	3	2	1	2	3	2	3	2	1	1	1	1	1	2	1	2	4	1	3	3
Zoonotic and other bacterial diseases	2	3	2	3	2	3	7	5	4	5	2	6	17	2	12	5	2	2	6	3	2	3	1	3	1	1
Neoplasms	3	1	10	9	1	9	6	1	9	6	4	8	4	7	7	7	8	9	3	11	5	7	5	8	7	8
Diseases of the respiratory system excluding diseases and upper respiratory tract, pneumonia and influenza	4	4	5	4	4	5	4	3	2	4	1	4	4	6	5	4	3	4	2	4	6	4	3	2	5	2
Pulmonary heart disease and diseases of the pulmonary circulation	5	5	4	2	6	4	1	8	6	1	5	3	1	4	5	1	5	6	7	1	7	8	7	6	4	5
Pneumonia	6	8	7	7	7	2	5	4	2	3	8	5	17	1	3	9	4	5	5	6	3	5	2	7	2	4
Cerebrovascular diseases	7	6	6	5	4	6	2	6	5	11	6	7	4	4	-	10	6	3	4	8	8	5	9	5	6	6
Diseases of the urinary system	8	9	8	8	8	8	8	10	7	7	6	1	14	7	3	7	7	7	9	7	4	1	6	4	8	9
Diseases of the gastrointestinal tract	9	7	3	6	9	9	8	9	10	11	9	9	8	12	8	12	13	12	8	5	10	10	10	10	9	7
Traumatic injuries	10	11	9	11	10	7	16	7	8	9	10	15	10	12	2	6	9	8	10	9	9	9	8	9	10	10
Diabetes mellitus	11	10	11	16	12	12	15	12	27	10	13	16	17	-	-	16	23	-	11	14	13	28	14	27	19	14
Signs, symptoms and abnormal clinical and laboratory findings	12	13	12	12	19	15	10	15	11	8	17	10	2	9	8	3	10	13	18	13	17	17	16	16	13	11
Hypertensive diseases	13	17	15	18	13	16	11	11	12	13	11	-	4	-	12	12	20	14	12	12	16	26	11	19	14	15
Diseases of the nervous system	14	14	18	15	11	17	16	13	18	18	12	10	10	12	12	16	17	14	15	19	15	11	15	14	11	12
Slow foetal growth, fatal malnutrition	15	18	13	13	15	11	23	19	15	14	16	10	17	-	-	-	12	25	13	17	11	12	24	12	12	21

1st: ■, 2nd: ■, 3rd: ■, bold: between 1-5th order

Source: Annual Health Bulletin 2017

Ischemic heart disease was ranked in the top three causes of hospital deaths among most of the districts, indicating that cardiovascular disease is a significant challenge in Sri Lanka. Neoplasms ranked first in Colombo, Kandy, and Galle, and third in Kurunegala. Cancer patients being transferred to tertiary hospitals

in these regions, such as Teaching and Provincial General Hospital, are one of the reasons why there are increased deaths caused by neoplasms in these districts. Zoonotic and other bacterial diseases are another leading communicable disease in the districts. It was also identified that diseases of the urinary system occurred at a higher rate in Vavuniya, Mullaitivu, and Polonnaruwa, which is considered to be due to the higher prevalence of chronic kidney disease with uncertain aetiology in northern district of Sri Lanka.

Table 3.4.4 shows leading causes of hospitalization by district in 2017.

Table 3.4.4 Leading Causes of Hospitalization by District (2017)

		Western Province			Central Province			Southern Province			Northern Province					Eastern Province			North Western Province		North Central Province		Uva Province		Sabara-gamuwa Province	
	Sri Lanka	Colombo	Gampaha	Kalutara	Kandy	Matale	Nuwara Eliya	Galle	Matara	Hambantota	Jaffna	Vavuniya	Mannar	Kilinochchi	Mullaitivu	Batticaloa	Ampara	Trincomalee	Kurunegala	Puttalam	Anuradhapura	Polonnaruwa	Badulla	Monaragala	Ratnapura	Kegalle
Injuries	1	1	1	1	1	1	1	1	1	1	1	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1
Signs, symptoms and abnormal clinical and laboratory findings	2	3	3	2	2	2	3	2	2	2	3	1	1	2	3	2	2	2	2	2	2	2	2	2	2	4
Viral diseases	3	2	2	3	3	3	5	3	4	4	4	5	6	3	5	3	3	3	4	3	5	4	4	5	3	2
Diseases of the respiratory system excluding diseases and upper respiratory tract, pneumonia and influenza	4	5	4	4	4	4	2	4	3	3	2	3	3	4	2	4	4	4	3	4	3	3	3	3	4	3
Diseases of the gastrointestinal tract	5	7	5	5	5	7	4	5	6	5	7	6	7	10	6	5	5	5	5	6	4	6	6	6	5	5
Diseases of the urinary system	6	6	7	8	6	8	12	6	8	6	9	9	8	5	4	8	7	7	6	8	6	5	5	4	6	7
Direct or indirect obstetric causes	7	8	8	7	7	6	6	9	5	10	5	7	4	6	8	6	6	6	8	5	7	7	8	7	8	10
Diseases of the skin and subcutaneous tissue	8	6	6	6	11	9	10	8	9	7	6	8	10	7	7	9	9	8	7	7	8	8	9	8	7	6
Diseases of the musculoskeletal system and connective tissue	9	9	9	9	9	10	7	10	10	8	10	4	5	11	9	7	8	10	13	13	9	10	7	9	9	8
Diseases of the eye and adnexa	10	10	12	13	8	5	11	11	7	16	8	13	31	17	28	17	12	11	9	9	18	9	12	13	10	14
Neoplasms	11	4	22	10	10	30	25	7	32	30	11	29	22	26	37	19	36	19	19	31	13	29	11	27	13	26
Other diseases of the upper respiratory tract.	12	16	10	12	12	11	9	15	12	15	12	11	15	8	10	10	11	9	11	12	10	11	10	10	11	9

1st: ■, 2nd: ■, 3rd: ■, bold: between 1-5th order

Source: Annual Health Bulletin 2017

The top cause of hospitalization in Sri Lanka was injuries, followed by signs, symptoms, abnormal clinical and laboratory findings, viral diseases, diseases of the respiratory system excluding diseases of the upper respiratory tract, pneumonia and influenza, and diseases of the gastrointestinal tract. This structure is common in other districts and therefore geographical differences are unlikely to exist. There is a clear need to increase the capacity of medical services, especially considering that injuries are the leading cause of hospitalization.

Increased risk of oral disease either directly or indirectly caused by aging is another major factor in deteriorating health conditions among elderly people. The National Oral Health Survey Sri Lanka 2015/2016, published in 2018, investigated oral health conditions, patterns of utilizations of dental services, and oral health habits targeting populations aged 5, 12, 15, 35-44 years (middle-aged), and 65-74 years (elderly) living around the country. Table 3.4.5 shows the summary of the survey results.

Table 3.4.5 Oral Health Indicators in Sri Lanka

Items	5 years	12 years	15 years	35-44 years	65-74 years
Oral health conditions					
Percentage of persons having permanent teeth					
>20 teeth	39.4	99.4	100.0	94.2	37.0
11-20 teeth	60.5	0.6	0.0	5.4	27.2
1-10 teeth	0.1	0.0	0.0	0.4	24.6
No teeth (edentulous)	0.0	0.0	0.0	0.0	11.3
Percentage of persons having dental caries					
Active caries	60.7	24.2	35.3	63.8	51.3
Missing teeth	3.6	3.3	7.4	82.4	97.4
Filled teeth	11.5	8.8	9.1	23.7	4.8
Percentage of persons having teeth with gingival bleeding-on-probing	18.3	44.7	46.5	52.6	50.4
Percentage of persons having dental calculus	13.7	47.0	49.3	70.7	71.6
Percentage of persons having periodontal pockets	-	-	5.4	25.3	44.4
Percentage of persons with partial denture	-	-	0.1	7.7	12.9
Percentage of persons with full denture	-	-	0.0	0.3	5.9
Patterns of utilization of dental services					
Percentage of persons living in the area less than 1 km apart from the nearest dental clinic.	-	67.3	65.3	64.0	65.2
Percentage of persons who visited to a dental clinic within the last year	-	59.6	31.4	30.9	18.4
Percentage of persons who never visited to a dental clinic	-	14.7	15.2	9.7	19.7
Percentage of persons who received tooth extraction	-	12.5	14.9	50.4	52.2
Percentage of persons who received permanent filling	-	13.3	13.7	17.0	3.1
Oral health habits					
Percentage of persons who clean their teeth twice a day	53.9	50.1	55.8	73.3	55.0
Percentage of persons who clean their teeth by toothbrush	96.7	97.5	98.4	95.9	70.4
Percentage of persons who use fluoridated toothpaste for tooth cleaning	75.6	80.0	82.1	79.3	59.0
Percentage of persons who have a daily habit of betel chewing	-	-	0.8	14.1	26.6
Percentage of persons who have a daily habit of smoking	-	-	0.0	8.5	9.3

yrs: years of age

Source: National Oral Health Survey Sri Lanka 2015/2016

As for patterns of oral disease conditions, adverse oral conditions were identified from reports that more than a half of the elderly participants (aged 65-74) had either gingival bleeding-on-probing or/and periodontal pocket(s), and a majority of them (97.4 %) were missing at least one tooth. Hence, periodontal disease is considered to be one of the major reasons for deteriorating oral health that leads to a missing tooth in the adult population.[37] While one out of ten elderly participants was edentulous, there were few in other age groups. Small percentages of the elderly participants wore partial (12.9 %) or full dentures (5.9 %) despite of increased tooth loss as they age.

In regard to utilization of dental services, more than a half of the elderly participants (65.2 %) answered there was a dental clinic within five kilometres of their house. However, only 18.4 % of the elderly participants had visited a dentist within a year, as opposed to 59.6 % for 12 years of age. It should be noted that nearly 20 % of the elderly had never visited a dentist previously. Tooth extraction was the most common treatment received by the middle-aged (35-44 years of age) and elderly participants, which implies that these participants had only emergency treatments and not regular dental care.

In terms of the oral health habits, a smaller percentage of elderly participants (70.4%) cleaned their teeth

[37] Periodontal disease is a disease in which bacterial build-up destroys the gums and other supporting structures over a long period. People with poor oral hygiene, smokers, people suffering from malnutrition, and diabetics are most likely to develop periodontal disease.

using a toothbrush while a majority of participants in other age groups (> 95 %) used one. one out of four elderly persons (23.1%) used their fingers for cleaning their teeth.

In the NCD Risk Factor Survey conducted by the MoH in 2008, tobacco use as a risk factor for NCD was investigated in 5 selected provinces in Sri Lanka. According to the survey, the number of nondaily smokers was significantly less than that of daily smokers. The numbers of non-smoking population in both sexes were identified significantly higher than those of smoking population. Table 3.4.6 shows smoking status by the category includes non-daily smoker, daily smoker and non-smoker.

Table 3.4.6 Smoking Status in Sri Lanka

Category	Male		Female		Both sexes	
	number	percentage (%)	number	percentage (%)	number	percentage (%)
Non-daily Smoker	431	7.0	7	0.1	438	3.5
Daily Smoker	1,402	22.8	18	0.3	1,420	11.5
Non Smoker	4,307	70.1	6,236	99.6	10,543	85.0
Total	6,140	100.0	6,261	100.0	12,401	100.0

Source: NCD Risk Factor Survey (2008)

Table 3.4.7 shows the prevalence of smoker and tobacco chewers detected among the screened population status by districts. The district with more than 10% of the prevalence of smokers are: Vavuniya, Kilinochchi, Nuwara Eliya, Mannar and Mullaitivu. The district with more than 10% of the prevalence of tobacco chewers are: Nuwala Eliya, Vavuniya, Badulla, Rathnapura, Monaragala, Mannar, Matale, Trincomalee, Anuradhapura, Puttalam, Mullaitivu, Kilinochchi, Hambantota, Polonnaruwa, Ampara, Jaffna and Batticaloa. The prevalence of tobacco chewers is higher than the one of smoker in each district.

Table 3.4.7 Prevalence of Smokers and Tobacco Chewers Detected among the Screened Population (%)

	Western Province			Central Province			Southern Province			Northern Province					Eastern Province			North Western Province		North Central Province		Uva Province		Sabara-gamuwa Province	
	Colombo	Gampaha	Kalutara	Kandy	Matale	Nuwara Eliya	Galle	Matara	Hambantota	Jaffna	Vavuniya	Mannar	Kilinochchi	Mullaitivu	Batticaloa	Ampara	Trincomalee	Kurunegala	Puttalam	Anuradhapura	Polonnaruwa	Badulla	Monaragala	Ratnapura	Kegalle
Smokers	5.60	4.21	4.01	3.54	6.77	11.83	3.43	2.84	7.24	7.24	12.47	10.84	11.89	10.60	5.22	6.38	7.72	2.77	4.86	6.83	6.23	8.10	8.31	5.11	3.62
Tobacco Chewers	5.86	6.18	9.95	4.87	15.12	30.73	5.07	8.38	12.27	11.20	21.92	16.69	12.67	12.76	10.71	11.63	15.09	9.36	13.39	14.30	11.79	21.61	17.76	19.83	7.86

Source: Annual Health Bulletin 2018

According to the National Oral Health Survey Sri Lanka 2015/2016, oral habits per generation are shown. Chewing tobacco and daily smoking are regarded as harmful habits for oral health, and although very low percentages among 5, 12, and 15-year-olds had a habit of chewing tobacco, higher percentages were observed in older age groups.

Table 3.4.8 shows the percentages of participants with a chewing tobacco habit by gender and age groups. More male participants of the middle-age group reported chewing tobacco than men in other age-groups while more female participants of the elderly group had the habit than women in other age groups.

Table 3.4.8 Habit of Betel Chewing by Gender and Age Group (%)

Gender	Age	No habit	Past (not within last 12 months)	Seldom (once a month or less)	Several (2-3 times a month)	Once a week	2-6 times a week	Everyday
Male	15 years	77.4	6.0	8.9	3.0	1.6	1.6	1.5
	35-44 years	51.4	4.8	6.9	3.8	3.4	5.1	24.7
	65-74 years	51.1	9.1	3.7	1.9	1.8	3.2	29.1
Female	15 years	94.5	2.7	1.7	0.4	0.5	0.0	0.2
	35-44 years	81.6	3.3	3.9	2.3	1.9	2.8	4.1
	65-74 years	54.4	7.8	5.0	2.9	2.0	3.8	24.1

Source: National Oral Health Survey Sri Lanka 2015/2016

Table 3.4.9 shows percentages of participants with a smoking habit by gender and age group. Percentages of smoking were moderately higher in older age groups: 0% in 15-year-olds, 8.5% in the middle-aged group, and 9.3% in the elderly group, respectively. It was identified that 17.4% of male participants in the middle-aged group and 18.1% in the elderly group had a daily smoking habit while comparatively few female participants reported one.

Table 3.4.9 Habit of Smoking by Gender and Age Group (%)

Sex	Age	No habit	Past (not within last 12 months)	Seldom (once a month or less)	Several (2-3 times a month)	Once a week	2-6 times a week	Everyday
Male	15 years	99.6	0.3	0.0	0.0	0.0	0.0	0.1
	35-44 years	69.1	4.6	3.3	1.6	1.4	2.7	17.4
	65-74 years	65.4	10.1	2.7	1.0	1.2	1.5	18.1
Female	15 years	100.0	0.0	0.0	0.0	0.1	0.0	0.0
	35-44 years	99.3	0.1	0.2	0.0	0.0	0.2	0.2
	65-74 years	98.9	0.3	0.0	0.0	0.0	0.1	0.6

Source: National Oral Health Survey Sri Lanka 2015/2016

As stated above, there is insufficient awareness of appropriate oral health practices and irregular consultations with dentist among elderly people, confirming that oral health conditions were worse as participants aged in Sri Lanka. Intervention targeting middle-aged and elderly populations in Sri Lanka is necessary to reduce the risk of oral disease and improve oral hygiene; WHO shows clear benefits of including oral health into measures against NCD.

(2) Difficulties in Daily Life

Using data from the aging population of Sri Lanka and the Thematic Report based on the Sri Lanka Population and Housing Census (SLPHC) in 2012, Table 3.4.10 and Figure 3.4.2 shows the percentages of the aging population with disabilities by sex. This report investigated the impact of physical and mental difficulties on "activity of daily living[38]", "instrumental activity of daily living[39]", and other aspects of daily life in 6 areas: "Seeing", "Hearing", "Walking", "Cognition", "Self-care", and "Communication." Higher percentages of elderly people (aged 60 or over) with difficulties in daily life were observed in female groups

[38] "Activity of daily living" refers to the minimum activities necessary for daily life, such as "getting up, transferring, moving, eating, changing clothes, defecating, bathing, and dressing." (Locomotive Syndrome, the Japanese Clinical Orthopaedic Association, http://www.jcoa.gr.jp/locomo/teigi.html)

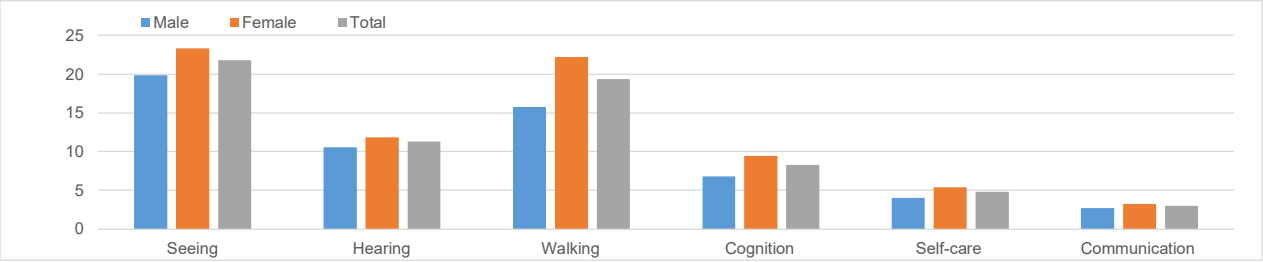
[39] Instrumental activity of daily living" refers to more complex daily activities including "housework (e.g., cleaning, cooking, washing, and shopping), use of transportation, phone answering and other communications, schedule adjustment, managing medication and finance, hobbies." (General Reference Material on Health, Japan 21, https://www.mhlw.go.jp/www1/topics/kenko21_11/s1.html)

than male groups. In addition, 20% of the elderly people had difficulties with either seeing or walking, or both, and 10 % reported difficulties with hearing and/or cognition.

Table 3.4.10 Aging Population with Disability by Gender

Gender	Population aged 60 years or over	Seeing		Hearing		Walking		Cognition		Self-care		Communication	
		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Male	1,115,651	221,390	19.8	117,794	10.6	175,964	15.8	76,027	6.8	44,780	4.0	29,781	2.7
Female	1,404,922	327,386	23.3	166,491	11.9	312,245	22.2	132,630	9.4	76,011	5.4	45,512	3.2
Total	2,520,573	548,776	21.8	284,285	11.3	488,209	19.4	208,657	8.3	120,791	4.8	75,293	3.0

Source: Created based on Aging population of Sri Lanka, Thematic Report based on SLPHC 2012, UNFPA (2017)



Source: Created based on Aging population of Sri Lanka, Thematic Report based on SLPHC 2012, UNFPA (2017)

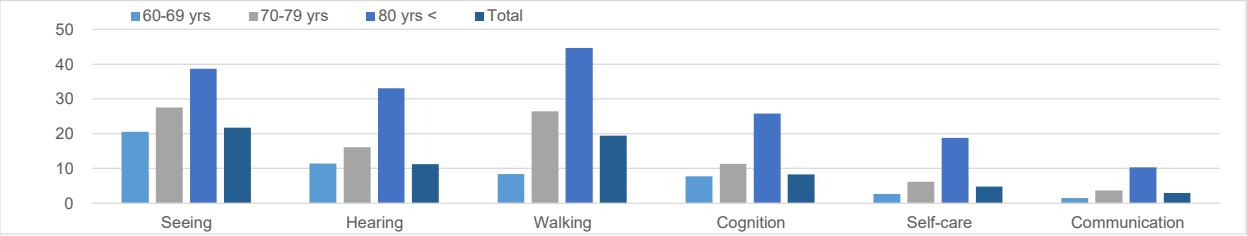
Figure 3.4.2 Aging Population with Disability by Gender

Table 3.4.11 and Figure 3.4.3 show distributions of age groups by type of difficulty. The percentage of people with a disability at aged 80 or over was two or three times higher than in those between 60-69 years of age in both seeing (38.7% vs. 20.5 %) and hearing (33.1% vs. 11.5%). In addition, only 8.4 % of 60-69 years of age had difficulty in walking, but nearly half of those aged 80 or over (44.6%) have difficulty in walking. Difficulties with self-care and communication were also more frequently reported in older age groups, and 18.8% of participants age 80 or over experiencing difficulty in the category of self-care. These findings indicate that there may be more old people who need physical and social support as the society of Sri Lanka ages.

Table 3.4.11 Age Groups by Type of Disability

Age group	Population aged 60 years or over	Seeing		Hearing		Walking		Cognition		Self-care		Communication	
		Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
60-69	1,551,199	318,697	20.5	177,759	11.5	129,664	8.4	120,928	7.8	42,244	2.7	22,520	1.5
70-79	695,600	191,808	27.6	112,088	16.1	183,407	26.4	78,629	11.3	42,947	6.2	25,809	3.7
80≦	273,774	105,871	38.7	90,483	33.1	122,094	44.6	70,462	25.7	51,388	18.8	28,105	10.3
Total	2,520,573	548,776	21.8	284,285	11.3	488,209	19.4	208,657	8.3	120,791	4.8	75,293	3.0

Source: Created based on Aging population of Sri Lanka, Thematic Report based on SLPHC 2012, UNFPA (2017)



Source: Created based on Aging population of Sri Lanka, Thematic Report based on SLPHC 2012, UNFPA (2017)

Figure 3.4.3 Age Groups by Type of Disability

CHAPTER 4 Present Status and Problems of Measures for Aging in Sri Lanka

This chapter summarizes and analyzes current situation and issues by major elderly related organizations and by topics in light of trend in aging measures in Sri Lanka.

4.1 Policies for Aging

4.1.1 Related Laws, Ordinances of the Prime Minister and Other Measures

(1) Trend since the 1980s

In Sri Lanka, various laws, ordinances, and policies concerning aging of society have been formulated since the 1980s as shown in Table 4.1.1. Especially, Protection of Elders Rights Act No. 9 in 2000 has a significant meaning. This clause has led to the establishment of National Secretariat for Elders (NSE). In 2010, 10 years after the foundation, 'Mahinda Chintana' a vision for the future was released and a wide variety of measures was addressed including geriatric health issue.

Table 4.1.1 Major Topics Related to Measures for Aging

Year	Major topics
1982	National Committee on Aging is established within the Ministry of Social Welfare.
1993	National policy for the elderly established
1997	Recommendations for health sector reform, including care for the elderly, by task teams directly under the President Identified key areas are as follows: - survey of the needs of the elderly - Development of manuals for training PHC staff and volunteers - Expansion of the daycare center network - Selection of elderly people at the divisional level - Assignment of community health nurses - Renovation of equipment and materials for hospitals for the elderly - HelpAge proposal to use religious facilities as day care centers - Project for Improvement of Facilities and Equipment for the Elderly - Raising Awareness of Elderly Care in Communities
1997	A statement in the annual health report that there is a need to prioritize the prevention and treatment of diabetes and cardiovascular disease in response to the increasing number of hospitalized patients
1998	Added provisions for community-based care for vulnerable groups, such as the elderly, to the 1999 – 2004 6-year development planning program by the National Planning Agency
1998	Formulating strategies for the care of the elderly in national population and reproductive health policies are as follows: (a) Empowering private providers, NGOs, community groups, and other communities to provide community care and services for the elderly (b) Development of social security schemes for the untargeted elderly, such as Employees Provident Fund (EPF) and ETF (Employees' Trust Fund) (c) Providing incentives for families to care for the elderly at home (d) Providing training for young people who wish to find work necessary for home care for the elderly
2000	Protection of Elders Rights Act No. 9 of 2000. (2000 Section 9 Protection of the Rights of the Elderly) This article establishes the National Commission on the Elderly, the NSE and the Commission on the Handling of Complaints by the Elderly within the Ministry of Social Welfare. The National Fund for the Elderly and ID for the Elderly were introduced. A senior citizens committee has been established at the local government level and at day care centers. Establishment of a pension scheme for people aged 70 or older who are not receiving any other financial assistance and have no family or relatives
2005	First consultation on Integrated Measures by the MoH and the Ministry of Social Welfare Related to Measures for Aging
2006	National Charter for the Elderly and National Policy passed the Cabinet. The purpose of this Charter is to ensure and strengthen

Year	Major topics
	the independence, dignity, social participation, self-realization, and quality of life of the elderly in a diverse living environment in the community, including care, acceptance, and respect.
2007	Director-General of Health Services participates in the regional high-level meeting of the Review of Implementation of the Madrid International Programme on Ageing held in China.
2010	Mahinda Chintana 'Mahinda Chintana' Announces Vision for the Future Development policy framework formulated by the national planning department and the Ministry of Finance Planning of the Government of Sri Lanka The policy framework identifies (a) disease and demographic change responses, (b) human resource management, and (c) enhanced responses to vulnerable groups as key issues in the health sector Demographics and epidemiology conversion cause the problem of burden of non-communicable disease and lifestyle habit illness for the aging. The proportion of people aged 60 and over is estimated to increase from the current 11% to 16% in 2020 and 29% in 2050. Therefore, health issues associated with aging, including more non-communicable diseases, will be a major future challenge.
2010	Key outcomes of the National Science Policy Forum are agreement on the direction of strengthening PHC for the elderly.
2010	National Action Plan for Human Rights Protection and Prevention developed for 2011 – 2016
2011	Implementation of a multisector consultative process supported by WHO as part of the National Action Plan for Aging 2011 – 2015
2011	Passage of the Cabinet of the Protection of the Rights of the Elderly Clause 5
2017	MoH developed a national elderly health policy
2018	The NSE formulated national policies for the elderly based on the 2006 policy. It has been forwarded to the national council for elders for getting approval and then it will be submitted for cabinet approval.

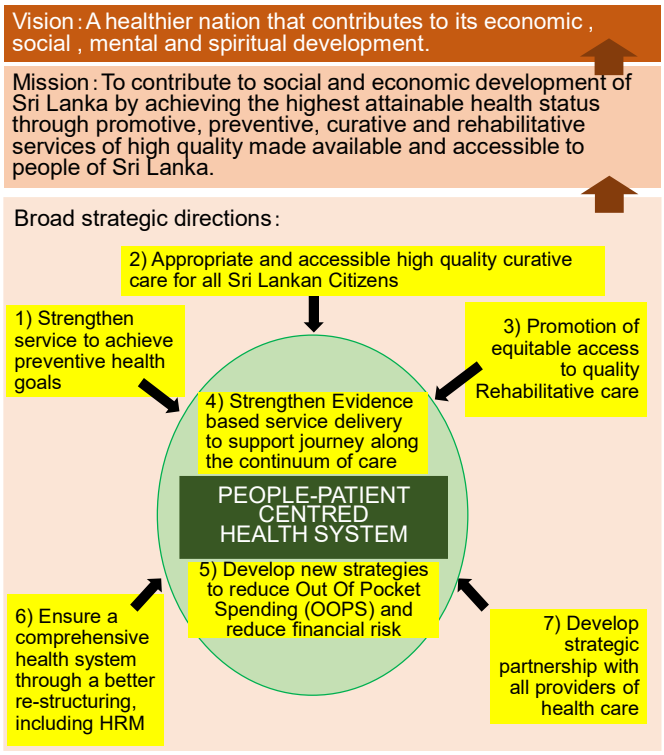
Based on SSD (2016) Long term Care of Older Persons in Sri Lanka p.25, adding topics after 2015 by JICA Survey Team

Source: JICA Survey Team

(2) Health Policies

1) National Health Policy 2016-2025

The mission of the National Health Policy 2016-2025 is 'to contribute to social and economic development of Sri Lanka by achieving the highest attainable health status through promotive, preventive, curative, and rehabilitative services of high quality made available and accessible to people of Sri Lanka,' indicating the broad strategic directions as shown in Figure 4.1.1. There are two horizontal directions for patient-centred health systems: 1) the continuum of care, and 2) reducing out of pocket spending and financial risk. There are also five task-based directions: 1) preventive health services, 2) curative care services, 3) rehabilitative care services, 4) comprehensive systems including human administration, and 5) partnership with all providers. Detailed policy statements are developed under the broad seven strategic directions. Strategies for elderly people and for NCD are included in the policy statements. Table 4.1.2 shows strategies for the aging population.



Source: JICA Survey Team, based on the National Health Policy

Figure 4.1.1 Framework of National Health Policy

Table 4.1.2 Elderly Care Measures in the National Health Policy

Directions		Measures
1	Strengthen service delivery to achieve preventive health goals	- To ensure the delivery of comprehensive health care system **to control and prevention of cancer.** - **To reduce mortality and morbidity of NCD** - To improve the health status and **reduce the dependency of the elderly,** disabled and displaced. - To address health issues related to urbanization **through health promotion and healthy settings concept.**[40] - **To promote the involvement of the community in health care** through health education and publicity. - To develop comprehensive health system **to reduce the burden of unknown chronic kidney diseases (CKDu).**
2	Appropriate and accessible high-quality curative care for all Sri Lankan citizens.	- To provide **comprehensive cardiac care services** in equitable manner. - To establish comprehensive and adequate **ICU facilities and Pain Clinics**[41] at appropriate centres. - To ensure the equitable distribution of comprehensive **neuro-surgical care** throughout the country. - To improve **the accessibility to comprehensive Eye Care** at all levels.
3	Promotion of equitable access to quality Rehabilitative care	- The mainstream health system should provide **palliative care** to all patients who are in need of such care for them to live and die with dignity. - To provide and equitable, efficient and quality **stroke care** to needy patients, with multi-disciplinary approach and medium/long term plans.

[40] WHO defines this as "place where people engage in daily activities and social context where various factors such as environment, organizations and human resource influence on health." A concept that places where people spend daily life such as schools, workplaces, hospitals, villages and cities are regarded as a place to health related issues can be solved.

[41] A means to mitigate or disappear pain for higher QOL by various medical treatment such as medicinal treatment based on multiple diagnosis for cause of the pain through symptoms and physical findings." (Japan Pain Clinic Academy https://www.jspc.gr.jp/igakusei/igakusei_about.html)

Directions		Measures
		- To develop and expand a responsive **mental service** with structural and process changes in different settings. - To ensure healthy ageing with multi sectoral collaboration - To provide equitable distribution of **Geriatric care** - To provide community based comprehensive **rehabilitative care** for the people with disabilities to enable them to self-support their daily activities. - To establish **a national system of endocrinology and diabetic care services** at different levels. - To ensure the delivery of quality, equitable & effective **oral health care services** to the community. - To ensure the reduction of morbidity and mortality due all types common **respiratory disease.**
4	Strengthen evidence-based service delivery to support journey along the continuum of care	- To ensure sharing of resources within a cluster to provide quality primary level care to the community. - To develop **a referral and back-referral system** for patients in each defined catchment area.
5	Develop new strategies to reduce out of pocket spending and reduce financial risk	- To provide certain costly devices (such cardiac stents, intra ocular lenses for cataract patients) at the expense of the Government. - To provide **all diagnostic services (including medical laboratory investigations) within the government hospitals at free of charge** for the patients.
6	Ensure a comprehensive health system through a better re-structuring, including human resource administration	- To reform the structure of NCD prevention program to cover all subcomponents as a separate NCD prevention division. - To establish a new structure for management of primary level curative services which include all divisional hospitals and primary medical care units of the country.
7	Develop strategic partnership with all providers of health care	- To collaborate with plantation companies in the delivery of health care for the estate workers. - To ascertain the idling periods of expensive bio medical equipment, medical laboratories and operation theatres and develop mechanisms to provide service to private sector with a fee for service for the government staff and generate revenue for the state.

The words written in bold letters are related to the health care for the elderly.

Source: JICA Survey Team

2) National Strategic Framework for the Development of Health Services 2016-2025

The identified issues, proposed strategies, and activities are categorized into the following five divisions in the National Strategic Framework for the Development of Health Services 2016-2025: 1) Public Health Sector, 2) Curative Health Services, 3) Rehabilitation services, 4) Health Administration and Human Resources for Health, and 5) Health Financing.

This strategic framework includes countermeasures against both vertical issues such as disease control and horizontal issues such as coordination between different sectors. Table 4.1.3 shows strategic themes directly related to measures for the elderly. The strategic areas, which include prevention, treatment, and rehabilitation, address issues and required actions for the elderly population in Sri Lanka in the fields of NCD, cancer control, mental health, and palliative care.

Table 4.1.3 Strategic Area and Theme for Elderly Care

Strategic area	Strategic theme 1	Strategic theme 2
1. Public Health Sector	1.1 Changing Disease Burden	1.1.1 NCD 1.1.4 Elderly/Ageing Population 1.1.5 Mental Health 1.1.18 Cancer Control
2. Curative Health Services	2.1 Patient Centred Care	2.1.1 Underutilization of primary health care 2.1.8 Comprehensive palliative care／highly

Strategic area	Strategic theme 1	Strategic theme 2
		specialized services
	2.5 Specialist Services	2.5.6 Palliative Care 2.5.10 Cardiology
3. Rehabilitation Services		-

Source: National Strategic Framework for the Development of Health Services 2016-2025

Identified issues and proposed strategies and activities for the elderly in each strategic theme (area) stated above are as follows in Table 4.1.4, Table 4.1.5 and Table 4.1.6.

Table 4.1.4 Issues and Strategies in "1. Public Health Sector"

Issues	Strategies
1.1.1 NCD	
- Increased Burden of Chronic NCD and risk factors - No database on Disease burden/No performance management indicators and no surveillance system - Gaps in intra and inter sectoral coordination - General Public not empowered of NCD targets	- Establishment of NCD Bureau with the appointment of DDG(NCD) with facilities for research screening and monitoring of NCD - Enhance Health Promotion of individuals. - Establish & sustain the Healthy settings approach[42] (healthy village, healthy market, healthy workplace, healthy canteen etc.) and strengthen the legal framework. - Establishment of subunits under DDG (NCD) to perform research, monitor the disease burden and implement national plans for CVD, DM, COPD, in addition to CKDu, A&E, Eye diseases) - Family medicine approach through primary level curative care institutions, accountable for a defined population.
1.1.4 Elderly / Aging population	
- Non availability of elderly and disable friendly environment. - Lack of awareness on active healthy ageing[43] - No specified service centres or no specialists in elderly care - Lack of intra and inter sectoral collaboration on elderly care - Lack of proper attitudes among young generation with regards to elders	- Establish programs for Healthy Ageing (creating public awareness and correcting attitudes of younger generation) - Promotion of elderly and disable friendly environment - Availability and equitable distribution of Geriatric Specialists.
1.1.5 Mental health	
- Depression will be the leading morbidity in 2030 according to Disease burden projection. - Increased magnitude of mental diseases (e.g. Suicide, dementia) - Inadequate public awareness on mental health issues - Mal distribution of Human resources island wide (e.g. University Psychiatrists are underutilized) - Deficiency of Counsellors, Clinical Psychologists, Psychiatrist Social Workers - Non availability of infrastructure at Provincial level	- Gradual expansion of services (system and protocols, cadre and infrastructure Development) - Promotion of Mental Health in different settings - Client friendly services - Empowerment of caregivers - Prevent social isolation of patients with Minot mental condition, arrange a proper long term follow up plan depending on the diagnosis.
1.1.18 Cancer control	
- Lack of awareness among general public about primary prevention of cancers - Non availability of services for detection of cancers through Primary Health Care (PHC).	- Increase in public awareness on primary prevention of cancers. - Establish facilities for detection of cancers through PHC - Establish diagnostic facilities for cancer at each district.

[42] Health, participation and safety opportunity optimization process for a high QOL even after aging
[43] The process of optimizing opportunities for improving health, participation, safety so that people are able to improve their quality of life in their ageing process.

Issues	Strategies
- Cancer diagnostic facilities are not available at district level	

Source: National Strategic Framework for Development of Health Services 2016-202

Table 4.1.5 Issues and Strategies in "2. Curative Health Services"

Issues	Strategies
2.1.1 Underutilization of PHC	
- Underutilization of PHC	- Establish at least one rehabilitation/geriatric/palliative care hospital per district to improve hospital bed utilization. - Establishment of a policy on referral system[44] - Strengthen public relations and availability of services of Primary Level Curative Institutions - Establish Emergency Trauma Unit / Preliminary Care Unit in all primary care institutions - Appoint Medical Officer for NCD to Healthy Lifestyle Center (HLC)[45] in Primary Level Curative Institutions (Divisional Hospital A, B, &C) with medical degree (B.Sc. Health Promotion) and provide facilities for field screening clinics as extension of HLC at village level. - Ensure availability of all relevant resources (Human resources, drugs, equipment etc.) of each primary care institutions.
2.1.8 Comprehensive palliative care / Highly specialized services	
- Comprehensive palliative care/highly specialized services not provided	- Establish one palliative care hospice in each district - Establishment of specialized centres at district level (poison, dialysis)
2.5.6 Palliative Care	
- A huge number of citizens suffer unnecessary at the end of the life in spite of existing scientifically valid and simple methods for addressing suffering incurably ill patients, chronically bed ridden, elderly and dying people.	Proposal submitted by Palliative Care Association of Sri Lanka - Integrate Palliative care to the mainstream health care system (at least a centre per district) - Medical Officer Obstetrics and Nursing Officer Obstetrics are to be professionally trained in Palliative care. - Community & Home-based care
2.5.10 Cardiology	
- Several major cities in the country have excellent cardiac services but basic facilities for the management of cardiac emergency are wanting in many peripheral institutions. - Standard cardiac care unit have not been placed according to the basis of population density and division of provinces	Proposals submitted by Sri Lanka Heart Association - Appropriate and accessible Cardiac care for all Sri Lankan citizens. - Clustering of hospitals for optimal cardiac care - Consider Population density VS Distance to nearest Cardiac Cath lab in designing new facilities. - Norm to have two Cardiac Cath lab per province with parallel cadre development.

Source: National Strategic Framework for Development of Health Services 2016-202

Table 4.1.6 Issues and Strategies in "3. Rehabilitation Services"

Issues	Strategies
3.1 Non availability of comprehensive health policy for rehabilitation services	Develop medium and long-term physical (and mental) rehabilitation strategic framework (based on the national disability policy)
3.2 Insufficient human resources for disability care (e.g. Physiotherapist, Occupational Therapist)	Develop Human Resources Health for rehabilitation services
3.3 Limited availability of Rehabilitation services (and	Establish/Expand comprehensive services at national and provincial levels

[44] Also called as "patient referral system" or "hospital coordination system" which introduce and transfer serious case patients which lower level medical facilities cannot examine to higher level medical facilities. Patients in recovery phase are introduced to local medical facilities for recovery support and rehabilitation. This kind of case is called "counter referral (reverse introduction)" (Japan Association for International Health, glossary)

[45] This is a function added to primary medical facilities. Adults above 35 years old are NCD screened. This is also explained in 4.3.2.

Issues	Strategies
infrastructure).	
3.4 Limited accessibility for rehabilitation services	1. Develop Community-based Rehabilitation (CBR) services 2. Promote inter disciplinary rehabilitation teams
3.5Affordability of rehabilitative services for general public	Increase budgetary provisions to equipment drugs and devices
3.6 Unavailability of proper social support or insurance scheme	Introduction of a national health insurance plan
3.7 Non availability of rehabilitation services at PHC level	1. Ensure coverage of a family physician to each citizen 2. Ensure sustainable CBR program for children with special needs through MOH 3. Extended services through Community nursing service
3.10 Inadequate participation and partnership of non-governmental sector in rehabilitation services (Private hospitals, Non-Governmental Organization (NGO), Community-based Organization (CBO) etc.)	1. Develop national plan for rehabilitation, with Non-Governmental sector involvement. 2. Central approach to be established including non-health sectors.
3.11 Deficiency in regulatory mechanism	Establishment of regulatory mechanism for rehabilitation services by developing a national plan (for government and private health care institutions)
3.13 Accessibility problem for disabled	Develop infrastructure to facilitate accessibility for disabled persons at all health institutions.
3.16 Lack of inter and intra sectoral coordination for rehabilitation services E.g.: CBR, Road Safety Policy	1. Strengthen the existing CBR program 2. Propagation of other forms/alternative medicine 3. Integration of all forms of medicine to form a combine service for rehabilitation care

Source: National Strategic Framework for Development of Health Services 2016-2025

(3) National Elderly Health Policy and Strategies

The National Elderly Health Policy was developed by the Directorate of Youth, Elderly and Disabled (YED), which was approved by the cabinet in January 2017. The policy-centred elder care as a national priority. Health policy for the elderly is currently being discussed to develop detailed plans. The National Elderly Health Policy has proposed seven strategies including establishment of health systems, strengthening service systems, cross sectorial cooperation, human resources, and evidence-based research in order to provide health services such as treatment, prevention, and rehabilitation equally and comprehensively in the field of elder care.

However, it has been identified throughout the process of developing the health policy that majority of elderly people who require care have not received sufficient services either at home or in facilities. The MoH developed the Elderly Health Care Delivery Plan in 2017 and has started some countermeasures such as establishing intermediate care beds in existing health care facilities.

According to the Data Collection Survey on Intermediate Care of Elderly Persons conducted by JICA in 2019, detailed strategic frameworks and caring action plans have not yet been established after the cabinet's decision in 2017, but services lead by the YED were reported to be based on the health policies and strategic plans mentioned above. However, more health care services targeting elderly people can be implemented in their communities. The following are health policies and summaries of strategic plans.

1) National Elderly Health Policy

Sri Lanka is aging, and the prevalence of NCD in the elderly is increasing significantly. Public medical

facilities provide medical services free of charge to achieve Universal Health Coverage (UHC). However, the use of and required budget for medical services are expected to increase due to the increasing elderly population and NCD numbers therein. While the current health system does not take into account the specific needs of the elderly, providing health care services as such (e.g., nursing care, rehabilitation services, day care services, and home care) is needed for the future. The National Elderly Health Policy was passed by the cabinet in January 2017 to reach this goal. The policy's purposes and strategies are shown in Table 4.1.7.

Table 4.1.7 Policy Objectives and Strategies of the National Elderly Health Policy

Major Policy Objectives
1. Ensure that, a comprehensive package of health care services is available for elderly individuals so that ageing individuals maintain optimum levels of health. 2. Ensure that health promotion and preventive health services are available throughout life course[46] for the entire population so that ill health and disabilities are minimized during old age. 3. Encourage and guide all elderly health care providers including private sector and NGOs. 4. Ensure that elderly health care services are delivered in an equitable manner. 5. Ensure that well trained human resources are available to manage elderly health care which include preventive, curative, palliative care, rehabilitative and long-term care. 6. Empower elderly care societies, volunteers, community at large, in all aspects of elderly care.
Strategies
1. Establish a mechanism to strengthen policy guidelines and service delivery measures for comprehensive health care service for older persons. 2. Establish a Multi-disciplinary and Multi-sectorial coordination at all levels on care of older persons. 3. Ensure optimal facilities and human resource provision to provide equitable, integrated curative, preventive and rehabilitative services at every service level. 4. Ensure planning, implementing, monitoring & evaluation of culture specific age appropriate interventions to promote Healthy Ageing at all levels. 5. Establish a mechanism to build capacity of health and other relevant service providers for care of older persons. 6. Promote research and adoption of evidence-based information to practice. 7. Establish information systems including old age disabilities to support care of the elderly.

Source: National Elderly Health Policy

2) Elderly Health Care Delivery Plan

The Elderly Health Care Delivery Plan was established by the YED in 2017, providing suggestions for ways to improve medical services for the increasingly elderly population in Sri Lanka. The details follow in Table 4.1.8.

The YED at the MoH says that this plan is only a proposal and it is not necessarily assumed to be enforced; implementation is up to the field. Accordingly, the YED is currently collaborating with the Colombo District to complete refurbishment and preparation of an Intermediate Elderly Care Unit at DH Athrugiriya, one of the underutilized divisional hospitals in Colombo District as a model centre.

Table 4.1.8 Summary of Elderly Health Care Delivery Plan

Medical facilities	Services	Progresses confirmed
Tertiary care health	National Institute of Geriatric Medicine at	Not implemented due to so many reasons. It was decided at the

[46] A holistic term widely used to refer to an entire life which contains various matters.
(https://www.jstage.jst.go.jp/article/ojjams/21/1/21_1_13/_pdf)

Medical facilities	Services	Progresses confirmed
facility (includes emergency)	Handala (present leprosy hospital) purposed centre of excellence in elderly health care including training and research	National Steering Committee for Elderly Care plan to develop it later for a Geriatric Training Facility. Until then to develop intermediate care units at underutilized divisional hospitals
	Stroke units are established in following facilities. - Teaching Hospital - Jaffna, Anuradhapura, Kurunegala, Kandy, Karapitiya. - Provincial General Hospital - Ratnapura, Badulla. - District General Hospital - Polonnaruwa, Ampara, Matara - Base Hospital - Mulleriyawa	According to the 2019 annual plan, stroke units are to be established at the following facilities (current progress is unknown): - Establish the stroke unit - Jaffna, Anuradhapura, Kurunegala, Kandy, Ratnapura, Ampara - Construct the stroke unit - Anuradhapura, Badulla, Polonnaruwa - Improve services at the stroke unit - Kandy, Karapitiya - Establish the stroke unit and procure the equipment – Mulleriyawa
	Rehabilitation Hospitals / Units are established in following facilities. - Colombo North Teaching Hospital-Ragama - Karapitiya - Badulla - Digana - Polonnaruwa	Ragama Rehabilitation Hospital is strengthening its rehabilitation system. In addition, the 2019 annual plan intends the following rehabilitation measures (implementation status is unknown.) - Alcohol Rehabilitation Center - Anuradhapura, Monaragala, Hambantota - Conversion of Maliban Hospital attached to Karapitiya Hospital as a rehabilitation hospital facility (YED: supported with allocations, but work not completed due to financial constraints) - Construction of the rehabilitation unit - Jaffna Teaching Hospital, Polonnaruwa District General Hospital Renovation of the rehabilitation unit - Trincomalee District General Hospital
	Establishment of Center for Prosthetics and orthotics	Not implemented (YED)
	Installation of interior, toilets, and corridors for the elderly in facilities.	Not implemented
	Improving outpatient services to meet the needs of the elderly in all health facilities.	Not implemented
Secondary care health facility	Establishment of facilities for long-term inpatient care for elderly. 9 provinces 26 divisions、1-4 hospitals are targeted per division.	The establishment of intermediate care facility in progress at the divisional hospital in Athurugiriya which will receive patients from CSTH, BH Homagama & NHSL
Primary care health facility	Implementation of long-term care at community level	Not implemented
	Providing primary medical services in collaboration with Elders committees	Not implemented
Others	Training human healthcare resource which is special in elderly medical care (Physiotherapist, Occupational therapist, Speech therapist, prosthetist, and orthotist.	Implemented as part of normal human resource development

Source: National Strategic Framework for the Development of Health Services 2016-2025

4.1.2 Administrative Subdivisions

Sri Lanka has one central government and nine provincial governments, each with its own resources. Each Province has jurisdiction over 2-5 Districts, and all 25 Districts have a total of 331 Divisional Secretariats and counties as smaller administrative units. The smallest administrative unit of the county is Grama

Niladhari (GN), which has 14,022 GN areas.[47]

Table 4.1.9 Number of Municipalities in Each District in Sri Lanka (2012)

Provinces	District	Municipalities
Western	Colombo	13
	Gampaha	13
	Kalutara	14
Central	Kandy	20
	Matale	11
	Nuwara Eliya	5
Southern	Galle	19
	Matara	16
	Hammbanthota	12
Northern	Jaffna	15
	Mannar	5
	Vavunia	4
	Mullativu	6
	Kilinochchi	4
Eastern	Batticaloa	14
	Ampara	20
	Trincomalee	11
North Western	Krunegala	30
	Puttalam	16
North Central	Anuradhapura	22
	Polonnarwa	7
Uva	Badulla	15
	Monaragara	11
Sabaragamwa	Rathnapura	17
	Kegalle	11

In the case that there are multiple municipalities in one municipality, those sub-municipalities are not counted.

Source: SRI LANKA Administrative Division https://citypopulation.de/php/srilanka-admin.php

4.2 Support for the Elderly by the Ministry of Social Welfare[48]

4.2.1 Administrative and Service Implementation Structure

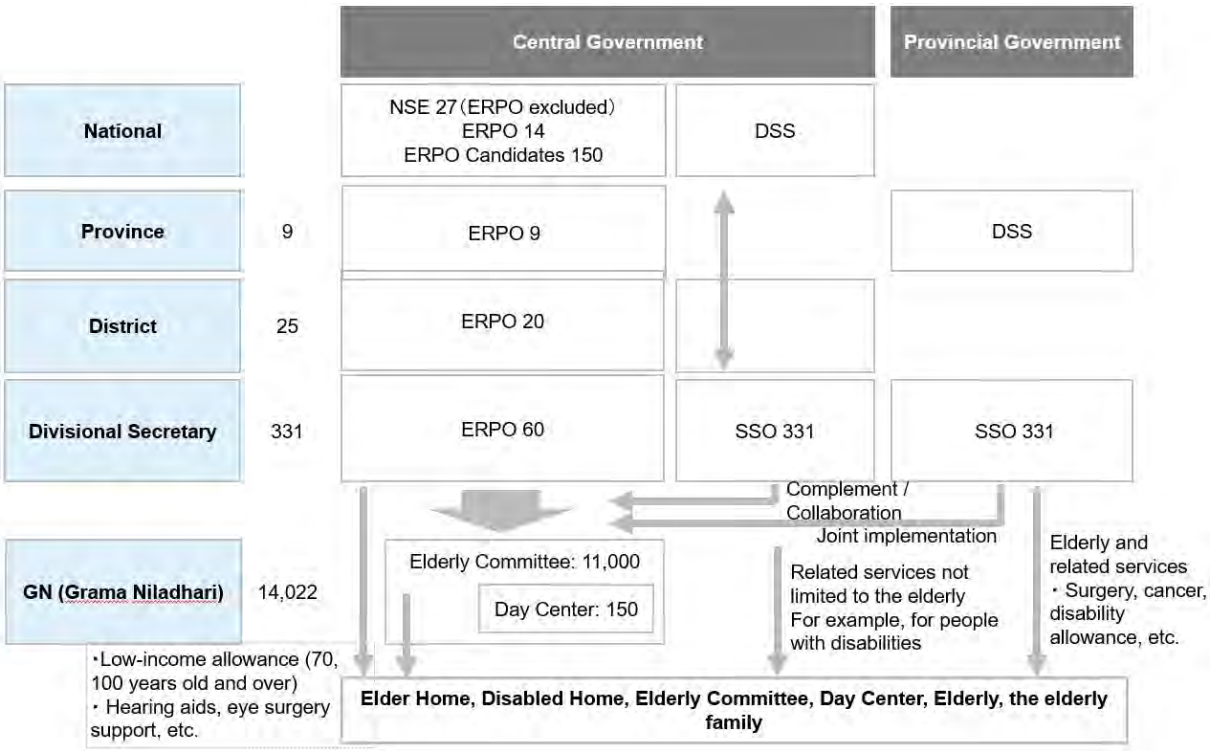
Based on the above-mentioned legal system, the protection of the rights of the elderly and economic support are being promoted. Based on the budgets related to the elderly of the central and state governments, each organization allocates the budget for each business, and the staff of each organization provides economic support and activities for related facilities, organizations, and the elderly in the field. However, according to the World Bank (2019), due to the rapid increase in the number of elderly people, the social systems that support the elderly, such as deposits, pensions, and nursing care, are inadequate in both content and scope.[49]

Figure 4.2.1 shows the overall picture of support for the elderly by the current Ministry of Social Welfare. The vertical axis on the left shows the administrative units, and the range narrows from the central, to

[47] Ministry of Public Administration and Management Website
(https://web.archive.org/web/20170110065520/http://www.pubad.gov.lk/web/index.php?option=com_content&view=category&id=19&layout=blog&Itemid=65&lang=en)
[48] After the August 2020 general election, NSE was transferred to MoH.
[49] World Bank "SRI LANKA DEVELOPMENT UPDATE" (2019), p.31

province, and eventually to GN. The number written next to the administrative unit is the number of each unit; Sri Lanka has one central government, 9 Provinces, 25 Districts, 331 Divisional Secretariats, and 14,022 GN areas. The organization of each unit is shown on the right. The central NSE refers to the National Secretariat for Elders (NSE), an agency that specializes in geriatric policy. Some of the agency's staff includes 14 Elders' Right Promotion Officers (ERPOs) + 7 development officers. ERPO exists in each administrative unit. The Department of Social Service (DSS) provides support for the socially vulnerable, mainly the elderly and other persons with disabilities. Specialized staff, called Social Service Officer (SSO), operate on a central, state, provincial, and county basis. SSO replaces the role of ERPO and addresses the issue of the elderly in situations where central, state, and local governments have social service departments and ERPOs are not located in such areas or where ERPOs alone are not sufficient.

In GN area, there are 11,935 organizations called "Elderly Committee" where mainly elderly people gather, and there are 150 day-centres where daytime activities are possible. The elderly and their families can receive various kinds of support from ERPO, SSO and Elderly Committee.



Source: JICA Survey Team

Figure 4.2.1 Support for the Elderly by Ministry of Social Welfare

According to Dominick, SSO of the of the Central Government's DSS, said there was not enough coordination (sharing information and sharing roles) at the GN district level. Other issues include the low participation of the elderly in society, the lack of passing on knowledge and experience to the younger generation, and the increased stress of the elderly as couples who move to the city call their parents to the city.[50] There have been reports of an increase in the number of cases in which the daughters of married

[50] Based on interviews in March 2020

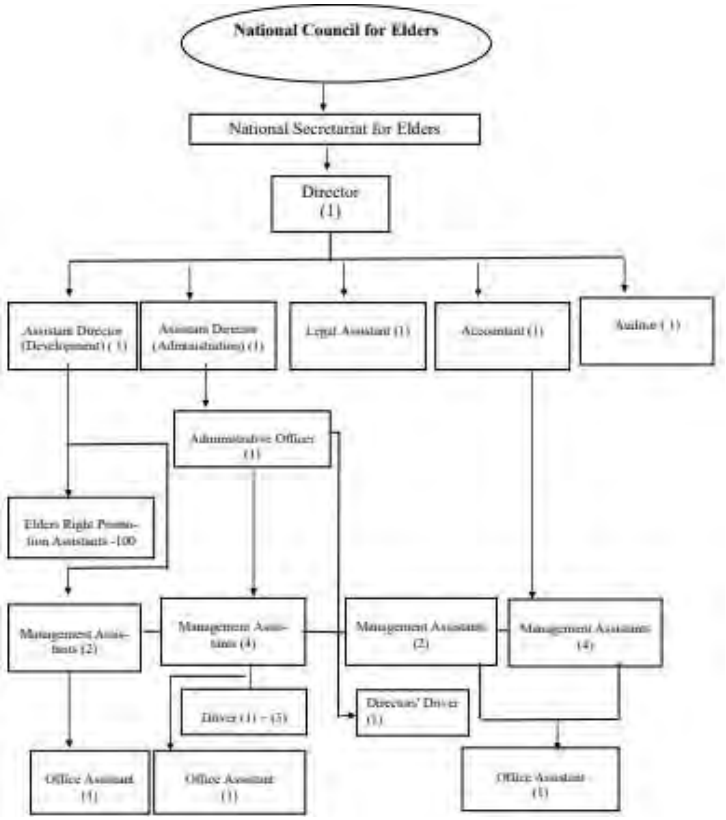
couples bring their mothers to their homes and fathers live alone, spurring the increase in dementia.

According to Mrs. Chandima, the head of the Western Province DSS, the following issues were raised; (1) although the NSE, the central government DSS, and the state government DSS are currently providing care for the elderly, many operations overlap and resources (time, people, funds, etc.) are not used appropriately; (2) the number of staff caregivers who provide care at elderly facilities is insufficient; and (3) the concept of "Self-Sustaining Home" in which healthy elderly people and those who need nursing care help each other is yet to spread.[51]

4.2.2 Administrative Role (National and Local Governments)

(1) National Secretariat for Elders (NSE)

NSE under the Ministry of Social Welfare is the main organization in Sri Lanka dealing with the welfare of the aged. Protection of Elders Rights Act No. 9 of 2000 (Section 9, 2000, Law for the Protection of the Rights of the Elderly). The National Council for Elders (NCE) is the highest decision-making body on the issue of the elderly. The term of office of NCE is 3 years, and it is composed of 16 persons such as staff of the ministry in charge, staff of organizations providing services for the elderly, and specialists such as doctors. The Rights of Elders Act Number 9 of 2000 and Protection of the Rights of Elders (amendment) Act Number 5 of 2011 stipulates that the Director of the NSE shall serve as Secretary Director of the NCE.



Source: NSE materials (Number of people in parentheses is the number of people placed)

Figure 4.2.2 NSE Organization Chart

[51] Based on interviews in March 2020

According to interviews as of March 2020, there are several vacancies, including Assistant Director, Legal Assistant, and others in the NSE Administration Department. In addition, there are 5 drivers and 140 candidates for Elders' Right Promotion Officers (ERPO) [Their salaries are paid by oher ministries and agencies, not by NSE, outside the organizational structure.] who are not included in the organizational chart.

The ERPO, which protects the rights of the elderly and takes charge of countermeasures, consists of 100 personnel, of which 96 are assigned; 14 are in charge of the central government (Head Office), 2 are in charge of Province [* in charge of communication with Province officials, they are not Province officials], 20 are in charge of Districts, and 60 are in charge of Divisions. A person in charge of a Province mainly communicates with its ERPOs in charge of Districts, and develops the activity policy for the ERPOs in charge of the Districts. A person in charge of a District is then a supervisor of itsERPOs in charge of the Divisions, and manages and supports the ERPOs in charge of the Divisions. The ERPO in charge of the Division carries out on-site surveys related to the elderly, monitoring of facilities for the elderly, support for the elderly committee, visits to the homes of the elderly, planning and implementing educational programs (pre-retirement programs, school partnership programs, nutrition and health programs, etc.), and planning and implementing events for the elderly (exercise programs, Elderly People's Day, etc.).

The system of ERPO started in 2005, and all of them were ERPOs in charge of Division at first. As the scope of ERPO operations expanded over the years, the role of managing ERPOs became necessary, and staff with long experience were promoted. The current recruitment requirements for ERPO are a bachelor's degree and a 2-year eldercare program administered by the National Institute for Social Development (NISD).[52]

Each ERPO performs its duties in accordance with the job description in Table 4.2.1. Regardless of the person in charge, ERPOs are required to perform a variety of tasks related to the elderly. Therefore, ERPOs basically enhance professional skills through work, mainly on-the-job training (OJT). On the other hand, all ERPOs are encouraged to take a diploma course for the elderly (night), and in 2020, about 20 persons are expected to take the course.[53]

Table 4.2.1 ERPO Job Description

Responsibility range	Implementation of NSE projects in cooperation with other agencies under MoWCASS - Track, assess and coordinate NSE projects and programs at the field level - Follow-up of NSE-related projects and programs at municipality level - Track, assess and coordinate NSE projects and programs at the field level - Identifying problems with older people, communicating identified problems to stakeholders, and implementing and following up on problem solutions - Fostering public awareness of NSE programs and progress - Responding to other NSE Director instructions - Activities related to the planning and implementation of new services in parallel
Duty contents	1. Planning in the appointed district 2. Map of districts, map update management

[52] The number of employees who want ERPO is less than other public organizations. The main reason is that NSE employees are covered by employee funds rather than government pensions. Details are described in 4 -4.
[53] Based on interviews with NSE in March 2020. If there is a seminar related to the work, you can participate.

	3. The Elder Right Protection Act, No. Support the activities and decision-making of NSEs established under 09 of 2000 4. Coordinating the delivery of services to older people at the national, state, provincial, county, and district levels 5. Direct application support to mediation committees from older persons not being cared for by children 6. Supporting the creation of IDs for people aged 60 or older, and educating central and state governments and NGOs 7. Provision of contact lenses to all low-income older persons in the county 8. Promotion of the establishment of the Elderday Center at the GN level for the elderly to be satisfied with their lives 9. Promotion of establishment of an elderly people committee at the county level and GN level 10. The Clause 16 of Elder Right Protection Act, No. Enrollment recommendations for providers of elderly support under 09 of 2000 11. Implementation of awareness-raising programs on senior services at the GN level and municipality level 12. Planning and implementation of workshops on services for the elderly conducted by central government, state government, and NGO staff 13. Implementation of surveys and censuses related to support for the elderly and the elderly 14. Support for the publication of books and magazines published by the NSE, and distribution of books and magazines published by the NSE to people 15. Organize and conduct a ceremony to celebrate International Aged Day on October 1, and provide guidance to rural communities 16. Submit monthly plans through the 25th of each month, run programs through the 5th of each month, submit activity reports 17. Broadcast to the Director of the NSE and the Provincial Director of Social Services and provide the County Assistant with monthly progress reports up to the 5th of each month 18. Other NSE and state level social service sector related programs and project work 19. Other duties appointed by the assistant director of a county

Based on NSE data

Source: JICA Survey Team

Table 4.2.2 Example of ERPO Operations

Name	Ms. Miuchala Maddepola
Summary	County ERPO Currently responsible for four nursing homes in the Gampaha region 4 facilities registered in western state, aiming to register with central government (NSE focus facilities) Support is provided to elderly people in cooperation with DSD officers, startup support officers, and agriculture support officers.
Job profile	<facility management> Visit facilities once or twice a week Monitor during visits The contents of the monitoring included the contents of the meals (Breakfast, lunch and dinner), the health conditions of residents, access to medical care, conditions of the building, conditions of care, security, etc. The date, content, and name of the monitoring should be recorded in the records of the facility. <home visit> Go to the home of the elderly who received an emergency call through the hotline and check the situation. provide in-hospital support and follow-up for people with no relatives Visit homes (I'm going.) to check business trends and challenges Check for illicit government subsidies (There were cases in which families with luxury items such as cameras received support funds for low-income earners.) <Support of the Elderly Committee> 100,000 rupees/month of financial support is provided as an initial treatment. Supporting Events and Participating as Government Representative (13 Year Old Committee Awards 87 Year-Old Man) As an educational activity, as a facilitator, we hold workshops at schools to teach children how to interact with the elderly.

Based on JICA Survey Team field surveys and additional hearing

Source: JICA Survey Team

1) Budget

The NSE is funded by the national Treasury Fund, a budget allocated from the MoWCASS, and by a portion of its own program, the Social Security Fund. According to budget documents provided by the NSE for the action plan from January to April 2020, the Social Security Fund is 2 billion rupees and the National Tresury Fund is 106.8 million rupees. The Social Security Fund is a program started in 2016 by the NSE with a Treasury Fund. The balance of the Social Security Fund is as follows. Disbursements from the fund began in 2019.

Table 4.2.3 Balance of Social Security Funds (rupee)

Year	Revenue	Item	Expenditure	Item	Total (Revenue - Expense)
2016	427,704,100.00	Reserve at least 2,000 rupees	250.00	Bank fees, etc.	
2017	471,094,400.00	Reserve at least 2,000 rupees		Bank fees, etc.	
	52,991,473.11	Interest	160,305.00		
2018	485,467,300.00	Reserve at least 2,000 rupees		Bank fees, etc.	
	83,336,973.34	Interest	1,000.00		
2019	502,813,900.00	Reserve at least 2,000 rupees		Project	
	166,032,975.09	Interest	287,432,837.43	Expenditure	
2020	34,990,700.00	Reserve at least 2,000 rupees		Project	
	42,911,339.32	Interest	-	Expenditure (-1/31)	
	2,267,343,160.86	Total	287,644,392.43	Total	
					1,979,689,768.43

Based on interviews with NSE

Source: JICA Survey Team

2) Results of NSE Activities

According to internal documents of NSE, the items of NSE activities and their results are shown in Table 4.2.4.

Table 4.2.4 NSE Activities and Results

Item	Achievement
Support for the establishment of the Elderly Committee	11,550 senior citizen committees
Support for facilities for the elderly[54]	306 facilities, 8,555 senior citizens, 2,000,000 rupees
Provision of equipment for the elderly (eyeglasses and hearing aids)	-
Implementation of the conciliation committee	-
Establishment of day centers	About 150 day centers, 2,500,000 rupees
Implementation of medical clinics for the elderly	2.97 million rupees
Training, education and research for the elderly	-
Implementation of programs before retirement	-
Provision of allowances for low-income people aged 70 and older	416,667 people , waiting list (137,771 persons)
Provision of benefits for persons aged 100 years or older (5,000 rupees per person per month)	386 people , waiting list (204 persons)
Issuance of ID cards for seniors 60 and older	800,000 persons

[54] According to the hearing with NSE in January, 2020, there is no sense of budget necessary for the establishment of 1 facility for the aged such as 50 persons. We would like to establish model facilities for both government and private sectors in each state (Planned to be implemented with WB support). At present, it is a service for independent people, but in the future, they are thinking of a service for elderly people of (Bedridden, wheelchair, dementia, etc.) who are not independent.

Item	Achievement
20,000 rupee loans for self employment support activities	612 cases
Provision of caregiver services	Not Implemented (Assuming training of 1,000 people with WB support)
Implementation of Health Camp (Monthly health checks for seniors at the DS level)	-

Based on interviews with NSE

Source: JICA Survey Team

In response to COVID-19, the NSE also paid special benefits to those aged 70 and older. The target is not only the elderly who are already receiving the elderly allowance, but also the elderly who are applying for the elderly allowance, and the elderly who are 70 years old or older who have not applied for the elderly allowance but are recommended by the elderly committee.

Table 4.2.5 Special Allowance for Aged 70 or older of 5,000 rupees

#	District	Confirmed Receipients	Waiting List	Number identified by village committees	Total Receipients	Total Paid	Total Amount	% Paid
		A	B	C	D= (A+B+C)	E	F=D*E	
1	Puttlam	16,229	6,110	1,789	24,128	24,085	120,425,000	99.82
2	Kurunegala	38,655	13,716	6,979	59,350	58,596	292,980,000	99
3	Badulla	25,036	4,649	2,552	32,237	30,054	150,270,000	93.23
4	Monaragala	11,227	3,065	332	14,624	14,363	71,815,000	98
5	Kegalla	17,163	8,686	3,472	29,321	28,880	144,400,000	98.50
6	Rathnapura	26,206	12,881	1,760	40,847	38,226	191,130,000	93.58
7	Matale	11,812	4,822	638	17,272	17,029	85,145,000	98.59
8	Mahanuwara	25,873	7,179	2,374	35,426	35,353	176,765,000	99.79
9	Nuwara Eliya	18,579	9,722	4,553	32,854	32,754	163,770,000	100
10	Hambantota	12,061	7,919	3,055	23,035	23,035	115,175,000	100
11	Matara	20809	8640	2342	31791	31,609	158,045,000	99.43
12	Galle	24,528	12,342	1,169	38,039	38,039	190,195,000	100
13	Kaluthara	27,028	10,895	1,370	39,293	39,293	196,465,000	100
14	Colombo	18026	7897	8958	34881	34,424	172,120,000	98.69
15	Gampaha	30,873	16,286	4,031	51,190	51,190	255,950,000	100
16	Anuradhapura	18,871	4,699	956	24,526	24,236	121,180,000	99
17	Polonnaruwa	5,662	4,427	1,973	12,062	11,652	58,260,000	96.60
18	Batticaloa	13,211	1,840	841	15,892	15,834	79,170,000	99.64
19	Ampara	14,859	3,529	2,826	21,214	20,736	103,680,000	97.75
20	Trincomalee	6,966	1,637	1,370	9,973	9,878	49,390,000	99.05
21	Jaffna	19,910	3,523	542	23,975	23,940	119,700,000	99.85
22	Vavuniya	3,315	1,257	181	4,753	4,753	23,765,000	100
23	Kilinochchi	3,823	725	372	4,920	4,909	24,545,000	99.78
24	Mannarama	2,572	627	231	3,430	3,430	17,150,000	100
25	Mulathiv	3,373	647	161	4,181	4,179	20,895,000	99.95

Based on NSE data, As of May 22, 2020

Source: JICA Survey Team

3) NSE's Engagements in Central Province[55]

The NSE places ERPO in each Dstrict. For example, there are 19 Divisions in Kandy District, and basically

[55] From the interview with Kandy's ERPO and SSO in September 2020.

1 ERPO is dispatched to each Division, and 2 SSOs correspond to 2 Divisions where ERPO is insufficient. Its activities are the same as those of the NSE Headquarters, including the provision of 2000 rupees to the elderly, support for holding events, and economic support for facilities for the elderly. Facilities for the elderly and residents throughout the Central Province are as follows (Kandy 13 facilities, 360 persons, Nuwara Eliya 3 facilities, 40 persons, Matale 3 facilities, 94 persons). Its budget is allocated from NSE headquarters based on previous year's performance and proposals. Provincial ERPO visits NSE's Colombo headquarters once every three months to report on progress. ERPOs in each Province have a monthly meeting.

Issues recognized by ERPOs and SSOs are as follows.

- Necessity of caregivers nurse - the fact that there are no managers or caregivers with sufficient skills in nursing homes.
- Lack of opportunities for elderly care, nutrition, and other related training at nursing homes
- Inadequate wage and job security for managers, caregivers and other staff
- Monitoring of facilities for the elderly by ERPO or SSO is irregular, and monitoring is conducted only when requested by facilities for the elderly.

(2) Department of Social Service (DSS)

The DSS[56] is the Department of Social Welfare responsible for overall social services in Sri Lanka. Specialized personnel, called Social Service Officers (SSOs[57]), perform their duties at the central, provincial and divisional levels respectively, to achieve the following objectives[58]. The DSS mainly targets people with disabilities, but it also includes people with disabilities due to aging, so it has an aspect of supporting the elderly.

Elderly Care-related Job Profile of SSOs

- Ensuring fair opportunities for persons with disabilities
- Providing financial security for persons with disabilities and minimizing psychological dependence
- Supporting effective participation of persons with disabilities in society
- Developing individuality, skills, and creativity as well as the physical and mental activities of persons with disabilities
- Educating people who provide services to people with disabilities about their knowledge, skills and attitudes
- Supporting volunteer organizations that provide services for people with disabilities

[56] After the 2020 August general election, there was a reorganization of ministries and DSS was transferred to MoH.
[57] SSO requires a bachelor's degree or National Institute for Social Development (NISD) certificate of completion of a 2-year eldercare program, which is less stringent than ERPO.
[58] Source: Department of Social Services Website.

Table 4.2.6 Elderly Care-related DSS Activities and Achievements (2018)

Item	Achievement
Community-based rehabilitation	14,503,000 rupees
Support for the visually impaired (Young people, teachers, etc.)	60 teachers participated in the workshop, 7.33 million rupees
Program for providing housing for the elderly in cooperation with hospitals (Support for living bases for the elderly)	About 10 persons per month (Hospitals such as Colombo Kandy)

Based on DSS Performance Report (2018) and additional hearings with DSS

Source: JICA Survey Team

Recruitment of SSO is carried out by the ministry[59], and the specialty as an SSO is polished after assignment. SSO must report to the Secretary of the Ministry of Social Welfare and the Director of Social Services through an undersecretary of the province or an undersecretary of the Division.

Table 4.2.7 Elderly Care-related SSO Job Description

Responsibility range	Government policy and program implementation, supervision, coordination, and follow-up for people in extreme poverty, special disabilities, and vulnerable situations - Planning, implementation, planning and coordination of all social service and welfare related programmes - Collaboration with other teams involved in implementing, planning, and coordinating social service programs - Post-Deployment SSO, Inexperienced SSO, Volunteer Training and Support - Prepare quarterly, semiannual, and annual progress reports and share them with social directors and other relevant organizations. - Proposals for social services and social welfare assistance
Job profile	1) Activities based on the following laws and regulations a. Protection of the rights of people with disabilities, No. 28 of 1996 (1996 Section 28 Protection of the Rights of Persons with Disabilities) b. Registration of volunteer social services organizations, No. 31 of 1980 , (Amendment, No. 8 of 1998) (1980 Section 31 Registration of volunteer social service organizations, amended 1998 Section 8) c. Elderly rights protection act No. 9 of 2000 (2000 Section 9 Protection of the Rights of the Elderly) d. Social security board act No. 17 or 1996 (SECTION 17 1996. SOCIAL SECURITY FUND) e. Prevention of domestic violence Act, No. 34 of 2005 (2005 Section 34 Prevention of Domestic Violence) f. National policy on disability (National Policy on Persons with Disabilities) g. Laws and regulations to protect right to access the places by the disabled: Act No. 26 of 1996 to protect the equal rights and access rights of the disabled provided by the United Nations on 20/12/1993 (December 20, 1993 UN Regulation of 1996, para. 26, protecting access to all parts of the elderly based on the protection of impartiality and access rights for persons with disabilities) h. Disaster management act, No. 13 of 2003 (Disaster management in 2003 para. 13) i. Loitering Ordinance (Tramp Act) j. Sports clubs and social clubs act, No. 17 of 1975 (1975. Section 17. Sports clubs, social clubs) k. Any other acts regarding social service and welfare that many come into force in the future (Future laws and regulations related to social services and welfare) 2) Implementation of community-based rehabilitation programs for persons with disabilities 3) Identifying social and family environmental issues and planning counseling and awareness-raising programs 4) Active collaboration with support programs implemented by the private sector to ensure that persons with disabilities have fair access to public facilities and service centres 5) Protection of the rights of the elderly and securing their welfare 6) Supervision and Guidance of Community Organizations for Community Development 7) Data Collection for Research for Human and Community Development 8) Coordinating resources with international organizations and NGOs to promote local and national development 9) Conduct and promote participation in awareness-raising sessions on social security programs 10) Proposals for medical and equipment needs to the Social Services Department, Department of Social Welfare, and the President's Secretariat

[59] The organizational shakeout around the beginning of 2021 transferred both NSE and DSS to State Minister of Primary Health Care, Epidemics and Covid Disease Control, State Ministry from MoH.

	11) Implementation of programs to obtain compensation and welfare from the government for various forms of social violence 12) Achieve social development and welfare goals by training and mentoring SSO and volunteers with expertise 13) Holding quarterly, semiannual, and annual progress reports and meetings and discussions with all stakeholders through the vice-ministers 14) Collecting data on all social service organizations and strengthening their relationships with social networks 15) an survey and report of the social problems of a sports club or social club that occur when recommending a license 16) Watch electronic and print news and take action when problems arise 17) If no district level SSO is appointed, the SSO above it is responsible 18) Identify recent social problems and devise solutions

Based on DSS data

Source: JICA Survey Team

Hospital intervention program is an independent program for the elderly by DSS. The program helps elderly people find a place to live after discharge from hospital, involving 57 SSOs, working with hospitals and covering 56 Divisions.[60] After hearing opinions from elderly people who meet the requirements (no family, no work, no family support), they arrange for a free facility for the elderly. Hospitals in Colombo and Kandy Districts support about 10 people every month.[61]

State governments also have DSSs, which provide more support than the central government. For example, the DSS in Western Province in charge of Colombo, Gampaha, and Kalutara Districts supports the followings.

- Poor and undependable people living in Western Province
- People with physical, mental, and social disabilities
- Elderly persons with no family
- Women affected under the Wanderer Ordinance
- Voluntary groups that provide services for the elderly and disabled

Table 4.2.8 Activities and Achievements of Western DSS (2016)

Item	Achievement
Educational support	6,414 people, 38,058,000 rupees
Support for facilities for the disabled	19 facilities, 12,874,050 rupees
Support for facilities for the elderly	30 facilities, 9,691,666 rupees
Supporting materials and equipment for people with Disabilities	1,610, 9,602,230 rupees [62]
Provision of contact lenses	161 people, 2,475,040 rupees
Provision of eyeglasses	9,835 cases
Support for Leprosy	311 people, 621,420 rupees
Support for cancer and thalassemia (anemia)	4,687 people, 26,219,800 rupees
Surgical support	116 people, 5,256,940 rupees
Support for Tuberculosis	202 people, 283,500 rupees
Entrepreneurial support	40 people, 383,500 rupees

Based on DSS Performance Report (2018) and additional hearings with DSS

Source: JICA Survey Team

[60] Doctors prepare medical certificates and conduct hearings for SSO. The interview items for the elderly are name, address, age, telephone number, divisional secretary, GN, guardian, medical history, etc. Based on the hearing with SSO in March 2020.
[61] Based on an SSO hearing in March 2020.
[62] 2016 Based on the number of 11 types of materials and equipment. 1.185 crutches, 2. 425 wheelchairs, 3. 75 tricycles, 4. 295 handrests, 5. 45 white crutches, 6. 150 walkers, 7. 310 wheelchairs with toilets, 8. 25 water mattresses, 9. pneumatic mattresses, 10. 55 crutches, 11.4 crutches, 50 crutches.

(3) Samurdhi Division (Department of Samurdhi Development: DSD)

The DSD is a Sri Lankan cash distribution department in the Ministry of Social Welfare. Based on the Divineguma Act No. 1 of 2013 (Section 1 of the Poverty Act), 5 related organizations were integrated and established, and various support for low-income people (6,000 rupees/month) is provided on a household basis.[63] [64] This support includes low-income elderly people. As of 1995, there were about 1.7 million such households, but as of 2017 the number had decreased to 1.4 million (1,385,516 persons).[65] In 2015, about 40 billion (40,209,736,640) rupees were disbursed for low income and vulnerable people.

Low-income earners' allowances, one of the main activities, are provided to households through the People's Bank or the Ceylon Bank by DSD employees. The amount of allowance varies depending on the number of households. As shown in the table below, support is provided to help target households get out of the situation by making a deposit or joining a fund in the future.

Table 4.2.9 Monthly Allowances for Low Income Families by Number of Households

Number of households	Allowance	Future deposit expenses	Cost of social security fund [66]	Home purchase cost [67]	Remaining cost of living
2 persons	1,500 rupees	100 rupees	100 rupees	80 rupees	1,220 rupees
3 persons	2,500 rupees	200 rupees	100 rupees	80 rupees	2,120 rupees
4 or more	3,500 rupees	300 rupees	100 rupees	80 rupees	3,020 rupees

Based on Samurdhi Performance Report (2015) and additional hearings

Source: JICA Survey Team

(4) Department of Pensions (DP)

The DP is a public pension division of the Ministry of Social Welfare. It was established on December 23, 1970, based on Paragraph 2 of the Pension Law of 1947.[68] In 2017, 600,867 people received some form of pension from the DP, with retirement payments amounting to Rs 20,737,220,000 and 43,173 eligible.[69] According to the latest information, the number of recipients is increasing.

Table 4.2.10 Pension Classification as of January 2020

Pension classification	Number of recipients	Amount paid (Rs.)
civil servant	346,312	10,394,918,458.13
widow and orphan	186,295	4,314,833,897.45

[63] The five organizations are the Samurdy Organization, the Southern Development Organization, the Outback Development Organization, and two divisions, the Kandy Farming Restoration Division and the Samurdy Commission Division.
[64] The baseline is Rs. 6000/man-month income, based on scientific calculations, taking into account various indicators (Education level, ethics, personal and family economic status, home status, etc.). From the interview with the assistant director of the department.
[65] The average number of Sri Lankan households is 3.8. Dividing the number of eligible households by the number of households, 364,601 households are eligible.
[66] The Social Security Fund also provides a guarantee of 10,500 rupees per month for outpatient expenses and 10,500 rupees per month for 2 years for student scholarships.
[67] There is a 1/331 chance of winning. From the interview with the assistant director of the department.
[68] Pensions in Sri Lanka have a long history, with some systems existing since the British colonial period. From the website. http://pensions.gov.lk/index.php?option=com_content&view=article&id=20&Itemid=153&lang=en
[69] The payment for the payment of 9 states is 169,747,750,000 rupees, and the subject number is 591,360 persons. Western states have a large influence on the national economy with more than 1/3 of the total amount and the number of people

Pension classification	Number of recipients	Amount paid (Rs.)
Army	101,656	3,698,566,110.54
faculty member	3,151	110,776,356.75
local government	4,101	86,277,945.71
Total	641,515	18,605,372,768.58

Source: Department of Pensions (2020) http://pensions.gov.lk/images/statistics/2020/February_2020/pdc_feb.png

(5) National Secretariat for Persons with Disabilities (NSPD)

The NSPD is an organization that supports persons with disabilities caused by congenital or acquired diseases. As disabled people get older, there are also elderly people with disabilities. The Protection of the Rights of Persons with Disabilities Act No. 28 of 1996 (1996 Paragraph 28 : Protection of the Rights of Persons with Disabilities , revised in 2016) was established and the Welfare Benefits Act, No. 24 of 2002 (SECTION 24 2002. WELFARE LAW) was established as the activity guideline. It requests the budget to the Ministry of Social Welfare and uses the allocated funds for independent activities. Current challenge is lack of funding.

NSPD has two main roles. One is to formulate and submit policies on persons with disabilities to Parliament, and the other is to provide direct assistance to persons with disabilities. A doctor diagnoses a person with a disability and issues a certificate for the person with a disability. Then various types of support are provided for the person with the disability with certificate.[70] At the field level of Divisional Secretariat, it cooperates and shares with SSO which supporta for persons with disabilities.

There is a public (operation entrusted to private sector) facility for the disabled, which was established in 1960, called the Victoria Facility. Admission to the facility is free, and its staff are not required like ERPO or SSO. In addition, there are private facilities for persons with disabilities, specialized facilities for dementia, and multiple day centers to provide support for persons with disabilities.

Table 4.2.11 NSPD Activities and Achievements

Item	Achievements
Research and policy recommendations on the protection of the rights of persons with disabilities	Draft, submit, amend 1467/15 and 2006 para. 10 17, finalize.
Support for housing for the disabled up to 250,000 rupees for new Housing and up to 150,000 rupees for renovation (landowner)	81 (completed), 266 (Schedule), 19,658,172.00 rupees
Support for Victorian Public Facilities	165 persons with disabilities, 84 employees, 9,000.00 rupees for facility maintenance, etc.
Support for the Care Center for Persons with Disabilities	9 Centers
Supporting the development of skills for people with disabilities	23 persons
Financial support for kidney disease patients	23,228 persons
Support for starting a business in single-parent households	574 households
Up to Rs. 25,000 Support startups by people with low-income disabilities	412 people, 10,053,057.00 rupees
Educational support for up to Rs. 10,000 children with disabilities	581 people, 3,957,431.08 rupees
Medical support for up to Rs. 20,000 people with disabilities	549 people, 8,888,806.40 rupees
Payment of Rs. 3,000/month allowance to people with low-income disabilities	32,000 people, 1,152,000.000 rupees
Support for materials and equipment related to the activities of people	50,888 for eyeglasses, 387 for wheelchairs, 128

[70] The materials and equipment will be procured through a technical committee attended by doctors and other experts. In addition, due to budgetary constraints, various types of support are limited to those aged 60 or younger.

Item	Achievements
with disabilities	for crutches, 108 for forearm crutches, 21 for walkers, 8 for hearing aids 20 special devices, 101 mobile services, 13,030,892.25 rupees

As of December 31, 2018

Source: JICA Survey Team prepared from NSPD Corporate Plan 2018 -2020 (2019), Ministry of Social Employment, Welfare and Kandian Heritage Performance Report 2017

4.2.3 Roles and Responsibilities of Service Providers

(1) Social Security Services

Although there is no clear definition of social security in Sri Lanka, the ILO phrase "Social security is the basis for the well-being of all workers, families and communities" is informative.[71] Social insurance, medical insurance, and cash benefits are available to guarantee a minimum standard of living for the people of Sri Lanka. Social insurance can be organized as follows, with reference to examples in Japan.

Table 4.2.12 Social Insurance in Sri Lanka

Type of insurance in Japan	Insurance in Sri Lanka	Insurance characteristics of Sri Lanka
Medical Insurance (universal insurance)	×	Not present. Public hospitals do not require the use of the system, with no individual burden.[72]
Medical Insurance (Consumer)	△	Optional. The rich people join.
Medical Insurance (Corporate)	△	Optional. A company enrols its employees.
Pension Insurance (nation)	×	Not present. Carry out savings
Pension Insurance (civil servant)	○	After mandatory retirement, 90% of the monthly salary in the final year will be paid (defined benefit plan).
Pension Insurance (private enterprise)	○	The "employee reserve fund" (EPF) is paid 8% by the employee and 12% by the company, and after the mandatory retirement age, the yield is added to the accumulated amount (defined contribution type).
Long-term care insurance	×	Not present. The cost of nursing care is borne by the patient and the family. Based on government and state support and Dana (endowment) from residents, individuals and families can receive services free of charge or at low cost. Facilities targeting the rich are expensive.
Employment insurance	△	There are two related points. - Employees Trust Fund ETF: The Employees' Trust Fund, No. 46 (1980) Employers can transfer 3% of a Worker's salary to a Worker's account, and if the Worker becomes unemployed, the Worker can withdraw the amount and interest that the Employer paid to the Worker's account - The Retirement Allowance Act, PAYMENT OF GRATUITY ACT, No. 12 (1983), allows workers to receive benefits for 5 years or more. The amount of retirement allowance depends on monthly or daily salary. a. Salaried Employees: Half of Last Salary b. Daily wage employee: 14 days
Workmen's compensation	△	Optional.[73] The percentage of compensation is limited to 20 ~ 100% depending on the

[71] ILO in Srilanka https://www.ilo.org/colombo/areasofwork/social-security/lang--en/index.html.

[72] In Sri Lanka, regardless of age, government public hospitals offer free admission. Therefore, there is little incentive for individuals to take out health insurance, except for the middle class and the rich who use private hospitals.

[73] JETRO (2017) According to a research report on Sri Lanka's health care and insurance system, it is desirable that enterprises should encourage and bear the cost of health insurance for their employees based on the Industrial Accident Compensation Regulation, 1934 No 19. The Sri Lankan Insurance Commission under the Ministry of Finance controls and supervises the

Type of insurance in Japan	Insurance in Sri Lanka	Insurance characteristics of Sri Lanka
insurance		degree of disability or disease. Businesses those who do not subscribe to insurance shall bear the actual costs.

Source: JETRO (2017), Iseki (2005), International Labour Foundation Website, KUNO Yasunari Certified Public Accountant Office Website, etc.

World Bank (2019) identifies specific challenges for Sri Lankan government's insurance scheme.[74] The Public Servants Pension Scheme (PSPS) has a heavy financial burden because of its extensive coverage. There are also problems with the mechanism itself, such as the difficulty of converting to an appropriate purchasing power parity value after retirement and the magnitude of the loss from leaving the public sector (major barrier to movement to the private sector). On the other hand, the scale of the Employees Provident Fund (EPF), which is a pension system for private companies, is small. The 2016 average was 579,000 rupees, which equates less than 3,000 rupees per month for a life expectancy of 20 years or more after retirement, below the national poverty standard. In addition, there are other problems such as the elderly who are not covered by the pension plan, those who are in the waiting list for elderly benefits, and those who have changed jobs between sectors and have multiple records and are not covered by insurance. Public medical care is available free of charge for medical insurance as mentioned above. Cash transfers are handled by the Samurdy division and the NSE.

(2) Social Welfare Services

1) Nursing Care (including Preventative) Services

[Prevention]

Sri Lanka does not have a care prevention service, but there are day care centers and elderly committees that have functions that lead to care prevention. The day care centers aregathering place for elderly people in Sri Lanka during the day. For example, H. P. Gooneratne at the HelpAge Day Care Center stated that, senior citizens interact with each other through activities such as making lamp wicks, flower pots, envelopes, recreation, and religious and cultural activities. Various activities of the elderly people committee also fulfil the function of the nursing care prevention.

In the field of care for the elderly, the MoH is implementing the "Happy Village Project". Their main activity is to prevent non-communicable diseases (NCDs) by using people aged 50 or over who are about to retire or who have reached retirement age as volunteers, and this has led to prevention of long-term care. In 2019, JETRO and the Young Owners' Association of Sri Lanka (COYLE) jointly launched the "Sri Lanka Health Management Awards" to honor local companies engaged in Japanese-style health management.

[Nursing Care Services]

Nursing care services for the elderly in Sri Lanka can be categorized as follows:. In Sri Lanka, people can

regulation of insurance companies. Only publicly listed companies (public company) are allowed to engage in insurance business.

[74] World Bank "SRI LANKA DEVELOPMENT UPDATE" (2019), p. 31.

receive free or inexpensive nursing care services. However, there are not enough facilities to provide services to the number of elderly people, and a system to provide appropriate services to elderly people living at home has not been established. As of 2020, there were 306 facilities for the elderly (3 by the central government, 3 by the provincial governments, and 300 by the private sector) in Sri Lanka.[75] In 2014, there were 242 facilities with 8,000 residents (by H.R. Anulawathie Menike (2015)), so it is assumed that the number of facilities has increased by 64 and the number of residents has also increased.

Moreover, the providers of long-term care services are changing from inside (at home) to outside. WB (2008) points out that Sri Lanka, as other Asian countries, is also shifting from family care to care based on external services due to several factors (For example, the decline in the number of children, generational differences in thinking, women's social advancement, etc.).[76] [77]

Table 4.2.13 Long-Term Care Services Available in Sri Lanka

Nursing care service	Service provider	Expenses	Target
Facilities for the elderly	Business	Medium to high price	A person who has financial ability and desires the high quality of care services
	Charity and NGOs central and state governments	Free to cheap	Women with no relatives
			Persons with no relatives or low income
Facilities for the disabled	Business	Medium to high price	People who are sick or disabled, have financial means, and want high quality care services
	Central government, State government, Charity and NGOs	Free to cheap	People who are sick or disabled, have no relatives, or have low income.
Dementia facility	Business	High price	Those who have been diagnosed with dementia in a hospital, can afford it, and want high-quality care.
	Central government, State government, Charity and NGOs	Free to Medium	Those who are diagnosed with dementia at a hospital, have no relatives, or have low income.
Day care	Business	Medium to high price	People who want to implement care prevention
	Elderly Committee, Charity and NGOs	Free to cheap	Those who cannot move into the facility or who want to do various activities during the day.
Home care	Personal caregiver/maid/nurse	High price	People who can afford and want high-quality care
	central and state governments	Low to medium price	Those who do not have vacancies in facilities for the elderly and who do not want to move in.
	Family	Free	People who are unable to move into an elderly facility because there are no vacancies, people with low incomes, and people who have family members who can provide care

Source: JICA Survey Team

a) Supervisory and Administrative Agencies

Central government's supervisory and administrative agency is the National Secretariat for Elderly under

[75] Source: NSE
[76] World Bank (2008) Sri Lanka Addressing the Needs of an Aging Population
[77] Nakai (2014) examines the income-related factors and lack of understanding of the system, as well as disagreements among caregivers, family members, and non-caregivers and the traditional idea of patriarchy. It can be inferred that the difference of intention between elderly persons themselves and their families and the idea of patriarchy affect the resistance to external services in Sri Lanka.

the Ministry of Social Welfare, and the state government's supervisory and administrative agency is Social Services Unit under the Ministry of Social Welfare.[78] Service providers submit a notification of registration to a supervisory or administrative agency, and whenapproved, a registration certificate is issued. Currently, it is necessary to register with the central and state governments in order to receive financial support, but the NSE aims to unify the registration systems to the central government. However, some businesses provide nursing care services without registration.[79] In addition, many businesses provide services free of charge or at a low cost because they receive financial support, but some business-oriented facilities for the elderly charge high fees mainly to the middle and wealthy elderly.

For facilities for the elderly, the Sri Lankan Standard (SLS) 1506: 2015 of the Sri Lankan Organization for Standardization defines detailed requirements not only for the location, facilities, equipment, but also for the structure, meals, staff, and meetings.

b) Facilities for the Elderly

Table 4.2.14 Classification of Institutions for the Elderly

Classification	Features
Government system	Support elderly people who are independent but have no relatives. The national and state governments pay the salaries of those working at the facility.
Private sector paid services	Pursuing profit, the sector supports elderly people who have financial capacity and seek high quality of care. Some name their business as LTD.
Private sector (Charity and NGOs)	Operate the facilities in accordance with the founding principles of each organization and support the elderly who meet the conditions.

Source: JICA Survey Team

Facilities for the elderly are broadly divided into three types. The private sector (businesses) mainly provides services for the wealthy and places importance on the quality of care. The private sector (charity organizations and NGOs) provides close personal care based on the principles of their own organization. The government sector provides services to the independent self-supporting elderly through central and state government officials.

The private sector (businesses) whose outline was confirmed through desktop research includes the following facilities. All of their websites show high quality with facility photos and service menu. (See detailed information of the Private Sector in Attachment-1)

[Elders' Committee]

As a Sri Lankan government policy, elders' committee was established in each GN, and elderly people are encouraged to participate in the committee. In the Gampaha District, for example, there are 91 elders' committees out of 101 GNs, with many elderly people joining unless there is a specific reason not to join.

[78] This difference is due to the difficulty of integration between central and state functions (Interview with the Director of Western State), since the NSE was established in 2000, while state governments have been providing elderly services since the 1980s.

[79] Reasons for non-registration include cases in which registration is not possible because necessary documents cannot be obtained or prepared, and cases in which registration is intended to prevent the income and expenditure of facilities from being disclosed through reports to supervisory and administrative organizations and visits to staff (From a hearing with the Director).

Table 4.2.15 Examples of the Elderly Committee

Name of the facility	Biyagama East Elder Committee (Gampaha Province)	Saviya Elder Committee (Colombo Province)
Activities	Conducting religious programs, visiting temples and related facilities, paying visits and condolence money at funerals (Collect 200 rupees to 300 rupees per community member to family members of deceased members), and participating in health education programs conducted by NSEs.	Implementation of religious programs, visits to temples and related facilities, visits, participation in health education programs conducted by the NSE, recreation conducted by the NSE, and participation in competitive events.
Participants	55 (53 over 60 , 2 over 55 -60)	60 (All 60 years of age or older)
regional support	Admission fee : 1500 rupees, monthly membership fee: 25 rupees	Admission free, monthly fee 50 rupees
Management	Representatives and secretariats selected from community members	Representatives and secretariats selected from community members

Source: JICA Survey Team

One of the activities is a competitive event, in which performers by committee dance, sing and perform , and ranking is decided among committees. The NSE and the local magnate determine the ranking (Participating committees don't vote). A committee with a high reputation for its performances will be presented with a microphone, karaoke set, and speakers. It is a short-term goal for those who participate in the committee, and the activity is stimulated. Each committee has its own membership fee and monthly membership fee, and its activities are diverse. These depend on delegates and secretariats selected from the committee members.

c) Home Care

[Public]

Caregivers that have been trained directly or indirectly by NSE provide services at the following costs.

Table 4.2.16 Cost of Home Care Provided by NSE

Service menu	Expenses
8 hours during the day	750 rupees
8 hours at night	900 rupees
24 hours a day	1,650 rupees
Add 1 hour for each menu	100 rupees

Source; NSE website http://srilankaeldercare.gov.lk/other.html

2) Cash Allowance Services

In addition to the elderly, the DSS is the main organization for social assistance. Older persons who do not meet the income standard of 6,000 rupees/man-month are entitled to cash benefits. In addition, facilities for the elderly and facilities for the disabled provide support for elderly people who have limited income and savings and cannot receive support from their families because they do not need to pay for living expenses and meals when they move in. For the elderly aged 70 or older, the NSE implements cash allowance on the basis of two criteria: 2,000 rupees per man-month on the condition of low income, and 5,000 rupees per man-month for the elderly aged 100 or older regardless of their income level. According to the 2019 NSE Progress Report, benefits for people aged 70 and over were paid to 416,667 people and benefits for people

aged 100 and over were paid to 367 people. According to the action plan for the period from January to April 2020, the budget is approximately Rs. 290 million and Rs. 800,000, respectively.[80] According to the 2012 "Sri Lanka Population and Housing Census", the number of people aged 70 or older was 969,374, and those aged 100 or older was included in the number of people aged 80 or older, 273,774. Not all of the eligible recipients received cash benefits.

3) Other Services

As a discount system for the elderly, "RAJYA OSUSALAS" a government-affiliated pharmacy across the country (State Pharmaceuticals Corporation) offers a 5% discount on medicines.

According to interviews with NSE, there are cases of elder abuse, such as (1) violence by family members, and (2) psychological abuse such as neglect or isolation of family members or facilities. The mediation committee by NSE plays the role of protecting the elderly as measures against abuse. At the same time, the NSE has implemented an elderly care awareness program for schools (Encouraging students to respect the elderly), and the Council on Women's Issues in the Ministry of Social Welfare has been responding to the issue of abuse of women, including elderly women.

4.2.4 Human Resources Supporting Elderly Care

Caregivers play a central role in providing care for the elderly, but total number of caregivers and the number of caregiver shortage are unknown.[81] The following table shows levels of National Vocational Qualification (NVQ) classification (level 1-7) for various vocational training qualifications which include caregivers.

Table 4.2.17 7 Levels of NVQ

	Level at the time of start	Positioning
1	Work is possible through direct supervision	Entry-level certification
2	Work is possible through guidance	Getting Started ~ Getting Started Level Certification
3	Need to check the quality of your work, but can work independently.	Getting Started Level Certification
4	Work independently	Intermediate Level Certification
5	Can provide guidance in addition to independent work	Basic level certification for education such as high school
6	Can supervise	Certification of educational level such as high school
7	Enables planning and implementation	University Level Certification

Based on VTA website

Source: JICA Survey Team,

Table 4.2.18 shows the number of caregivers registered in the NVQ.[82]

Table 4.2.18 Number of Caregivers Registered in NVQ

[80] Of the total, 145,000 are aged 70 or older and 160 are aged 100 or older. In 2019, actual costs of 985.55 million rupees and 205,400 rupees were divided by 1/3 of the corresponding period, resulting in 328.51 million rupees and 684,667 rupees, respectively. This suggests that the budget is based on the previous year's figures.
[81] Since there are many informal caregivers (Unqualified), the actual number of NSEs is not known.
[82] There is also the Sri Lanka Qualifications Framework (Sri Lanka Qualification Framework: SLQF), in which mainly government employees learn theory.

Year	Level 3		Level 4		Total
	Male	Female	Male	Female	
2015	8	6	27	24	65
2016	4	3	13	12	32
2017	25	10	10	6	51
2018	157	101	3	2	263
Total	194	120	53	44	411

Source: Kaihatsu Management Consulting Lanka (Pvt.) Ltd. (2019) p.29

In the future, the NSE intends to train 10,000 caregivers with NVQ Level 3 and 4 qualifications, but in light of the current qualifications, the NSE recommends that caregivers first acquire NVQ Level 2.[83] About 50 caregivers have registered with the NSE and found work through the NSE. In 2017, the NSE trained 17 people. In 2019, with the support of the World Bank, a training program was planned for 1,000 people but the training program was not implemented due to lack of preparation.[84] Demand for caregivers is high, and various educational and training institutions train caregivers as shown in Table 4.2.19. Training courses, qualifications, and caregiver experience in Sri Lanka[85] provided by various organizations will increase the possibility of working at well-paid facilities for the elderly both in Sri Lanka and abroad.[86] However, due to the lack of attractiveness in compensation, work itself, social perception and career, it is difficult to attract trainees in reality.[87]

Table 4.2.19 Institutions Providing Caregiver Training

Category	Japanese	Abbreviation	Summary
Government system	National Training Industry Training Institute	NAITA	Positioning: Education for Youth Develop competency standards and vocational education programs Courses Provided: Specialized Courses Content: NVQ Level 1 -4 174, NVQ Level 5 -6 43, including Caring Bar
	National Institute for Social Development	NISD	Positioning: Training Social Workers to Promote Social Welfare and Social Development Provided education: Bachelor's degree, Master's degree Content: Social work, counseling, child protection, sign language interpretation, geriatrics/elderly care
	National Elderly Secretariat	NSE	Implemented as part of NSE work
	Sri Lanka Foreign Employment Service	SLBFE	Positioning: The organization sends Sri Lankans to overseas, Japan, Korea, etc. Cre giving is one of the 14 fields in which there are opportunities to work in Japan. Content: Implementation of NVQ Level 3, Level 4, and previously Level 2 for pre-departure education on care work.

[83] Based on a hearing with NSE in January 2020.
[84] The budget was to be funded by NSE's social security fund. However, training implementation at that scale could not procured and the number of trainees was also not enough.
[85] From the said hearing, 3-4 year caregiver experience in Sri Lanka opens career opportunities in overseas (Singapore, Japan, etc.)
[86] From the said hearing, 50,000 -60,000 rupees/month (Bedridden elderly facilities for business use, etc.) is treated well in Japan. However, Kaihatsu Management Consulting Lanka (Pvt.) Ltd. (2019) describes that 75,000 rupees/month for caregivers in the private sector and 135,000 rupees/month including meals. This is not the case with overseas caregivers. In addition, NISD interviews showed that those who want to get a higher paying job (NGO, caregivers in private nursing homes) among the caregivers would have an advantage if they had such a qualification and would take such a course.
[87] For example, NSE tries to recruit caregiver trainees through newspapers, electronic media, ERPO, elders' committees but they recognize the issue that not enough people apply for such training due to reasons such as hard work (bathroom care etc.,), poor social recognition (perceived as an infamous job), low pay, no career path to work overseas and so on.

Category	Japanese	Abbreviation	Summary
Non-governmental organization	HelpAge Sri Lanka	HelpAge	Implemented as one of the main activities (Refer to 5 -1 -3.)
Private sector business	International Healthcare Academy	IHCA	Positioning: TVEC certified. Content: NVQ Level 4 provides one-year caregiver education. Students can work as caregivers in Canada, the United States, the United Kingdom, Japan, Singapore, Taiwan, Australia, and the Middle East.

Based on Kaihatsu Management Consulting Lanka (Pvt.) Ltd. (2019), etc.

Source: JICA Survey Team,

The following is examples of salary level when caregivers work in the facilities for the aged.[88]

- Government-affiliated facility for the elderly 20,000 -25,000 rupees/month
- Private facilities for the elderly (charity) 30,000 rupees/month
- Private facilities for the elderly (business) 50,000 rupees/month

In recent years, it has become possible to train caregivers online and learn about dementia care. The online courses offered by the Dubai-based Laimoon have official British credentials and are also available in Sri Lanka.

Table 4.2.20 Examples of Rymoon Caregiver Programs

Module 1	Care and support for infants and toddlers, including bathing
Module 2	Care and support for children
Module 3	Promoting social, intellectual, creative, and emotional development
Module 4	promotion of children's physical growth
Module 5	Rule-Based care and support for older people
Module 6	Care and support for people with special needs
Module 7	Maintaining a healthy and safe environment
Module 8	Emergency response
Module 9	Cleaning the living room, dining room, bedroom, toilet, bathroom and kitchen
Module 10	Clothes, sheets, laundry, irons
Module 11	Hot meals & Cold meals
Module 12	Professionalism at work
Module 13	Therapy massage
Module 14	Skin test, vital check

Based on https://courses.laimoon.com/course/caregiver-course-1/online,

Source: JICA Survey Team

Table 4.2.21 Examples of Limoon's Official Dementia Awareness Certification Program

Module 1	Overview of Dementia
Module 2	Signs and symptoms of dementia
Module 3	Approach to care for individuals who develop symptoms of dementia
Module 4	Communication
Module 5	Care learning
Module 6	Safety and Dementia
Module 7	Activity and Dementia
Module 8	Certain challenging behaviors and dementia
Module 9	Support for caregivers with dementia

[88] Based on a hearing with HelpAge in January 2020.

Based on https://courses.laimoon.com/course/dementia-awareness-diploma-course-centre-of-excellence/online

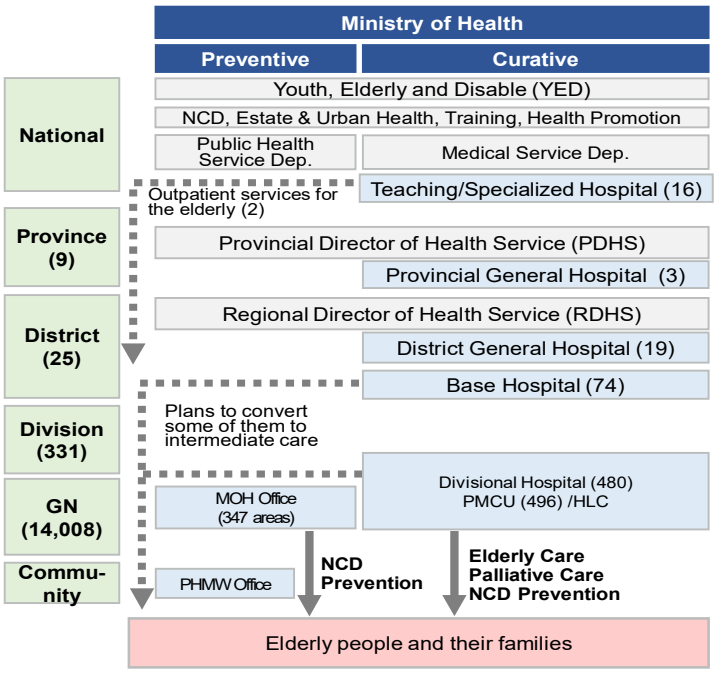
Source: JICA Survey Team

4.3 Elderly Care Support under the MoH

The MoH is the central government ministry responsible for Sri Lankan elderly health care. Its departments related to medical services for the elderly and their implementation structures are shown below.

4.3.1 National and Provincial Governments

The MoH is the central ministry responsible for health and health services to all the citizens including seniors in Sri Lanka. Sri Lankan government provides free and decentralized health services in public sector in terms of equity, efficiency and effectiveness. Health services mainly divided as curative and Preventive. The MoH and 9 Provincial Health departments are providing services in all levels of care. Curative health services consist of all the hospitals, which are categorized as Tertiary Care (National, Teaching, Provincial General, and District General), Secondary Care (Base Hospitals A and B), Primary Care (District, Divisional and Primary Medical Care Units). All the Teaching Hospitals are under the MoH and other hospitals are under Provincial Health Departments. The Preventive Health Services (Public Health Services) include specialized campaigns and Medical Officer of Health Divisions. These specialized campaigns are working as National Focal Points for relevant subject profile (e.g. Directorate for YED, NCD, Mental Health, FHB and etc..) and the activities decided by them are implemented by the service providers at the provincial and regional (District) levels. Medical Officer of Health divisions coincide geographically with Divisional Secretariat areas. (Figure 4.3.1) The MoH is regulating all the hospitals in public and private sectors.



Source: JICA Survey Team, number of facilities are described based on the Annual Health Bulletin 2017 (MoH)

Figure 4.3.1 Elderly Care Support under the MoH

The structure of the MoH consists of specialized units in different departments or divisions under the jurisdiction of the Director General of Health Services. The YED, which is established under the Deputy Director General (Public Health Services II), works on measures for the elderly. Other directors and units that are responsible for controlling common diseases within the adult population are also partially involved in elder care. These directors and units are the NCD Department and its NCD Unit, the Cancer Control Program Unit, the Mental Health Unit, and the Department of Dental Services. The Health Promotion Bureau and the Family Health Bureau and Nutrition Unit are also involved in disease prevention and health promotion for the elderly, while the Estates and Urban Health Unit under the Department of Public Health Services, and the Primary Care Services Unit, the Tertiary Care Services Unit, and the Private Health Sector Development Unit under the Director of Private Medical Services, are in charge of improving the overall quality of health and medical services. With regards to human resources planning and development, the Director of Education, Training, and Research is engaged in the development of medical personnel and the Nursing (Public Health) Unit under the Director of Public Health II and the Medical Services Nursing Unit under the Director of Medical Services I are also involved. Thus, while the YED is primarily responsible for the elderly care, many other directors and units are partially involved.

Decentralization promoted in Sri Lanka and health services at GNs, DS, Districts are implemented by provincial governments and supervised by the national level (MoH). The provincial government is the competent authority for the local public health system. There are the Provincial Director of Health Services (PDHS) at the provincial level and the Regional Director of Health Services (RDHS) at the district level. The PDHS oversees and operates provincial general hospitals, district general hospitals, base hospitals, divisional hospitals, primary medical care units (PMCUs), and MOH offices.

According to the YED, PMCU in Sri Lanka is described as a network of all Primary Medical Care Units including divisional hospitals. During the past, there were Central Dispensaries / Maternity Homes, Rural and District Hospitals, which classified as Primary Health Care Units. With the re-organization of PHC in Sri Lanka, all these hospitals were named as PMCUs.

Maintaining community health services in the Sri Lankan health system is the sole responsibility of Medical Officers of Health (MOH) appointed to each Divisional Secretariat area. A team consists of MOH, AMOH, SPHI, PHNS, PHI and PHMW work together in all activities for protection and promotion of health, mainly focusing on maternal & child health and prevention of Communicable Diseases. Likewise, one DS area is divided by PHIs and each PHI is covering 6-10 GN areas. A PHMW is appointed to every GN area and is usually residing in the same area.

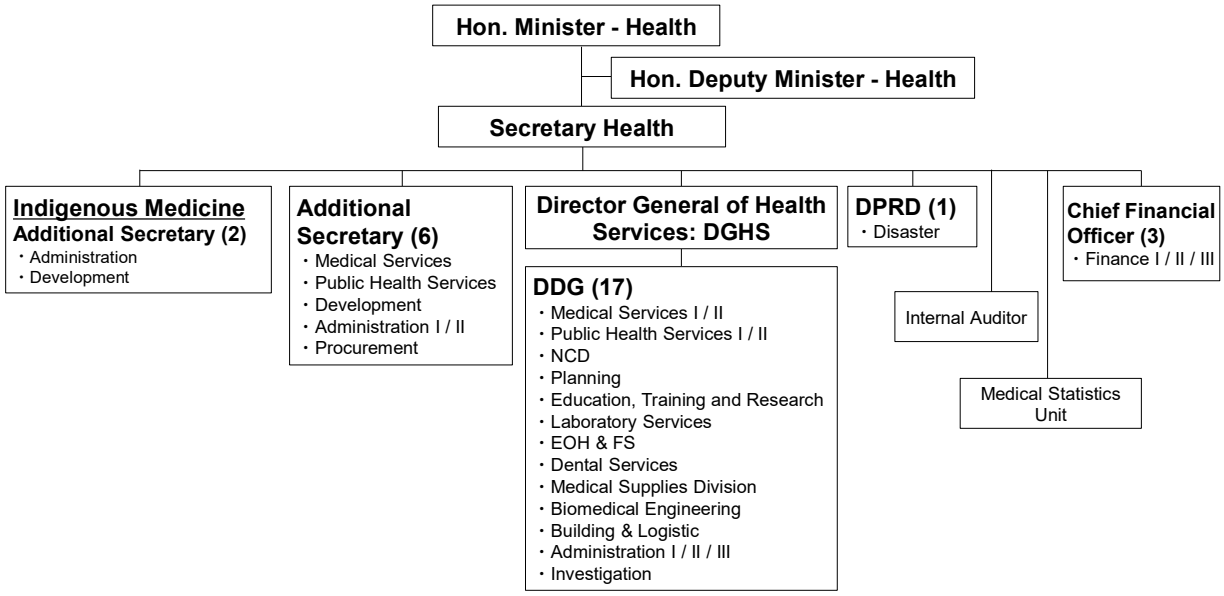
Healthy Lifestyle Centres supporting NCD prevention have been established in PMCUs.

(1) MoH (National Level)

The MoH in Sri Lanka consists of two sectors: the indigenous medicine sector and the health care sector. There are about 120 departments in the health sector, which are directly supervised by the Secretary of Health under the supervision of the Minister of Health and the Deputy Minister of Health. It is divided into three divisions: the Finance Division with three Chief Financial Officers, the Administration Divisions with

six Additional Secretaries under the Secretary of Health, and the Operations Division with the Director General of Health Services under the Secretary of Health. There are 17 Deputy Director General of Health Services, Disaster preparedness and Response unit and The Medical Statistics Unit are under the Secretary, MoH.

An overview of the organizational structure is shown in Figure 4.3.2.



Based on the Annual Action Plan 2019 and information provided by YED

Source: JICA Survey Team

Figure 4.3.2 Organizational Structure Overview of the MoH

The MoH has professional service sections such as the section of Public Health Services, the section of Medical Services, and the section of Dental Services under their umbrella. The section of Public Health Services is divided into two parts, I and II; the former deals with prevention of infectious diseases specifically and the latter with prevention of other diseases. The main unit in charge of elderly-related matters is the YED, which is set up under the section of Public Health Services II. The YED is primarily responsible for policy and planning of measures for the elderly. Other sections related to health care services for the elderly, such as NCD measures, nutrition, and mental health, have also established. The section of Medical Services is divided into two subsections, I and II. The section of Medical Services I handles specialized medical services including hospital management for tertiary care health facilities and specialty hospitals, while the section of Medical Services II handles the services provided by medical officers and oversees divisional hospitals and PMCUs. Other relevant sections of the health system, such as education, training, and research, are also involved in elder care. The sections and units related to political measures for the elderly are shown in

Table 4.3.1.

Table 4.3.1 Sections and Units for the Elderly Care in the MoH

Section	Directorate/Unit	Responsibilities and Tasks for Elderly Care
Public Health Services II	Youth, Elderly, and Disabled (YED)	Responsible for elder care.
	Nursing (Public Health)	Responsible for the supervision of nurses and midwives working in the MoH office.
	Health Promotion Bureau	Responsible for improving health (not directly involve with aging care).
	Family Health Bureau	Responsible for maternal and new-born health, family planning, etc.
	Nutrition	Develops guidelines for improving the nutrition of the elderly. Planning to train specialists in elder nutrition.
	Estate & Urban Health	Responsible for providing health care services in estate and urban settings.
Medical Service I	Tertiary Care Services	Responsible for tertiary levelled and specialized medical services.
Medical Service II	Primary Care Services	Responsible for primary and secondary levelled medical services.
	Private Health Sector Development	Responsible for registration and monitoring of the private health sector.
Dental Service	Dental Service	Develop policy plans and measures for dental health - implement and monitor these measures.
Non-Communicable Diseases (NCD)	Non-Communicable Diseases (NCD)	Promote primary and secondary preventive measures of NCD targeting adults including the elderly.
	Cancer Control Program	Develop measures against cancer and pain relief targeting the adult population including the elderly.
	Mental Health	Develop political plans and measures for mental health disorders - implement and monitor these measures.
	Chronic Kidney Diseases (CKD)	Develop political plans and measures for CKD - implement and monitor these measures
Education, Training and Research	Nursing Education	Develop political plans for training nurses and midwives
	Training	Develop plans for training paramedical crews
Planning		All over planning, estimation and allocation of budgets, policy development, cadre development and health information.
Medical Statistics Unit (The Census and Statistics Department under the Ministry of Finance and Planning)		Health information management

Source: JICA Survey Team

Regarding responsibilities and tasks of elderly care of each section or unit shown in

Table 4.3.1, information obtained through interviews and internet sources are shown below.

1) Section of Public Health Services

a) Directorate of Youth, Elderly and Disabled (YED)

As per the decisions of the Presidential Task Force 1997 on Health Sector Reforms, the Directorate of Youth, Elderly and Disabled (YED) was established in the MoH to strengthen public health services for youth, elderly and disabled in Sri Lanka. The government of Sri Lanka has given its attention to elders as respectable senior citizens of the country. The National Health Policy of the MoH Sri Lanka has prioritized care for the elders and it is demonstrated by establishing a separate directorate. According to the organizational structure of the MoH, the Directorate is functioning under Deputy Director General Public Health Services II. Currently, there is a permanent Deputy Director, who is acting for the Director. The staff consists of Senior Consultant Community Physician experienced in elderly care, Medical Officers, Programme Planning Officer, Development Officer, two health assistants and driver.

The YED is the national focal point for working on the health of youth, elderly and persons with disabilities in Sri Lanka. The goal of the YED is to improve the quality of health among youth, elderly and disabled persons through the improvement of health facilities, disability prevention and health promotion by coordinating, planning, implementing, monitoring and evaluating of activities related to programme areas. According to the YED, tit is continuously providing technical assistance to other public health units in the MoH as well as other ministries such as Ministry of Youth Affairs and Sports, Education, Ministry of Higher Education, Ministry of Defence and so on. The YED explained that it works in good coordination and collaboration with all stakeholders towards healthy ageing in Sri Lanka.

YED mentioned that the it has planned and taken measures to create environments and increased awareness on Active Healthy Ageing among all groups of population. Improving advocacy on healthy eating habits, importance of physical activity and maintaining good mental health avoiding stress are some of the important facts elaborated by YED in its activities. YED is collaborating with other public health directorates and ministries like Ministry of Education, Ministry of Sports and Youth Affairs, Ministry of Agriculture, and so on in the implementation of Active Healthy Ageing programme. According to the YED, the pre-retirement programme conducted by the YED annually at public departments received meaningful outcomes in maintaining good health after retirement. The YED launched the National Elderly Health Policy in 2017, which reflects the commitment of the government to ensure comprehensive elderly health care services to all senior citizens of Sri Lanka. All the activities for elderly care are planned based on the policy statements and the strategies in the policy. The directorate is receiving funds to implement its Annual Action Plan from the government of Sri Lanka and the United Nations (UN) agencies such as WHO, UNFPA and so on.

Addressing the National Elderly Health Care Policy and understanding the service needs and the unmet needs of the elderly population in the country, the YED introduced Elderly Health Care Delivery Plan with the support of JICA. By this project, the YED had proposed to develop the existing health system more elderly friendly by improving accessibility, providing disable friendly toilets, acquiring equipment for elderly care and improving rehabilitation services. Accordingly, 2 to 3 underutilized hospitals in each

district are to be identified to be developed as "Sadha Piyasa" Elderly Intermediate Care Units. 52 "Sadha Piyasa" units island wide will be established in the near future. At the time of the survey, the first ever intermediate elderly care unit at Divisional Hospital Athurugiriya is on its' development process. The infrastructure development and procurement of equipment required for elderly care at Athurugirya Unit completed with government funds. According to administrative structure of Sri Lanka, almost all hospitals decided on Elderly Care Delivery Plan belong to provinces and they are under Provincial Director of Health Services. During the implementation process of the plan, the YED is collaborating with provincial and regional directors of health services and hoping to invite corporate stakeholders for the maintenance of "Sadha Piyasa "units.

The YED is collaborating with provincial health services to fulfil most of the expected targets of the Directorate. E.g. Capacity building in elderly care, awareness of risk behaviours among youth, sensitization of youth to elderly, creating elderly and disabled friendly environments in hospitals. Nutrition unit of the MoH, in collaboration with the YED completed developing National Nutritional Quality Standards for Elderly People in the community and long-term care facilities. Estate and Urban Health Unit collaborated with the YED to improve awareness among responsible persons attached to Urban Development Authority regarding Elderly Friendly City approach. Creating accessibility and elderly friendly facilities in all buildings and public places indicated as a mandatory requirement in construction in the Urban Development Policy.

The YED planned to commence ICOPE programme (Integrated Care for Older People) last year. Due to the pandemic, the staff capacity-building programme could not be conducted to start the programme. Through ICOPE, the older people will get an opportunity to identify and get early solutions for their impairments in nutrition, vision, hearing, mentality and mobility. Two pilot projects will be conducted at DH Maligawatta and DH Athurugiriya in Colombo District.

The directorate is planning to introduce a regulatory mechanism to register all long-term care facilities. Registration at NSE will be mandatory to all care homes under this mechanism. Annual renewal of registration after thorough evaluation by a team including health and social service authorities will create the need of well maintenance of environment and service provision at Long Term care homes for elderly.

Being the country with highest trend of ageing population in South Asia the problem in caring elderly parents/grandparents by working & migrating children is a major issue in Sri Lanka. Still, there is no proper day care/day activity centres available to minimize this issue. Some children are facing financial constrains as they cannot go to work leaving behind the parents at home. Therefore, this requirement should be a priority. Support from a country providing essential elderly care services to build up model day care centres at least at Colombo, Gampaha, Kandy and Galle (districts with the highest number of working population) will be very much worthwhile.

Introduction of community-based integrated care (CBIC) to Sri Lankan communities will be very much appropriate, to cater the needs of older people in a methodical way, with high collaboration of health and social service authorities.

There are 7 rehabilitation units at Ragama Rehabilitation Hospital, Karapitiya (Galle), Digana (Kandy), Jayanthipura (Polonnaruwa), Ampara, Batticaloa and Kandagolla (Badulla). The country will need more rehabilitation facilities to face emerging trend of aging population. Therefore, YED is planning to improve facilities for rehabilitation in the upcoming intermediate care units at PHC level. DDG Education, Training and Research identified training of physiotherapists and occupational therapists as a major component in their programme.

According to accounts of the MoH, capacity building of the service providers and the community achieved with marked improvement of results by training of health staff on elderly care, training of caregivers for elderly, especially for frail elders at community level. Pre-retirement programme is conducted annually at different settings to help people promote active healthy ageing. Improvements in inter and intra sectoral coordination with multi-stakeholders. Especially NSE, Ministry of Higher Education and UN donor agencies helped the Directorate in planning and implementation of capacity building programmes for elderly care givers and advocacy on active healthy ageing and elderly care. Elderly Care is introduced as a subject in the undergraduate curriculum in Medicine and curriculum for Public Health Midwife. Another recent advancement towards better elderly care was establishment of accredited curriculum in MD Geriatric Medicine and Diploma in Elderly Care, which was commenced at Post Graduate Institute of Medicine, for postgraduate trainees. The YED provides technical assistance with the single consultant attached to the unit. The elderly care model was included in MOH training, PHI & PHMW training at National Institute of Health Sciences conducted by the YED. Apart from the Geriatric Medicine, lectures on elderly care to post graduate trainees in MSc/MD Community Medicine, Medical Administration, Disaster management and so on were delivered by the YED. The YED provides assistance to caregiver training conducted at Vocational Training Centres.

Table 4.3.2 Key Performance Indicators- Directorate of Youth, Elderly & Disabled

No	Indicator	Target for 2020	Progress		
			2018	2019	2020
01	Percentage of advocacy programme completed (Elderly)		100%	-	100%
02	Elderly health policy in place		-	-	
03	Percentage of multi stakeholders steering committee meetings held on Elderly health care		90%	-	
04	Infrastructure development of selected rehabilitation centres		100%	98%	
05	Purchase equipment for the Prosthetics and Orthotics work shops		100%	-	
06	Celebration Disability day		100%	100%	
07	IEC material printed on Elderly health care		100%		100%
09	Building maintenance in TH Karapitiya - (Maliban Rehabilitation Hospital)		99.98%	100%	-
10	Establishment of Intermediate Elderly Care Unit - DH Athurugiriya	90%			70.87%
11	Printing IEC material & development of videos to youth, Elderly, Disabled persons and protection and prevention of COVID 19.				100%
12	Sensitization of Youth on caring Elderly (printing booklet Youth 2 Elderly & Elder diary)				100%
13	Capacity building for hospital staff on Elderly care			100%	
14	Technical assistance on caregiver training by Ministry of Higher Education			70%	

** In 2020 planned programmes not conducted due to Pandemic of COVID19

Lack of proper registration, monitoring and evaluation system for long-term care facilities (Elderly Homes) identified as a major issue by the YED. Standards introduced by NSE and National Standards Institute of Sri Lanka are not considered as a tool for licensing and registration as a caring facility. Almost all long-term care facilities have business registration. Very few registered under NSE.

Old Age Dependency Ratio in Sri Lanka is higher than the Child Dependency Ratio. There is a considerable increase in the proportion of old and oldest old in the ageing population. Therefore, facilitating care for Older Persons by working and migrating children found to be a major issue. Introduction of Day Care Centres and Day Activity Centres with recreational activities are important to overcome this issue.

The YED mentioned that it should facilitate with human resources and necessary equipment for smooth implementation of its activities.

The YED is planning to introduce Community Based Elderly Care, which integrates both the health and social service system in the community through the collaboration of PMCUs and MOH Offices, with JICA assistance under the project "Capacity Enhancement of Elderly Service Management in the Community of Sri Lanka" in the near future.

b) Health Promotion Bureau

The bureau plays a central role in health education, health promotion, and dissemination and sharing of health-related information. In recent years, the bureau has achieved results by empowering and mobilizing communities through health promotion, resulting in improved quality of life. The bureau works with support groups and other organizations, particularly those targeting mothers, to conduct prevention and promotion activities regarding nutrition, environmental safety, viruses, alcoholism, sexual violence, and abuse. The bureau also conducts health promotions in the workplace. The initiative intending to support mothers in particular has been implemented in a total of 630 locations, one to three locations in each MOH area in 2018. This initiative has plans to be implemented in each GN in near future. The challenge of this initiative is to maintain the interest and sustainability of stakeholders and participants. It is necessary to emphasize cooperation with this bureau in preventing NCD, regarding of elders' health.

The Health Promotion Bureau consists of 13 units, including the one in charge of hospital and community health promotion. The Community Health Promotion Unit, one of the above 13 units, is in charge of NCD prevention in the community in cooperation with the YED and NCD units of the MoH. The unit promotes the Happy Village Project, which mobilizes the elderly as volunteers so that they can work with the local health care workers and disseminate knowledge for NCD prevention and promote overall health to residents. These NCD prevention efforts contribute immensely to extending a healthy lifespan and improving the overall health of the elderly. The initiative is also directly involving the elderly as volunteers and leads to the social participation of them; further cooperation with the YED and NCD units is desirable for the future. The Happy Village project is described in more detail below.

Happy Village Project

The Happy Village project is led by the Community Health Promotion Unit, which aims to reduce the prevalence key risk factors for NCD in the community and empower community human resources to address overall physical, mental, social, and spiritual health. It also promotes health in rural areas.

In a village or GN of about 250 people with 50 to 100 households in a cluster the activities will be led by the following members.

- Village / Grassroots Level Manager: MOH
- Facilitator: PHC worker (PHCW) - for example, PHMW, public health inspector (PHI), senior public health nursing sister (PHNS), etc.
- Mediator: health education officer (HEO)
- Volunteer group: 5-10 elderly people per village

The process of the Happy Village Project is shown in Table 4.3.3.

Table 4.3.3 Activity Process of Happy Village Project

	Process	In-charge	Efforts
1.	- Instructor training for HEO - Advocacy to CCP at the provincial and divisional levels	Health Promotion Bureau, the MoH	- Development, testing and agreement of Happy Village process - Appropriate use of Happy Village project process, Information, Education and Communication (IEC) teaching materials, and other equipment
2.	- Action Plan Development by HEO and CCP	Provincial Health Office	- Identification of officials/ leaders from government agencies and private sector to promote cooperation - Advocacy aimed at support from health directors at provincial and divisional levels - Planning of monitoring and evaluation methods suitable for the site - Identification of divisional level multi-sector platforms to share progress
3.	- Introduction of Happy Village Project - PHCW specific MOH office that can be a model - Identification of an enthusiastic PHCW that can be a model	Office of MOH	- Advocacy for MOH staff - Development of a rural-level health promotion platform to reduce the burden on MOH offices - Distribution of mobile sound system of the MOH office - Introduction of Happy Village stickers and its posting at the MOH office
4.	- Training by CCP / HEO for their own PHC staff - advocacy and training for MOH officers by CCP	CCP/ HEO	- Introduction and appropriate use of IEC teaching materials - Training of MOH officers (on supporting PHC workers and monitoring their progress)
5.	- Identification of 3 major collaborators - Determining the most suitable situation for action - Meeting with target group	Rural community people	- Main collaborators: Grassroots level - Meeting with multi-sector team - Identification of the innovators to participate as volunteers
6.	- Training for volunteer groups by PHCW - Creating an action plan	Elderly volunteer group	- Training contents: a Communication b Happy Village Process c Grassroots NCD Prevention and Health Promotion Interventions d Identification of Issues and Priority

	Process	In-charge	Efforts
			e Fundamentals of Feasibility Assessment and Project Planning - Activities expected of volunteers a Weekly home visits b Biweekly volunteer meetings

Source: HAPPY VILLAGE CONCEPT & OVERVIEW, Health Promotion Bureau

The Happy Village Project aims to be implemented in at least two locations in the MOH area by 2020. At this time, the program has been implemented in 260 total locations with at least one in each MOH area.

[Future Measures for the Aging Considered Necessary by the Unit Officers]

- Difficulties with day-to-day life and financial problems are major issues for elderly people. Although the pension system is one active strategy in place in an aging society to help, establishing a supporting system (a platform) for elderly people to adapt in the community after being discharged from the hospital should be included in future strategies.
- Interventions for diabetes including prevention and control, food safety and nutrition education, and support toward becoming independent in society are necessary for health promotion strategies for the elderly. In order to implement these strategies, it is necessary to establish a platform which has bases in hospitals. It would be ideal to establish a system for a SSO to visit the homes of elders to check if their house structure puts them at risk for injury and offer safety advice as needed.
- A Day-care Service Center should also be established for the aging issue. Family members usually work during the day, and such a service would be helpful for them. Additionally, it would be an ideal way for the elderly people to help each other and have some opportunities to earn some money through the system. Currently, there is no systematic approach to day care services in Sri Lanka.
- It is important to involve existing human resources, including the allocated Health Education Officers in each district and other community workers working in the Happy Village Project or mother support groups, with planned activities for promoting health education.
- New PHNOs have been trained and allocated in HLCs. PHNOs are expected to be engaged in palliative care, elder care, NCD strategies, and school education. Development of checklists for the education of community workers and volunteers is necessary.
- Health education in various work environments and for health care professionals, patients, and family members is necessary. Workers in estate areas, fishermen, people living in slums, and non-regular employments tend to have financial and societal disadvantages, therefore, establishing a platform and services to help these people make enough income is important. A lot of elderly people are able to earn their own income even if they are over 60 or 65 years of age and providing them with employment opportunities is also. The retirement age is generally 65 in private sectors and 60 in public sectors in Sri Lanka. A shortage of human resources will result in a higher demand for elderly people in the workplace.
- Rehabilitation services for elderly patients are necessary so that they are able to return to society without any problems.
- Other topics of importance regarding elder care in Sri Lanka are promoting mental and psychological care, social engagement, entertainment, support for appropriate medication and diet, oral health care,

financial support, and nutrition support. There are some elderly people who become isolated due to having fewer opportunities to go out after their retirement; it is important to engage with them and encourage them to participate in society. In addition, financial support such as a bank loan, financial risk support, and microcredit can be considered as good opportunities for assistance.

- In terms of ongoing elder support strategies by the MOWCASS, there is an economic support program for those in poverty called Samurdhi. The main issue is that relevant documents are not developed or managed in a proper way.

c) Family Health Bureau

Japan has been implementing measures against the fertility decline, in addition to improving services for the elderly as a response to the aging society. On the other hand, the MoH in Sri Lanka does not consider fertility decline as a cause for rapidly ageing population and does not include an approach to counter the fertility decline into the current elderly policy. Although the Family Health Bureau is not directly related to the elderly policy in Sri Lanka at this time, it is introduced here for reference for future discussion in view of the situation of Japan's fertility policy.

The Family Health Bureau aims to maintain and improve the health of the people of Sri Lanka, especially women and children, and to improve quality of life (QOL[89]) through the betterment of the family environment. It provides comprehensive, sustainable, equitable, and quality maternal and child health services in a supportive and culturally acceptable and family friendly settings.
The Family Health Bureau plays a central role in maternal and child health and is responsible for planning, coordinating, monitoring, and evaluating maternal and child health and family planning services in the national family health program. The main components of this program are maternal health, child health, women's health, and family planning. Services related to the Family Health Bureau are provided through a wide network of systematic operations at medical facilities of the MoH, provincial health services, and the MOH areas.

The Family Health Bureau has 13 technical units, each of which is responsible for maternal and child health, nutrition, development and special support, gender, and oral health for pregnant women, new-borns, and adolescents.

d) Nutrition Unit

This unit developed "National nutrition quality standard for elderly people" and "Implementation of the national nutrition quality standard" for caregivers in elderly homes and "Nutrition guide for community elderly people" last year, funded by the WHO. These guidelines are currently in the MoH approval process. However, it is accompanied by uncertainty due to changes in the governing parties and their potential new intentions. This unit is considering advocating for food safety and nutrition assessment to the upper echelons of the MoH in order promote policy reflection. They are also reviewing the Population-Based Nutrition Guideline developed in 2011, specifically the section on elder care. The

[89] An abbreviation of Quality of Life (quality of daily life, quality of entire life). Generally used as QOL.

specific nutritional guidance includes avoiding excessive intake of fat, salt, and carbohydrates, weight management, adequate fluid intake, and healthy cooking methods.

[Future Plans]

- Establishment of services to improve the nutritional health of the elderly is necessary. Plans to apply for funding through the WHO, enhance awareness and education regarding healthy meals for the elderly using the standard and the guidelines developed last year. The nutrition requirements developed will be introduced to elderly homes in the near future to help provide nutritious meals to the facility.
- Educating and training specialists in elder nutrition among MOH officers and PHNOs will be necessary. Leaders for those specialists are also needed. Nutrition education should be included in the necessary training components of PHC.

[Challenges Recognized by the Unit]

- Dietary service framework for the elderly is not systematically established.
- Services for the elderly are available in elder facilities, nursing care facilities, and palliative care facilities, however most elderly people are primarily supported by family members at home. There is a need to increase the above services due to the employment patterns and working conditions of these family members; appropriate nutrition services are provided to the elderly not only by their families but also at the facilities. The meals at the facilities for the elderly are provided by donations, however the nutritional value and quality of these meals is considered poor. These facilities need to provide dietary services that also take nutrition into consideration.
- There are few specialists in elderly nutrition. One staff member in this unit is writing a doctoral thesis on elderly nutrition.
- One challenge is that the number of geriatricians is very limited in Sri Lanka.

e) Estate and Urban Health Unit

Sri Lanka is divided into urban, rural, and estate areas, and this unit aims to improve health care services in the estate areas in particular. Estate areas have long provided medical services in their own way without governmental laws and standards. This unit especially deals with these areas while national vertical programs such as tuberculosis campaign are carried out by the health services unit of each local government under the supervision of the MoH.

Since 53.2% of the population[90] in Nuwara Eliya District resides in the estate areas, a significantly higher percentage than other regions, the situation there can best represent the overall situation in the estate areas. Table 4.3.4 shows the population distribution of Sri Lanka, Colombo City of Western Province, and two districts in Central Province.

Table 4.3.4 Distribution of Population of Survey Sites, by Urban, Rural, and Estate Area

	Population	Percentage of Population (%)

[90] Census of Population and Housing 2012

		Urban	Rural	Estate Area
Sri Lanka	20,271,464	18.3	77.3	4.4
Colombo City, Western Province	2,310,136	77.5	22.2	0.4
Kandy District, Central Province	1,370,247	12.1	82.0	5.9
Nuwara Eliya District, Central Province	706,726	5.9	40.9	53.2

Source: SLPHC 2012

The Plantation Human Development Trust (PHDT) has developed and implemented a number of infrastructure and social development programs in housing and infrastructure, water and sanitation, health and nutrition, child care and development, farm workers' housing cooperatives, training and development, and sports and welfare in these areas, working closely with the relevant ministries, trade unions, local plantation companies, local governments, NGOs, and other public and private organizations. Although the PHDT does not provide specialized services for medical treatment, the organization does provide health and well-being related services.

The current issues in the fields of health and medical services in the estate areas are as follows.

[Situation of Health and Medical Services in Estate Areas]

- About 500 families live in each community (village) in the estate areas. MOH offices are allocated at the community level to provide mother and child care as a preventive measure, and PMCUs, divisional hospitals, and base hospitals mainly provide treatment as a curative measure.
  There are also about 600 estate medical facilities in the estate area (no records). These institutions are divided into maternal and child health and sanitation clinics, pharmacies, and hospitals. About 450 facilities, excluding 106 facilities with no information, are being considered for conversion to public medical institutions within three years. Of these, 44 facilities became medical institutions under government control in 2007 and 56 facilities are expected to be PMCUs. The other 150 facilities have not been assessed and decided how to convert. However, sufficient financial budget is required for these institutional shifts including acquisition of land, construction, and equipment purchases, and there is unfortunately no such specific budget in place at this time. Although the Asian Development Bank (ADB) and the World Bank are supposed to support some of these shifts, the actual subsidy is small and no other support is expected. The Ministry of Finance and Planning will determine the new positions and salaries of the health care staff in these new public medical institutions. In addition to the Ministry of Finance and Planning, the Cadre commission, which is a government agency, is responsible for decisions regarding the employment of medical personnel. Local authorities make the employment decisions regarding other personnel such as support staff, cleaning staff, and drivers for health care facilities.
- According to National Health Strategies a public health service centre is planned to establish in the community. This centre will include a community centre, an outpatient department and maternal and child health clinic and so on. This will provide both health and community services.

- This model requires support from other sectors including microfinance, social empowerment, and social services. Other possibilities of technical support include the introduction of innovations such as the planning, implementation, and evaluation of the KAIZEN project in Japan, information technologies (IT) such as Geographic Information System (GIS) mapping and information sharing, penalization, and the linking of information with community settings.

[Challenges of Medical and Health Services in the Estate Areas Recognized by Unit Officers]

- It is difficult to comply with Sri Lankan laws in the estate area. The health system in the estate area is also different from that in other regions of the country, and the Estate Medical Assistance, which is medical personnel engaged in medical services, is hired and trained by the estate company. These Estate Medical Assistances have not received education or qualifications regulated by the national government and the quality of their medical services may not be guaranteed. It is not possible to grasp the actual conditions of their services.
- Although some say that there is a shortage of health care personnel, the issue is actually that management is not properly operated. For example, if you were a driver, you could only do the job of driving. If you were a doctor, you would work in a private medical facility after working in a public hospital during the day. The issue is not that there is a shortage of health care professionals, but that there needs to be a review of the allocation of medical personnel and their work content.

2) Section of Medical Services

There are two Deputy Director Generals for Medical Services in the MoH. DDG MS I and DDG MS II. They are responsible in maintaining medical services in both curative and public health institutions in the country. This section is responsible for public medical facilities such as tertiary and specialized hospitals such as teaching hospitals and provincial and district general hospitals, divisional hospitals and PMCUs. Responsibilities include the hiring, placement, promotion, and reassignment of medical officers.

Specialized education for medical doctors is offered at nine universities across the country and internships and special doctors are under the purview of this section. Specialized education in geriatrics is conducted at two facilities in Colombo and Kandy (Colombo South Teaching Hospital and Peradeniya General Hospital), led by the Tertiary Care Service Unit.

Care for the elderly ranges from preventive and simple medical services to advanced medical services such as cancer treatment. Preventive and simple medical services need to draw on the services of the community. In addition, family support is essential, but does not encompass all care needs. Services for the elderly need to be provided with three main focuses: (1) community, (2) prevention, and (3) treatment. Tertiary services, with the exception of orthopaedics, can be provided at teaching, national, provincial, and district hospitals in each province.

For a medical officer, in order to work in a public hospital, candidates must register with the Medical Council of Sri Lanka and work as an intern for one year after graduation. They will be employed as medical officer under MoH and should complete one year of clinical experience (internship) in medicine,

surgery, paediatrics and gynaecology under close supervision of consultants respective clinical areas. Successful completion of internship will make them as permanent medical doctors in the government. Then, they will decide whether to remain in general medicine, or to become a special doctor or a hospital manager. If they decide to become a special doctor or hospital manager, they will receive specialized education. Specialized training for medical doctors is offered at nine universities[91] across the country.

[Future Measures for Elderly People Considered by the Section Officers]

- One planned strategy for the elderly involves shifting the divisional hospitals to rehabilitation hospitals. Patients prefer upper-level hospitals to base hospitals, expecting specialized care, and many divisional hospitals have a small number of patients despite a sufficient number of staff and beds. Therefore, there is a plan to merge some divisional hospitals into rehabilitation hospitals to better utilize them. If these ideas are realized and if rehabilitation is required among some patients who have been treated for cerebral infarctions, myocardial infarctions, or orthopaedic disease at a tertiary care health facility, they will be referred to these rehabilitation hospitals before returning home after discharge. The section considers the following functional requirements for shifting a divisional hospital to a rehabilitation hospital: (1) A multidisciplinary team consisting of physiotherapists, occupational therapists, and social workers, (2) A combination of primary, secondary, and tertiary level preventive approaches through health education provided at divisional hospitals, and (3) provision of regular home care by a PHNO after patients who have undergone rehabilitation at a divisional hospital return home. It is desirable to build a social rehabilitation support system so that patients are referred from tertiary care health facilities to rehabilitation hospitals, combining these above functions in the community setting. In addition, it is also preferable to have a system in which special doctors based in secondary and tertiary care health facilities regularly visit divisional hospitals.

- Currently, one rehabilitation facility for mental illness is established per province. There are only two rehabilitation services that do not involve mental illness, the Digana Rehabilitation Hospital and the Ragama Rehabilitation Center in Kandy, but the Ragama Rehabilitation Center is the only one that mainly handles elderly patients. This centre and its team of rehabilitation specialists is certified as a model case (Centre of Excellence).

- While the required number of physiotherapists is sufficient, the number of occupational therapists is extremely small. In addition, although the education curriculum for other healthcare professionals, including MOHs and PHNOs, deals with rehabilitation and elderly services, they are not adequately taught in a specialized manner. While the appropriate training of caregivers has not yet been addressed, it is indeed a very important area the MoH should be looking into.

a) Primary Care Services Unit

The main role of this unit is to bridge the policy making and medical fields. Specific responsibilities include preparing service guidelines and other documents for district hospitals and PMCUs, monitoring

[91] Sri Jayawardenepura, Karapitiya, Keriya, Peradeniya, Jaffna, Batticaloa, Rathnapula, Kuliyapitiya, Kotelawala Defence University

and evaluating them, and visiting facilities to provide advice and suggestions for clinical improvement at the primary level. It also plays a role in the Medical Board and holds tenders and other events.

The HLC is used to provide screening tests for NCD as part of the PMCU and the current HLC and PMCU offer facility-based services. In addition, the MOHs and PHMW/PHNO provide on-site testing services. Patients requiring treatment are kept in HLC/PMCUs, but patients who are not able to visit a HLC/PMCU, the MOH are generally prescribed simple medication by the PHMW/PHNO.

[Challenges and measures for elderly people in the future considered by officers of the unit]

As a strategy for the elderly, it is desirable that a multidisciplinary team consisting of different health care professionals in both preventive and therapeutic systems work together effectively. So far, HLC/PMCU, MOHs, and PHMWs/PHNOs have not cooperated in terms of treatment and prevention, however it is important to establish a system by educating different health care professionals as one team and incentivizing them to collaborate. Prevention, treatment, and rehabilitation services need to be combined in order to provide services so that special doctors visit elder care facilities on a regular basis.

b) Private Health Service Regulatory Council (PHSRC)

This is a council established under the MoH based on the Private Medical Institution Registration Act, which was approved by the Parliament in July 2006. Headed by the Director-General of Medical Services of the MoH, the council consists of 28 people, including the Director of the MoH's Private Medical Sector Development division, Directors of Health Services for all provinces in Sri Lanka, and other members and staff of professional organizations in specialized fields such as law, nursing, and finance.

Private sector health service facilities and healthcare professionals are required to register with the PHSRC, and the standards set forth by the PHSRC maintain the quality of training for facilities and staff - ensuring the quality of patient care services. The council develops and monitors quality assurance programs for patient care in private medical facilities with the aim of developing and monitoring standards. It is also responsible for the collection and disclosure of related health information and statistics and the registration of private medical facilities.

[Registration with PHSRC]

Registration items are divided into nine categories and fees are set for each item. Details are shown in Table 4.3.5. The registration is valid for one year and needs to be renewed every year.

Table 4.3.5 PHSRC Registration Categories and Fees

#	Categories	Fee
1	**Private Hospitals, Nursing Homes, and Maternity Homes**	
	a) 1-20 Beds	Rs. 20,000/-
	b) 26-50 Beds	Rs. 30,000/-
	c) 51-100 Beds	Rs. 50,000/-
	d) 101 and More Beds	Rs. 1,000/- per bed
2	**Medical Laboratories**	
	a) Small Lab/ Collecting Center	Rs. 5,000/-

#	Categories	Fee
	b) Medium Lab	Rs. 15,000/-
	c) Large Lab	Rs. 50,000/-
3	**Medical Centres / Screening Centres / Day Care Medical Centres / Channel Consultations**	Rs. 15,000/-
4	**Full time General Practices/ Dispensaries/ Medical Clinics/ Full Time Dental Surgeries** (Not Employed by Government or other registered medical institution)	Rs. 10,000/-
5	**Part time General Practices/ Dispensaries/ Medical Clinics/ Full Time Dental Surgeries** (Employed by Government or other registered medical institution)	Rs. 5,000/-
6	**Full time Medical Specialist Practices** (Not Employed by Government or other registered medical institution)	Rs. 15,000/-
7	**Part time Medical Specialist Practices** (Employed by Government or other registered medical institution)	Rs. 10,000/-
8	**Private Emergency Services**	Rs. 10,000/-
9	**Other Private Health Facilities**	
	a) Blood transfusion bank	Rs. 25,000/-
	b) Stem cell bank	Rs. 50,000/-
	c) Dental examination	Rs. 5,000/-
	d) Home care nursing service	Rs. 5,000/-
	e) Medical personnel training institution	Rs. 20,000/-

Source: PHSRC website (http://www.phsrc.lk/)

In addition to the above categories, nurses are to be registered by medical facility.

As part of the registration process, private medical facilities and healthcare professionals working in private medical facilities must prepare and submit the appropriate application forms and other required documentation to the PDHS depending on the type of service delivery and affiliation. The PDHS will review the documents and conduct a site inspection. If the requirements are met, the applicable forms will be submitted to this Council. The six members of the Registration-Application-Evaluation Committee makes a final decision on registration in consultation with after review and verification of the documents submitted is done by the Council.

Private medical facilities and all health care workers working at one are required to register with the PHSRC, but, in reality, they often practice without registration. There are also cases where insurance companies do not reimburse the cost of medical treatment at such unregistered facilities.

[Guidelines / Regulations for Private Health Facilities]

To ensure the quality of services provided by private health facilities, the PHSRC has formulated guidelines according to services and occupations. As of September 2020, there are nine, of which “homes providing long-term care" and "home care nursing services" define provisions related to services for the elderly. Table 4.3.6 and Table 4.3.7 give an overview of each.

Table 4.3.6 Outline of Guidelines for Homes Providing Long-Term Care

Item	Content
Facility	The facility providing long-term care, including rehabilitation and palliative care for patients with chronic diseases (cancer - psychiatric/ neurological diseases, diseases of orthopaedics / rehabilitation - chronic renal diseases, etc.)
Staff	- Doctors registered with the Sri Lanka Medical Association (in case of emergency)

Item	Content
	- Nurses registered with Sri Lanka Medical Association / Sri Lanka Nursing Association or PHSRC - Nursing assistant / assistant - Medical specialists in each specialty (visit-based)
Available emergency treatment	- Primary emergency service - Emergency ambulance service - First-aid medicine and continuous supply
Waste treatment	Maintain an appropriate waste management system, water and sewage system, and facilities for treating medical waste.
Physical environment	Based on the standards set by the social welfare sector
Equipment	- Access to toilets and washrooms that are friendly to the disabled and the elderly - Safety measures
Spiritual services	Religious facilities, places of worship, etc.
Counselling room	Establishment of counselling room for medical consultation
Visitor facilities	Free access to visitors
Recreation facilities	Create facilities for reading and radio/ TV - and an environment for walking or resting in the garden

Source: GUIDELINES FOR HOMES PROVIDING LONG-TERM CARE (http://www.phsrc.lk/pages_e.php?id=3); Accessed on September 1, 2020

Table 4.3.7 Outline of Guideline for Home Care Nursing Services

Item	Contents
Explanation	An institution that provides basic minimum care at the patient's home / place of residence
Home Nursing Services / Facilities	1. Assign full-time staff with qualifications as nurses 2. Overall supervision by a medical doctor responsible for patient care 3. Build a system for emergency care 4. Ensure a sufficient number (i.e., minimum 10) of care providers for providing continuous services 5. Ensure a communication system that care providers can make contact from the visiting place 6. Providing the necessary equipment, transportation, or their costs 7. Set the uniform code
Care provider	1. Have a certificate of completion of training at a government-certified institution 2. Secure skills and knowledge 3. Have a basic toolkit necessary for the minimum care of the patient (e.g., scissors, forceps, gloves, bandages, cotton balls, and others) 4. Can use a communication system to ensure contact with the facility 5. Wear appropriate clothing specified by the facility during work

Source: GUIDELINE FOR HOME CARE NURSING SERVICES (http://www.phsrc.lk/pages_e.php?id=3) - accessed on September 1, 2020

[Overview of registered private medical facilities]

The PHSRC publishes a list of registered private medical facilities on its webpage so their users know about the facilities and medical staff. Table 4.3.8 shows the annual changes in the numbers of registered facilities and personnel since 2017.

Table 4.3.8 Registered Public Medical Facilities and Personnel at PHSRC (2017-2020)

Item		2017	2018	2019	2020*
Facilities	Private Hospitals, Nursing Homes, and Maternity Homes	116	117	115	69
	Medical Centres / Screening Centres / Day Care Medical Centres / Channel Consultations	191	182	186	107
	Medical Laboratories	405	449	436	165
	Other medical facilities	40	45	60	35

Item			2017	2018	2019	2020*
Health care workers	General practice	Full-time	188	355	416	227
		Part-time	117	171	196	134
	Dentist	Full-time	12	20	25	18
		Part-time	27	33	40	24
	Medical specialist	Full-time	4	7	5	4
		Part-time	4	6	7	1
	Nurse		2,383*			
Services	Private Emergency Medical Service		10	10	11	7

Based on the data on the PHSRC website (http://www.phsrc.lk/) - accessed on September 10, 2020

* The source does not recognize the numbers of registered nurses each year.

Source: JICA Survey Team

There has been no significant increase or decrease in the numbers of medical facilities since 2017. The numbers of full-time and part-time general practitioners are increasing, especially full-time, while medical specialists are limited.

[Challenges recognized by the Council]

It has been frequently reported that medical practices by facilities and personnel who are not registered with this council occur. In cases where such reports are received, the facility or medical technician in question will be contacted and advised to register with the council. If they fail to respond to the council, they will be banned from operating or otherwise punished. Many such cases have been identified, especially in rural areas. Similarly, if the employment of a medical doctor who is not registered with this council is confirmed from the evidence of his or her Social Security enrolment status, the PDHS will visit the facility and recommend removing the unqualified personnel from practice.

Regardless of the Council's effort such as setting the maximum price of medical services and attempting to ensure the quality of services, it is a fact that there are some cases that have not followed the regulations. Recommendations have been issued to facilities that have set higher prices for services above capacity; this facility has filed a complaint and is currently in mediation. The court has stated that it is not appropriate for this council to set a price cap, but a decision is expected this June.

Challenges in health sectors include a shortage of medical personnel, including medical doctors, nurses, medical staff, and laboratory technicians. As for whether there is a trend toward preferring to work in private sectors rather than public sectors among medical personnel because it is generally assumed that private hospitals pay much more than public hospitals, the council indicated that the preference for working in the private sector is unlikely to occur as there are many advantages to being a government employee.

The Government Medical Officers Association, which is an association of health care professionals, is claiming that registration of a facility with the council is not required, leading to a huge controversy. The registration requirements for medical facilities do not necessarily ensure service quality; they only include the numbers of beds, not the numbers of health care providers, etc. Therefore, it was assumed that further improvement of the registration details and additional supervision would be necessary. Nonetheless, it can be said that the system for supervising private medical services is developing after the establishment of

the registration system.

3) The Dental Services Unit

This unit is responsible for ensuring that resources, including personnel, are available at the request of the dental departments of public healthcare institutions. The unit does not develop policies, strategies, and action plans or identifying issues in the field, but the National Dental Hospital / Institute of Dental Services is in charge of these tasks.

Dental services in Sri Lanka are divided into two categories: preventive services such as health education and dental treatment services in medical facilities. Prevention is mainly handled by the Health Promotion Bureau and the Family Health Bureau. In terms of treatment, there are five specialties (oral and maxillofacial surgeons (OMF), orthodontics, community dentistry, conservative dentistry, and oral epidemiology), with three disciplines - OMF, orthodontics, and conservative dentistry - concerned with the problems of the elderly. The number of dental-related personnel and facilities, including the above specialist dentists, is shown in Table 4.3.9. The number of general dentists has increased significantly since 1984 but the number of specialists has only increased slightly in the 30 years since then. There is only one educational institute for dentistry (Peradeniya University) in Sri Lanka with around 100 graduates annually.

Table 4.3.9 Dental Medical Personnel and Number of Facilities

Category		1984	1994	2002	2015
Specialized Dentist	Oral Maxillofacial Surgery	10	15	22	28
	Orthodontics	3	4	7	21
	Community Dentistry	12	5	6	11
	Restorative Dentistry	0	0	2	9
	Oral Pathology	0	0	0	1
Dentist		311	387	765	1536
School Dental Therapist		434	490	450	383
Dental Technicians		12	38	11	50
Public Dental Clinic		201	335	312	712
School Dental Clinic		213	350	379	488

Source: National Oral Health Survey Sri Lanka 2015/2016

4) Section of NCD

This section is in charge of NCD measures. There are National Policy for NCD and National Multi-sectoral Action Plans for the Prevention and Control of Non-communicable Diseases 2016-2020 developed by the national government that have been implemented by this section. This section has especially focused on monitoring primary and secondary preventive measures for NCD conducted in divisional hospitals and PMCUs, including HLCs. The section of Medical Services is in charge of treatment and the section of Medical Services or the YED focus on rehabilitation.

a) NCD Unit

[Responsibilities and Current Situations]

There are about 1,010 HLCs across the country. Although it is planned that HLCs will be established at all district hospitals and PMCUs in the future, this has not yet been achieved. The HLCs consist of medical officers, PHNOs or nurses, PHMWs, support staff, and volunteers. The HLCs, which used to target only patients aged 35-65 years, currently have no age limit and so cater to elderly patients.

Secondary prevention for NCD involves screening. Screening includes checking smoking status, alcohol consumption, exercise practices, physical measurements, body mass index (BMI), blood pressure, blood glucose, blood cholesterol, and blood creatinine (if measurable), and interviews regarding risk factors proposed by WHO. The HLCs provide support for dietary education and lifestyle improvements based on the results of these measurements. In the case that abnormal values are found, the patients are provided with treatment. In addition, screening for oral cancer, thyroid cancer, cervical cancer, breast cancer and other cancers will be carried out once a year. These examinations are not organized screenings but rather voluntary examinations. The actual coverage is about 10% despite the current target of 25%. The coverage rate has increased over the last several years but does not reach a level that would contribute to the early detection of disease. Another issue is that the data are not sufficiently accurate; duplicate data, for example, are often recorded.

b) Cancer Control Program Unit

This unit is in charge of services such as cancer screening, treatment, and palliative care. It focuses on cancer screening aimed at early detection and treatment but includes screening for cervical and breast cancer only. There are a total of 24 hospitals that specialize in cancer, with at least one in each prefecture capable of providing cancer diagnosis and treatment services. As for specialized doctors, there are about 30 oncologists, and surgeons specializing in various organs that are available to perform operations. The number of radiologists is extremely limited.

There are cervical and breast cancer screening services available. Specifically, the PHMWs and MOHs conduct examinations by educating medical doctors and nurses who visit well-women clinics on how to test for cervical cancer. Coverage has been very successful, averaging 50-60%, and reaching nearly 100% in some divisions. For breast cancer, women are palpated as a rule first and only these at high risk are examined by mammography. For other diseases such as oral cancer, high-risk individuals such as betel chewers, smokers, and those with significant alcohol intake are also examined. Information on these screening is generally shared with women when they receive health (well-women) services or when PHMWs, PHNOs, or others visit them. In terms of treatment, radiotherapy is available at six hospitals. Only Maharagama and Jaffna Teaching Hospitals in the Northern Province have the capability to provide linear accelerator treatment. There are currently 24 cancer treatment centres with about 30 special doctors for palliative care. There is one governmental health facility and seven NGO based facilities for hospice care.

[Challenges recognized by Cancer Control Program Unit]

As the number of colorectal cancer diagnoses among the elderly is increasing, medical doctors need to improve their colonoscopy examination techniques. Financial and technical support is expected for their improvement.

There is a plan to establish model cancer hospitals in each province in the future. In order to do so, facilities, equipment, and human resource development are necessary. There is a lack of necessary equipment for diagnosis and treatment. The number of medical doctors capable of performing radiotherapy is also limited.

There are currently 24 cancer centres for treatment and this unit is aiming to develop a comprehensive team for palliative care services consisting of different professionals who are able to provide palliative care services at these centres, as well as to establish a network for the service provision. There are few special doctors and nurses with expertise in palliative care, and so there is a need to build a team of healthcare professionals with this specialization. It would be good to get support for setting up a palliative care team, building teamwork, and educational activities. Palliative care can be provided in public institutions, private clinics (hospices), and communities. In general, the concept of palliative care is not yet widespread; therefore, awareness-raising activities should be carried out through media, leaflets, and social media as well as the team building mentioned above.

It is not known whether people who tested positive in screenings were eventually treated or not or what the overall outcome was. This is due to the fact that these health information management systems have not been established.

As the population ages, the prevalence of cancer among the elderly is expected to increase. Cancer screening services for women up to 60 years of age, mainly in the reproductive age group, has been covered, however screening services for the elderly need to be considered, taking the transition to an aging society into account. Techniques for post-operative reconstruction after breast cancer, for example, will be needed in the future.

c) Mental Health Unit

The health sector in Sri Lanka is divided into treatment and prevention. In terms of treatment for mental health, psychiatric health services are provided in upper levelled hospitals of base hospital type A[92]. On the other hand, in terms of prevention, there are various actions to be done to promote preventive measures for a better life. The following are some of the items which need to be done as mental health measures for the elderly are considered in the unit.

- Establishing care centres for elderly people and caregivers in the MOH offices
- Building a team that collaborates not only with medical professionals but also with multi-professionals and NGOs using the MOH system.
- Organizing events for caregivers (sharing experiences, exercise, singing, etc.) to reduce the stress of caring for the elderly.

[92] Facility classification and requirements are shown in 4.3.2.

- Creating a mechanism to implement the above activities (equivalent to a local community support centre).

It is understood that no facility in Sri Lanka can accommodate long-term hospitalization for patients with mental illness, so the MoWCASS is considering the development of guidelines for long-term hospitalization facilities. It is recognized that there is no specific responsibility on the part of the MoH to develop measures against mental illness, it is rather the responsibility of the MoWCASS.

5) Section of Education, Training, and Research

There are two units in the headquarters, one in charge of nurse education and the other paramedical education. The main roles of the units are shown below.

a) Training Unit

The Unit primarily coordinates basic education and in-service training for paramedic professionals. The unit evaluates the content of training applications and funds training if it is approved.

For in-service training, an orientation session regarding research and teaching institutions is held at the beginning of each year to explain how to apply for training and how to fill out the application forms. Applications for training are accepted throughout the year and judged based on content, relevance, and budget size. The unit will ask applicants for amendment as necessary, and it is common for the amended application to be accepted. The MoH has not specified the topics of training and has accepted training requests on demand

It also covers the cost of individual training courses, which is determined by taking into account the background of the applicant and the effect of the training course. Up to Rs. 50,000 will be allocated by a committee consisting of the Head of the Training Unit, Head of the Medical Services section, and the Head of the Nursing Unit. The approval of the DGHS and other senior officials will be required for Rs. 50,000 and above.

A diploma course (six months) is available for paramedics. After completing the diploma, they will be given the opportunity to enter university and receive a degree if they pass the examination with practical experience. The diploma is under the jurisdiction of the MoH. The university is treated differently as it is under the jurisdiction of the Ministry of Higher Education. Diploma courses are available for pharmacists, nurses, PHIs, PHMWs, prosthetists, dental therapists, entomologists, occupational therapists, physiotherapists[93], radiographers, EEG technicians, ophthalmology technicians and public health inspectors. There is a current shortage of public health inspectors, PHMWs and nurses. The training of PHNOs is particularly necessary to strengthen elder care services. There is a rehabilitation centre in Ragama. However, there is no rehabilitation centre specifically for the elderly. The unit recognizes the need to strengthen rehabilitation services for the elderly, but no concrete plan has been developed yet.

[93] Diploma courses are until 2019. Bachelor courses in universities will be available in 2020.

b) Nursing Education Unit

Nursing education involves a three-year diploma or a bachelor's degree course under the jurisdiction of the Ministry of Higher Education, Technology, and Innovation. There are 16 nursing schools nationwide under the MoH, three of which focus in specialized education - the mental nursing school, the higher nursing school, and the military school. There are five nursing colleges[94] under the Ministry of Higher Education and a degree in nursing can be obtained after the completion of a bachelor's degree.

9,000 people become nurses annually after receiving nursing education, 2,500 to 3,000 of which are employed by public institutions. According to the 2017 Annual Health Statistics, the total number of nurses[95] is 37,111, but the required number of nurses is calculated to be 51,000[96]. About 2,000 new employees were hired in January 2020 and about 2,000 more will be hired in August 2020.

Personnel who have graduated from nursing school are positioned at the beginner level of medical technicians called grade 3, and, after gaining a certain period of work experience and passing an examination, they can take specialized courses. Major specialization courses include intensive care, operating room, community health, paediatrics, emergency, renal disease, midwifery, and stoma care. Although a curriculum for specialty courses in palliative nursing has been recently developed, courses have not yet been offered. If a nurse completes either of specialty courses, he/she can be promoted to grade 2, and eventually to grade 1. The promotion courses would be categorized into nursing education, hospital services, and public health nursing. They would attend a year and a half of diploma training. Six months of the training will be in midwifery for women and mental illness for men, and the other year in either education and leadership, hospital administration, or community health.

Elder care is only part of the three-year diploma course for a nurse, and there are no other opportunities to receive additional training specializing in elder care. Therefore, unfortunately, nurses do not have the necessary skills in this field. There is no in-service training specific to elder care and it is recognized that training needs to be developed in the future.

According to the interview with the Director of Education, Research and Training for nurses, since 2019, PHNO training has emerged as a new occupation. Last year, 105 people were trained in the first training and assigned to the HLC and they are to provide home care nursing. This training process is said to be for half a year, and a PHNO's main duties, such as NCD measures and palliative care, are in the curriculum; however, it does not include rehabilitation for the elderly and it includes a part of rehabilitation for cancer care.

6) Medical Statistics Unit

The Medical Statistics Unit under the MoH has its own MIS to collect all health information from each

[94] There are seven of them in a 2014 document: Open University of Sri Lanka, University of Sri Ja'pura, University of Jaffna, University of Rahuna, Eastern University, University of Peradeniya, and Defence University.
[95] Total number of matrons, ward sisters, principals/ sister tutors, nursing officers, and supervising public health nursing sisters/ public health nursing sisters—not including pupil nurses.
[96] Based on an interview at the Nursing Education Unit, Education, Training and Research Unit, the Ministry of Health.

health facility in the country. A Medical Statistician and 3 Assistant Statisticians are recruited from the Census and Statistics Department which is under the Ministry of Finance and Planning. The other staff attached to this unit are recruited by MoH. It is also directly located under the Secretary of Health in the MoH. This unit is collecting data information from each health facility using the information system. 85 percent of data from health facilities are entered on internet and is available for analyses in this unit. Some facilities that do not have a computer send data to this unit on a regular basis or to the local health office for data entry. For each patient, a disease name according to the 10th revision of the International Classification of Diseases (ICD-10), hospitalization and discharge date, outcome, and other data is registered and reported. The data is about treatment only, does not involved the number of implemented preventive services.

(2) Local Government

A survey was conducted in Central Province in order to investigate the situation facing local health authorities.

1) Central Province

a) Provincial Department of Health Services (PDHS)

[Situation regarding Elderly Care]

Regarding care for the elderly and people with disabilities, there is a lack of public awareness of the policies and plans by the YED and the country and of the national-level programs. In addition, there is no confirmation of provincial policy or monitoring opportunity by the national level, nor is there coordination with the Ministry. Therefore, the Province is currently developing plans by itself for providing elder and disability care. The Central Province aims to set up a service delivery system for the short term, IT and referral systems for the medium term, and appropriate placement of supportive care for the long term. Table 4.3.10 shows the outline of the aging countermeasure plan currently being developed in the Central Province.

Table 4.3.10 Action Plan for Aging Society in the Central Province (Under development)

#	Activities	Detailed plan
1	Planning and implementation of a community screening program	Using the MOH office, develop and maintain a registration system for the elderly and, through this system, record and manage information on the inconvenience of the elderly, the morbidity of NCD, the poverty situation, etc.
2	Building an evaluation team for elder care	This activity aims to evaluate the physical, mental, and better-living conditions of the elderly. In addition to geriatric specialists, this team shall consist of specialist members from various fields, such as family health consultants, ophthalmologists, dentists, psychiatrists, general practitioners, physiotherapists, occupational therapists, and sociologists. It is assumed that an ophthalmologist evaluates visual acuity, a dentist oral hygiene, a physiotherapist the level of disability, and a psychologist the implementation status of counselling. These evaluations shall be carried out at the MOH level. Securing IT facilities necessary for analysis and evaluation of this information, hiring staff, and other factors shall also be considered.
3	Training on awareness program	Conduct training for the staff of health and other sectors regarding the elder care awareness program.

#	Activities	Detailed plan
4	Implementation of enlightenment programs for the social participation of the elderly.	
5	Social and recreational activity plans	
6	Utilization of the referral system for the identified patient	A PHNO identifies a patient. The MOH office coordinates the patient's treatment.
7	Dementia care	A new ward was constructed at the Udagama Atabage Divisional Hospital in Kandy District as a long-term medical facility for dementia care, but due to a lack of staff, no service has been provided yet. In addition, at the Divisional Hospital Walapane and Divisional Hospital Maskeliya in Nuwara Eliya district, two beds will be allocated for mental illness with the aim of strengthening the psychiatric ward and including care for mental illness in the elderly.
8	Reconstruction of ordinary medical facilities	Aim to improve services for the elderly by installing/renovating slopes, toilets for the disabled, and others in hospitals and introducing a priority service and clinic for the elderly, training for services for the elderly.
9	Expansion of palliative care	Install beds for palliative care in all medical facilities. Also provide home care, such as catheter replacement and intravenous drip for palliative care patients by a PHNO.
10	Improving the quality of elderly care facilities	Create a database of elder care facilities and register them to improve their quality of services. While some of the facilities do not meet the requirements, ensure the quality of facilities and services by registering the facilities and regularly inspecting them. At the same time, if necessary, consider providing funds and conducting regular medical examinations.
11	Improvement of rehabilitation function	Consider the installation of a rehabilitation function at the Divisional Hospital Leliambe in the Matale district and the construction of a rehabilitation hospital at the Divisional Hospital Hanguranketha in Nuwara Eliya district. Regarding the former, aim to provide services by securing trained personnel in 2021. For the latter, aim to build a large-scale rehabilitation centre by investing about 1 billion rupees.

b) Regional Directorate of Health Services (RDHS)

Nuwara Eliya RDHS (Nuwara Eliya District, Central Province)

[Characteristics of Nuwara Eliya District]

- The target population of this district is approximately 760,000, of which 40 % (305,000) live in estate areas.
- The estate areas are widely located in this district, and places such as Maskeliya, Lindula, Kotagala, Bogawantalawa, and Ambagamuwa are 100% estate. In these areas, lifestyles and religious and cultural ways of thinking are very different from those in other areas.

The health service provision for the elderly in this district is as follows.

[Current situation regarding NCD measures]

- In this district, all HLCs conduct screening for NCD among adults over 35 years old. The screening items includes interviews regarding risks of cardiovascular disease, measuring BMI, and blood sugar level.
- All data is submitted by the MOH offices or the HLCs and analysed in the District.
- Few people came to the HLC for screening when it first opened, so the patients visiting the outpatient clinic were referred to the HLC for the NCD screening.
- There are only three elders care homes in Nuwara Eliya District. The MOH office provides medical examinations and other services.

[Challenges on NCD measures recognized by Nuwara Eliya RDHS]

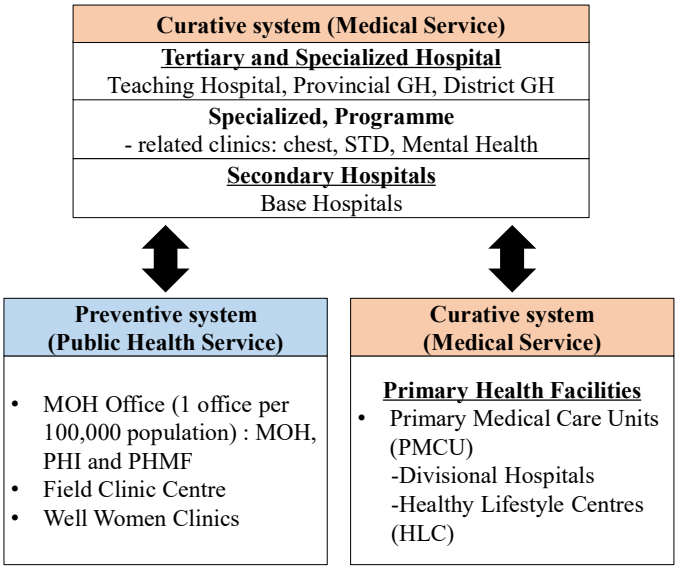
- A very small number of males participate in their health check-ups in the district (9.8%). In addition, there is a high prevalence of high-risk behaviours in this district, such as alcohol intake, smoking, chewing tobacco, and so on.
- In the estate area, there is a dispensary (pharmacy) created by the management of the estate company, and it is common for residents of the estate area to use the dispensary. There are many cases in which health personnel at the dispensaries have not received qualified education. Also, it is difficult to collect accurate information about the operation of these dispensaries.
- There is a shortage of health care professionals in this district. The ratio of patients to medical doctor is higher than in other areas and it is difficult to provide the necessary services. Under these circumstances, it is also difficult for health care professionals to visit these communities; hence, it is more desirable to encourage patients living in remote areas to visit health care facilities while minimizing transportation time for the health care providers.
- Local customs and living environments in the estate areas make health education more challenging. For example, salaries paid on a daily basis are used for purchasing alcohol. Estate owners have set up a bar inside the estate to encourage people to drink alcohol. In addition, some the residents in estate area believe that alcohol is effective in reducing stomach pain, and so women, including pregnant women, drink it as well; domestic violence is also reported. The PHMW has been trying to educate people, especially pregnant mothers and their family members, to correct these misconceptions, however their efforts are often in vain.
- Regarding NCD screening, many residents in the estate area are not obese and thinning is often a problem. Therefore, the estate region has different health characteristics than Colombo and other regions.
- Regarding data management, mistakes, such as counting the same person many times, have been confirmed. In some areas, 70-80% of data is duplicated and there were also confirmed cases of the same person intentionally making different reports, which emphasizes the necessity of data management by computer. The MoH is promoting data management of NCD by using a computer but it has not yet been implemented in this district.

  NCD are an issue for elderly people as well, but specific actions focusing on the elderly have not yet been implemented. As for mental illness (dementia) in the elderly, referring patients to a nearby hospital with a psychiatry department is common if major symptoms occur. However, in the future, it is desirable that doctors closer to the community (medical doctors located in the MOH office, PMCU, etc.) deal with the mental health of these elderly people. Training for these medical doctors to better implement elder care in the psychiatric field shall be planned.

4.3.2 Current Healthcare Delivery System in Sri Lanka

The MoH administers health sector by dividing it into two sub-systems, preventive and curative. Regarding the preventive system, one MOH Office is established per 100,000 people under the control of the section of Public Health Services of MoH. MOH offices are composed of the MOH as the team leader, with a

Public Health Inspector (PHI) and Public Health Midwife (PHMW) at the grassroots level offering preventive health cares.



Based on Sri Lanka Essential Health Service Package 2019 and information provided by YED

Source: JICA Survey Team

Figure 4.3.3 Health care management system in Sri Lanka

In terms of the curative system, there are divisional hospitals and PMCU as primary care health facilities, base hospitals as secondary care health facilities, and teaching hospitals, provincial general hospitals and district general hospitals as tertiary care health facilities under the control of the section of Public Health Services of the MoH.

Teaching hospitals and provincial and district general hospitals collaborate to cover all medical fields. Base hospitals, which are regarded as secondary care health facilities, provide major specific services including internal medicine, surgery, obstetrics and gynaecology, paediatrics including outpatient department and inpatient wards, and clinics. Base hospitals are divided into two different levels: A and B. The type A includes the general departments and some special departments such as otolaryngology, dermatology, psychiatry, radiology, and others. They have two consultants to main specialities. Type B contains at least one consultant to main specialities and one each assigned to other specialities such as radiology, anaesthesia, psychiatry, ophthalmology and otorhinolaryngology. Most of the base hospitals have Preliminary Care Units.

Among PMCUs, divisional hospitals are devoted to outpatient care, clinics and inpatient services. Most of the divisional hospitals have an Emergency Trauma (Treatment) Unit (ETU). After stabilizing the condition, patients are transferring to apex hospital. Non-critical cases and normal pregnancies are admitted for inward care. Former central dispensaries are converted to HLC, as functional units for the screening of NCD. Medical Officers at divisional hospitals provide medical services on normal deliveries and general medicine. Most clinics conduct outreach clinics such as mental health clinic. Divisional hospitals are also divided into

three different types depending on their inpatient capacities (Type A: > 100, Type B: between 50-100, Type C: < 50). Table 4.3.11 shows eligibility requirements for the above facilities.

Table 4.3.11 Classifications of Public Health Facilities and Eligible Requirements

		Teach / Prov Gen. HP	Dis Gen HP	Base HP type A/B	Div HP type A/B/C A:>=100 beds, B:50-99 beds, C:< 50 beds	PMCU
Referral level		Tertiary		Secondary	Primary	
Outpatient ward	Preparation care unit Emergency care unit Screening section	○			Limited capacity of emergency care and screening	Outpatient services Limited capacity of emergency care
Clinic		○			Policlinic including prenatal and postpartum care, family planning, care for child, women's clinic.	
Inpatient ward	Internal Medicine	3	2	A:2 / B:1	1 Internal medicine・Surgery (Male)	-
	Surgery	3	2	A:2 / B:1	1 Internal medicine Surgery (Female)	-
	Paediatrics	3	2	A:2 / B:1	1	-
	Obstetrics & Gynaecology	3	2	A:2 / B:1	Labour room/inpatient ward for pregnant and postpartum women	-
	Neurology	1	*	-	-	-
	Cardiology	1	*	-	-	-
	Dermatology	1	1	-	-	-
	Psychiatry	1	1	*	-	-
	Rheumatology	1	1	*	-	-
	Oncology	1	-	-	-	-
	Sexually Transmitted Infections (STI)/HIV	1	1	*	-	-
	Neurosurgery	1	-	-	-	-
	Orthopaedics	2	1	-	-	-
	ENT (Surgery)	2	1	A:1 / B:0	-	-
	Ophthalmology (Surgery)	2	1	A:1 / B:0	-	-
	Urology and genital course (Surgery)	1	-	-	-	-
	Nephrology	1	-	-	-	-
	Neonatal unit	1	1	-	-	-
	Thoracic medicine	○	*	-	-	-
	Blood Transfusion Medicine	○	*	-	-	-
Intensive Care Unit (ICU)	Internal ICU (MICU)	○	○	○	-	-
	Surgical ICU (SICU)	○	○	○	-	-
	Cardiological ICU (CICU)	○	-	-	-	-
	Coronary ICU (CCU)	○	-	-	-	-
Preliminary Care Units (PCU)				○		
Emergency Treatment Units (ETU)				○[97]	○	
Operating room		○	○	○	A small operating room	-
Diagnostic services	Radiology	○	○	○	Basic examination room	-
	Pathology (Tissues, blood,	○	○	○		-

[97] ETU is available at some hospitals where PCUs are not available.

	Teach / Prov Gen. HP	Dis Gen HP	Base HP type A/B	Div HP type A/B/C A:>=100 beds, B:50-99 beds, C:< 50 beds	PMCU
microorganisms)					
Accident・Injured Surgery Dept.	○	-	-	-	-
Forensic Medicine Dept.	○	○	○	-	-
Maxillofacial surgery Dept.	○	○	○	Dental Dept.	-
Orthodontics Dept.	○	-	-		-
Public Health Dept.	○	○	-	Clinic (Available for outreach clinic or home visit service by hospitals)	-
Medical Statistics Dept.	Medical Statistics	Medical Records		-	-
Anaesthesia Dept./Unit.	Anaesthesia	Anaesthesia		-	-
Other facilities	-	-	-	Follow up care facility for patients referred from upper levelled medical facilities.	Facility provide first aids before referring patients to upper levelled facilities.
Remark		*Added if required			

* Number refers to number of units to be established. ○ refers to a unit which the number to establish is not determined.
Source: Teach HP: Teaching Hospital, Prov/Dist Gen HP: Provincial/District General Hospital, Base HP: Base Hospital, Div HP: Divisional Hospital. Dept.: Department, Ref: Recategorization of hospitals (MoH) and Data collection survey on health sector in Democratic Socialist Republic of Sri Lanka (JICA)

Decentralization is promoted in Sri Lanka, and therefore secondary and tertiary care health facilities are under the jurisdiction of the MoH while primary care health facilities are under each provincial government.

(1) Health Service System of Sri Lanka

The numbers of public medical facilities by types and districts are shown in Table 4.3.12, Table 4.3.13 and Table 4.3.14.

Table 4.3.12 Number of Public Healthcare Facilities by Types

District	Population (1000)	Teach HP	Prov Gen HP	Dist Gen. HP	Base HP A	Base HP B	Div HP A	Div HP B	Div HP C	PMCU/MH	Others	PMCU	MOH Area
Colombo	2,419	7			3	1	1	6	2	5	34	28	16
Gampaha	2,391	1		2	1	2	4	1	7		23	45	16
Kalutara	1,271			1	3	2	2	7	6		21	11	15
Kandy	1,452	3		1		2		14	33		59	28	23
Matale	514			1	1			4	14		20	15	13
Nuwara Eliya	756			1	1	1	2	8	14		27	21	13
Galle	1,113	2			2	1	2	7	9	2	26	24	20
Matara	851			1		2	2	6	5		16	21	17
Habantota	647			1	1	2		9	8		22	13	12
Jaffna	608	1			2	2		4	19		28	16	14
Kilinochchi	124			1		1		1	6		9	3	4
Mullaitivu	107			1		2	2	2	4		11	4	5
Vavuniya	184			1		1		1	6		9	5	4
Mannar	96			1			1	4	5		11	9	5

District	Population (1000)	Teach HP	Prov Gen HP	Dist Gen. HP	Base HP A	Base HP B	Div HP A	Div HP B	Div HP C	PMCU/MH	Others	PMCU	MOH Area
Batticaloa	560	1			2	2	2	3	12		22	14	14
Ampara*	705			1		2		1	6		10	15	7
Kalmunai*					3	4		3	7	3	20	9	13
Trincomalee	412			1	1	3			11		16	18	12
Kurunegala	1,694		1		1	3	9	11	20	1	46	54	29
Puttalam	814			1	1	1	2	4	9		18	30	13
Anuradhapura	918	1				3	4	10	21		40	21	19
Polonnaruwa	431			1		2	1	4	4		12	16	7
Badulla	864		1		2	1	2	9	32		47	16	16
Monaragala	485			1		3	1	5	8		18	10	11
Ratnapura	1,151		1	1		4	7	7	18		39	29	18
Kegalle	877			1		3	6	3	10		24	21	11
Sri Lanka (total)	21,444	16	3	19	24	50	50	134	296	11	628	496	347

Teach HP: Teaching Hospital, Prov/Dist Gen HP: provincial/District General Hospital, Base HP: Base Hospital, Div HP: Divisional Hospital. * Following districts have Divisional Hospitals without any inward equipment; Gampaha1, Jaffna1, Kilinochchi1, Mullaitivu 3, Puttalam1, Badulla10, Kegalle 6. Cancer institute, mental or dental hospitals are categorized as others.

Source: Annual Health Bulletin 2017

Table 4.3.13 Bed Numbers of Public Health Facility by Different Level

District	Population (1000)	Teach HP	Prov Gen HP	Dist Gen. HP	Base HP A	Base HP B	Div HP A	Div HP B	Div HP C	PMCU/MH	Others	Beds per 1000
Colombo	2,419	8,039			1,286	286	91	404	66	60	14,230	5.9
Gampaha	2,391	1,569		1,440	636	291	632	84	216		6,033	2.5
Kalutara	1,271			927	1,047	206	207	502	180		3,069	2.4
Kandy	1,452	3,941		473		602		1,011	1,038		7,274	5.0
Matale	514			845	315			272	354		1,786	3.5
Nuwara Eliya	756			422	158	172	245	570	414		1,981	2.6
Galle	1,113	2,294			903	125	213	509	323	21	4,397	4.0
Matara	851			1,214		425	211	527	162		2,539	3.0
Habantota	647			675	297	376		705	281		2,410	3.7
Jaffna	608	1,313			691	266		346	430		3,046	5.0
Kilinochchi	124			293		43		103	130		569	4.6
Mullaitivu	107			202		95	118	38	39		492	5.1
Vavuniya	184			670		93		37	81		881	4.8
Mannar	96			331			105	254	112		802	7.5
Batticaloa	560	1,001			448	383	158	189	407		2,586	4.6
Ampara*	705			756		339		70	203		1,368	4.8
Kalmunai*					994	479		221	291	50	2,035	-
Trincomalee	412			497	240	329			379		1,445	3.5
Kurunegala	1,694		2,002		651	980	1,067	774	533	14	6,021	3.6
Puttalam	814			593	405	374	261	196	224		2,053	2.5
Anuradhapura	918	2,153				358	460	642	672		4,298	4.7
Polonnaruwa	431			930		216	136	193	126		1,601	3.7
Badulla	864		1,513		820	167	235	578	556		3,869	4.5

District	Population (1000)	Teach HP	Prov Gen HP	Dist Gen. HP	Base HP A	Base HP B	Div HP A	Div HP B	Div HP C	PMCU/MH	Others	Beds per 1000
Monaragala	485			480		475	102	402	242		1,701	3.5
Ratnapura	1,151		1,561	484		846	583	357	341		4,180	3.6
Kegalle	877			848		1,034	521	92	101		2,609	3.0
Sri Lanka (total)	21,444	20,310	5,076	12,080	8,891	8,960	5,345	9,076	7,901	145	83,275	3.9

Teach HP: Teaching Hospital, Prov/Dist Gen HP: provincial/District General Hospital, Base HP: Base Hospital,

Div HP: Divisional Hospital.

* Kalmunai is located in Ampara, and Kalmunai's population is included in that of Ampara. Number of bed per 1000 for Ampara was calculated from total beds of Ampara and Kalmunai.

** Following districts have Divisional Hospitals without any inward equipment: Gampaha1, Jaffna1, Kilinochchi1, Mullaitivu 3, Puttalam1, Badulla10, Kegalle 6.

*** Cancer institute, mental or dental hospitals are categorized as others.

Source: Annual Health Bulletin 2017

Table 4.3.14 Distributions of HLC

	2011	2012	2013	2014	2015	2016	2017
Number of HLC	126	420	672	760	814	826	871
Percentage of districts which have at least 2 HLC and more per MOH area (%)	-	-	56.0	69.5	77.8	79.6	83.4

Source: Annual Health Bulletin 2017

4.3.3 Roles and Current Situation of Service Providers

Services are broadly classified into prevention and treatment. To better understand the roles and actual conditions of the medical facilities in each category, examples, mainly from Central Province are shown below.

A. Central Province

(1) Preventive Sector

1) MOH Office

a) Kandy District, Central Province: Pasbage (Nawalapitiya) MOH Office

[Summary]

The facility provides preventive services to approximately 64,000 residents in the target area. The staff consists of two MOHs, 21 PHMWs, six PHIs and one PHNS. There are 29 GNs in the target area, with some PHMWs serving two districts. As a general rule, motorbikes would be provided to the PHMWs who are in charge of divisions without public transport, but this does not apply to them all. PHMWs mainly provide maternal and child health services and visit households with women, children, and adolescents regularly. PHIs focus on sanitation, food safety, and school health as their duties.

[Services for the Elderly]

- MOHs provide screening services of NCD as part of mother and child health. PHMWs and medical

officers mainly test blood pressure and blood sugar level of adults over 35 years old. Regarding NCD services, it is aimed to cover approximately 1% of the target population.

- The number of NCD screenings is 30-40 per month and about 70% of those are women. Of all the people screened, the percentages of senior citizens are about 10% for women, 21% for men, and 13% for both, indicating that the percentage of elders who are screened is higher among men than women. The implementation status in recent months is shown in Table 4.3.15.
- MOHs regularly visit elderly care facilities to assess physical health and conduct medical checks in coordination with other welfare services.
- MOHs promote the prevention of smoking and chewing tobacco and provide dietary education for adults.
- There is no program for the elderly and their registration system in place nor the government does grasp information on the elderly in the jurisdiction.

Table 4.3.15 Number of NCD Screening at Pasbage MOH Office

		July		August		September		October		Total period	
		Total	Elders	Total	Elders	Total	Elders	Total	Elders	Total	Elders
Female	Number	57	5	120	15	22	0	36	2	235	22
	%*	71.3%	8.8%	69.8%	12.5%	56.4%	0.0%	75.0%	5.6%	69.3%	9.4%
Male	Number	23	5	52	15	17	0	12	2	104	22
	%	28.7%	21.7%	30.2%	28.8%	43.6%	0.0%	25.0%	16.7%	30.7%	21.2%
Total	Number	80	10	172	30	39	0	48	4	339	44
	%	100%	12.5%	100%	17.4%	100%	0.0%	100%	8.3%	100%	13.0%

Based on interviews at the facility site.

Source: JICA Survey Team

b) Nuwara Eliya District, Central Province: Nuwara Eliya MoH Office

The MOH office covers two MOH areas (32 GNs), mainly in Nuwara Eliya, with a population of 90,000 people and a coverage area of 8km. The majority of this area is in the estate area. Maternal and child health services (prenatal and postnatal care and paediatric care) are provided by PHMWs, sanitation and occupational health services by PHIs, and NCD screening, health education, and referral to treatment by PHMWs and PHIs. NCD screening includes assessments of BMI, blood pressure, blood sugar levels, neoplasms (breast cancer palpation, cervical cancer, oral cancer risk check), and infectious diseases. Other services include school health, immunizations, women's health (well-women) clinics (NCD screening, breast cancer palpation, cervical cancer testing, similar services as described above), and oral health care (school health).

Staff consisted of two MOHs, two assistant MOHs, one chief PHI, six PHIs, 26 PHMWs, two senior PHMWs, and one PHNS; in terms of transportation, PHIs are supplied with motorbikes, but most PHMWs are not provided with motorbikes or other forms of transport. As there is no public transport, they have to use tuk-tuks or other forms of transport or travel on foot; PHMWs cover two to three PHMW areas per person, with a target population of 1,000 to 4,000 people.

[Elder Care Services]

Table 4.3.16 shows recent results of NCD screenings.

Table 4.3.16 Screening Number of NCD at Nuwara Eliya MOH Office

	Male		Female		Total	
	Total	Over 60 years of age	Total	Over 60 years of age	Total	Over 60 years of age
October 2019	59	3	64	7	123	10
January 2020	12	2	32	4	44	6

Based on interviews at the facility site

Source: JICA Survey Team

- Regarding homes for the elderly, it seems that there are one or two nursing homes supported by NGOs (World Vision) in the Stony Cliff and Kotagara MOH areas. There are nursing facilities in the estates in some areas but not in the Nuwara Eliya.
- Family registration is limited to those who are eligible for maternal and child health services and there is no registration system for the elderly.
- Staff of the MOH office have received NCD training, but no special training for elderly care. The staff will consult with elderly people if the patients ask for support; otherwise staff are not actively talking about the health of the elderly.
- Measures for aging is included in the essential service package disseminated in 2019 according to the UHC policy of the government, although it has not been realized yet. Persons at the provincial and district level, such as the staff of base hospitals, may have been trained in the NCD of this package supported by ADB, but the staff of the facility had not received training of elder care and palliative care.

[Challenges in Implementing Services (Including Elderly Care) recognized by Nuwara Eliya MoH Office]

- The MOH office does not have any mechanism to provide services for the elderly. Due to the lack of human resources, it is better to cooperate to provide elder services with other units. PHNOs are allocated in the HLCs in the Divisional Hospitals, covering approximately 20 GNs per facility. Securing sufficient personnel to provide the appropriate services should be prioritized.
- The usage rate of health care services is low because many men work outside the division. Even if health-related events such as health and dietary education seminars are held, most of the participants are women.

c) Nuwara Eliya district, Central Province: Maskeliya MOH Office

This MOH office has a target population of approximately 75,000 people, with a staff of three PHIs, 12 PHMWs and one SPHMWs; there are 25 divisions covered by the PHMWs in this region, so one PHMW covers two divisions. The main tasks are environmental health, toilet sanitation, water quality, food quality and hygiene, school health, and infectious disease and NCD prevention. PHMWs are in charge of supporting households with females between the ages of 15 and 49 years. There are no rules, standards, or regulations regarding support for the elderly, although PHIs see trend of the elderly people.

[Elderly Care Services]

- For NCD, an outreach clinic is held once a week on Tuesday. There is a separate record table used for assessing oral cancer (via interview), chest pain, blood sugar level, blood pressure, BMI measurement, breast cancer palpation, and providing health education. Each patient has his or her own booklet of records and the results are recorded in that booklet. PHMWs, PHIs, and MOHs are engaged in the health check-ups and PHIs provide health education.
- Last year, NCD screening was conducted for approximately 2,000 people. Adults aged 35 and over were screened for the prescribed items, except cholesterol, which was assessed by interview as there is no function to measure blood concentration of the cholesterol.

[Challenges in Implementing Services (including Elderly Care) recognized by Maskeliya MOH Office]

- There is a shortage of human resources. There are 13 PHMWs allocated for 25 PHMW areas, three PHIs allocated for 5 PHIs and two MOHs. Two of the three PHIs are recently deployed.
- People living in this area are less likely to use medical services. Nuwara Eliya District General Hospital provides services for elderly patients depending on their needs.

(2) Curative Sector

1) Tertiary Level Healthcare Facilities

There are only two tertiary health care facilities in Sri Lanka that have clinics or departments for the elderly; one is Colombo South Teaching Hospital in Colombo City in Western Province and the other is the Teaching Hospital Peradeniya in Kandy District of Central Province. An overview of each is given below.

a) Kandy District, Central Province: Teaching Hospital Peradeniya

Elderly patients were previously treated equally to general patients at the Teaching Hospital Peradeniya, however, an outpatient department and clinic for geriatric care was established to provide services specifically to the elderly in October 2017.

The Geriatric Department primarily focuses on outpatient and clinic services for the elderly, as well as referral of elderly patients to other departments, providing mental health care, and care for the elderly during hospitalization. Specifically, when an elderly patient comes to an outpatient clinic, after being interviewed and checking body temperature and blood pressure measurements, he or she is referred to the Geriatric Outpatient Clinic. Diagnoses are made at the Clinic and the patient receives medication treatment in the Geriatric Clinic in case he or she has a chronic condition that requires medical follow-up or is referred to a specialized department in case more specialized treatment is needed. Currently, there are approximately 400 elderly patients registered in the clinic and approximately 60 to 70 visits to the clinic per day. The Geriatric Outpatient Clinic is open every Monday. By establishing the Geriatric Outpatient Clinic, the department helps the elderly avoid long wait time.

The department also functions as a day care centre. It is open to the elderly on Saturday and offers health promotion and relaxation programs, health education, and other activities such as chatting, organizing

fairs, training in handicrafts, and earning income through market sales. Health education for the elderly is conducted in collaboration with the Health Education Unit and others on topics such as nutrition, epidemiological information, self-management, dengue fever, and infectious disease prevention.

There is no function to provide rehabilitation services. Patients are referred to the Teaching Hospital Kandy or the Rehabilitation Hospital Digana if patients need rehabilitation services. Referrals to rehabilitation facilities are handled by the inpatient ward and not by the geriatric department.

The main diseases of the elderly are diabetes, hypertension, orthopaedic issues such as knee pain, and psychiatric illnesses and neurological diseases, such as Alzheimer disease and dementia. Since the Teaching Hospital Peradeniya does not have otorhinolaryngology department and cardiac department, patients with these diseases are referred to the Teaching Hospital Kandy. The Teaching Hospital Kandy collaborates with the Peradeniya University General Hospital to prioritize elderly patients for diagnosis and treatments.

Poor elderly people often become homeless and when a homeless person is found to be in poor health, a police officer arranges for them to be taken him/her to a hospital to be treated. If the hospitalized elderly person does not have any relative or house, the SSO is contacted and asked to arrange for an elderly home. When no elderly home is available, the elderly person may stay in the hospital for an extended period of time. There have been only two such cases in the past and there is no current case. If it is found that an elderly person has not received the Rs. 1,900/- provided by the MoWCASS, the SSO would assist with these procedures. As an example of collaboration with other social welfare agencies, 60 wheelchairs were provided to the department by the non-profit organization (NPO) HelpAge.

The staff consists of a professor, several medical officers, nurse specialist for the elderly, and two support staff. The medical officers in the department consult with Prof. Chandrika about diagnosis and treatment and provide services after receiving permission. There is only one specialist nurse for the elderly.

[Situation Regarding Elderly Care Services]

- There are seven rehabilitation centres in Sri Lanka; one is Ragama Rehabilitation Center near Colombo, another is Digana Rehabilitation centres in Kandy District of Central Province.[98]
- Few facilities in Sri Lanka provide services for the elderly. In Central Province, care for elderly people is provided in the District Hospital Kadugannawa.

[Challenges in Elderly Care Services recognized by Teaching Hospital Peradeniya]

- Traveling is very difficult for the elderly because they have to use public transport when visiting health care facilities in remote areas.
- There is a lack of professional education in the elder care. Appropriate care training for elderly people among health care workers and caregivers is needed.

[98] Over the course of the survey, among the 7 rehabilitation centres in Sri Lanka, 5 rehabilitation centres provide rehabilitation services for psychiatric patients and two provide physical rehabilitation services.

b) Kandy District, Central Province: District General Hospital Nawalapitiya

This District General Hospital under the jurisdiction of the Provincial Health Department covers a population of approximately 400,000 people across Nuwara Eliya district and Kandy district, including rural areas, particularly estate areas, where the health system is not well established and services need to be improved. As a 2.5-3rd level tertiary health care facility that includes these areas, there is a need to address the special disease structure. The facility provides medical, surgical, ophthalmic, rehabilitation, and psychiatric services. The facility does not have the necessary specialized equipment for rehabilitation and provides services similar to a day-care centre. The most common ailments in the elderly are diabetes, hypertension, stroke, hyperlipidaemia, hyperuricemia, Chronic Obstructive Pulmonary Disease (COPD), NCD such as asthma, dementia, psychiatric disorders, ophthalmological disorders such as cataracts, and traffic accidents.

Tuberculosis patients are treated with medication in the hospital and/or followed up with at their home because TB cases are common in the region. The hospital has staff including medical special doctors in surgery, orthopaedics, and ophthalmology, as well as medical officers. The number of outpatients is 1200-1500 per day. Ten clinics (internal medicine, surgery, paediatrics, obstetrics and gynaecology, rheumatology, dermatology, ophthalmology, psychiatry, tuberculosis, oral surgery, haematology, and orthopaedics) are in operation. Psychiatry Department has only outpatient service and treatment such as injection and medication are available. The majority of ophthalmologic operations are performed on cataract patients, but the department also treats patients with glaucoma and other conditions. There is one ophthalmologist, three medical officers (ophthalmology), five nurses, two ophthalmic technicians, and five minor staff, and ophthalmic clinics are held three times a week while ophthalmic surgeries are performed four days a week.

The hospital has an inpatient ward for the elderly. Handrails are equipped in the toilets of female inpatient wards, funded by the JICA Grassroots Technical Cooperation Project[99], but not in the male wards. Each ward has about 35 beds and is staffed by about four nurses and two health assistants during the day and two nurses at night. Elderly people who have difficulty walking use a wheelchair for going to the toilet.

[Challenges Recognized by District General Hospital Nawalapitiya]

- In terms of strengthening services for elderly people, the health sector needs to improve the quality of services by expanding the facilities, increasing the number of staff in the main hospital, and collaborating with the MoWCASS and others.
- One elderly person without housing had stayed in the inpatient ward for six months. These cases need to be coordinated with the MoWCASS to provide services to help them reintegrate into society after discharge from the hospital.

[99] The handrails are installed in a part of the toilets and the elderly cannot move to the toilet by themselves.

2) Secondary Levelled Healthcare Facilities

a) Nuwara Eliya district, Central Province: Base Hospital Dickoya (Type A)

The facility covers Maskeliya, Kotagaram, Agarapathana, and Bogahawatta. It has a very high bed occupancy; the facility has two physicians, a surgeon, and a paediatrician as well as an ophthalmologist. There is also the Emergency Trauma Unit (ETU) that receives patients from the surrounding medical facilities. There is a Neonatal Intensive Care Unit (NICU) which manages new-borns weighing less than 2,500 g. Due to the lack of space, there are only two beds in NICU and no CT scan, however health care professionals have given maximum effort with their limited diagnostics and treatments.

- The patients who are not able to be treated in this centre will be transferred to District General Hospital Nuwara Eliya, District General Hospital Nawalapitiya, Teaching Hospital Kandy, and Teaching Hospital Peradeniya. The referred patients are followed up with by this centre once their condition is resolved. For cardiac cases, a cardiologist and a neurosurgeon from the District General Hospital Nuwara Eliya and a neurosurgeon from the Teaching Hospital Kandy will visit the hospital twice a month to examine and operate on patients. Rheumatology cases will also be referred to either Nuwara Eliya or Kandy. Patients with respiratory disease are examined and treated twice a month by a thoracic medicine specialist at Provincial General Hospital Nuwara Eliya. The hospital has a Health Promotion Unit and a Health Education Unit.

[Situation Regarding Elderly Care]

- The most common diseases in the elderly are cardiac diseases, stroke, and COPD in this region.
- There is a five-bed rehabilitation unit with one physiotherapist. Since there is no equipment required for rehabilitation, the hospital only provides guidance on self-rehabilitation after discharge. A stroke unit has been established to improve services but there is no rehabilitation service in place.
- The hospital has an ophthalmologist who is able to treat ocular diseases in the hospital (details below).
- Depression, dementia, and alcoholism are the most common psychiatric disorders among the elderly. There is no psychiatry department, however a psychiatrist will be assigned to the unit in April. Although there is no inpatient ward, the hospital will provide outpatient services as a clinic. It is envisioned that psychiatrists, medical officers (psychiatrists), and nurses (trained in counselling) will be available to deal with these disorders.
- Regarding collaboration with MoWCASS, a social services officer from the Divisional Secretariat comes to the hospital once a week to assist patients eligible for social services to mediate subsidy benefits for the elderly, for example.

- Training in elder care was provided by the Sri Lankan Society of Geriatrics last year and preparations for the stroke ward began with this training. The training was held for two days and mainly concerned the diagnosis and treatment of diseases and ailments that are highly prevalent in the elderly, such as falls, dementia, cardiac disease, and COPD. Two participants from the main hospital, including the director, participated in the training.

[Discussion with Ophthalmologists]

- The Ophthalmologic Clinic is held on Mondays and Wednesdays and serves approximately 200 patients per day. The clinic conducts about 20 eye surgeries per day on the other days. Ninety percent of the eye surgeries are for cataracts. On Saturdays they examine children at school.
- The main issues are medication allergies (including eye drops), which is the main cause of seasonal diseases, and cataracts.
- The equipment required for ophthalmic surgery is generally supplied by the Medical Supply Division (MSD), though some is purchased by the hospital at its own expense. Local anaesthesia can be provided at the main hospital but patients requiring general anaesthesia should be referred to another hospital.
- There are about 70 ophthalmologists throughout Sri Lanka, 30 of whom work in private health care institutions. There are relatively more in urban areas and fewer in rural areas.
- Ophthalmological challenges, such as diabetic retinopathy, have a negative impact on daily life; blood sugar control is therefore important. Health education is important because of the high prevalence of incestuous marriages in the estates area, which are associated with increased risk of diabetes and eye disease. Glaucoma is another challenge, but patients are less likely to recognize the symptoms, often causing some delay in diagnosis.
- Nutrition is another challenge. Dietary education by nutritionists, especially regarding an anti-diabetic diet, is necessary because of generally unbalanced diet and overemphasis on items like roti and sambal. Mothers are more literate, and so health education regarding children, such as giving oral rehydration solutions to children with diarrhoea has been more successful.

3) Primary Care Health Facilities (Divisional Hospitals, PMCU)

a) Kandy District, Central Province: Divisional Hospital Kadugannawa (Type A)

Although it was not possible to conduct an overview interview of the facility, the survey team visited the inpatient ward and interviewed the PHNOs assigned to the HLC. While the hospital does not have the inpatient ward for the elderly, it does have beds for them. The number of inpatients was low, with only two women on the female ward at the time of the visit. Both of the patients were admitted to the hospital due to injuries caused by falls. The hospital accepts cases that can be treated with medication, although they are unable to treat bone fractures, resulting in transfer to other medical facilities. These patients were being treated with antibiotics. They were living with their children's families. However, they were away during the day due to work.

[Overview of the HLC adjoining the Divisional Hospital]

The target population of this HLC is about 15,000 people with 27 GNs.

The PHNOs on duty have completed a 6-month diploma course and, after completing their diploma, are assigned to the HLCs in the main hospital, where they are responsible for NCD prevention, elder care, and palliative care in the HLCs. However, no training opportunities, guidelines, or instructions on these tasks were provided to the staff prior to their assignments. Essentially, the staff was told that they were supposed to do home nursing and that bikes and other equipment would be provided, but this has not yet

occurred, so they only travel to the community about once a week. Palliative care requires equipment for changing catheters, etc., however the equipment for home care is limited. There is a data entry system for patient information in the computer, however as there was no training on how to use it, it has only been implemented through self-study.

The implementation of NCD prevention services in this HLC is as follows

- Implementation is twofold; there is NCD screening and following up. For NCD screening, when patients of eligible age who have not yet been enrolled in the HLC are identified among outpatients, they are referred to the HLC for enrolment.
- There are 800 patients enrolled in the program, serving approximately 3,000 patients per year, or about 15 patients per day. The main patients are diabetic and hypertensive patients and there are many cases of asthma due to regional characteristics.
- The hospital distributes a government-provided clinic book in which registration numbers are written and managed.
- Cervical cancer is not handled by the HLC as the MOH office is responsible for testing for cervical cancer. Only high-risk cases are referred to dentistry for oral cancer testing, such as smokers and betel chewers.

b) Nuwara Eliya district, Central Province: Divisional Hospital Maskeliya (Type A)

The hospital covers 65,000 population living in 11 GNs. The farthest places covered are between 15 and 20 km away. The coverage area is relatively poor and many people work even they are over the age of 60. There are six inpatient wards with 120 beds: emergency, paediatric, internal medicine, surgery, dentistry, and obstetrics and gynaecology departments and emergency, paediatric, internal medicine (male and female), and surgery (male and female) wards. Staff tenure is shown in Table 4.3.17; 22 of the 52 positions are vacant.

Table 4.3.17 Staff of Divisional Hospital Maskeliya

Occupation	Position	Current	Shortage
Medical Officer	5	3	2
Nurse	10	6	4
Nursing Aid	8	7	1
Cleaning/Support staff	17	9	8
Ambulance driver	1	1	0
Pharmacist	1	1	0
Pharmacy staff	1	1	0
MW	4	3	1
Oral Surgeon	1	1	0
Development officer		1	

Source: Interview at the facility site

Of the three physicians originally working there, two of them resigned a year ago, leaving only the director, who was unable to adequately care for the patients and had to refer many of them to the Base Hospital Dickoya. As a result, the bed occupancy rate dropped to about 14% from 30%. Two physicians were

recently assigned to the hospital although they have only a few-year experience and need to be trained. The Director expects to increase the number of patients due to the newly assigned doctors. There are about 150 to 200 outpatients and 10 to 20 inpatients per day. The outpatient clinic is open from 8:00 AM to 12:00 PM and 2:00 PM to 4:00 PM on weekdays, 8:00 AM to 12:00 PM on Saturdays and 8:00 AM to 10:00 AM on Sundays and is open 24 hours a day for inpatients and emergency patients.

Blood glucose, BMI, blood cholesterol (using sticks), hypertension, breast cancer (palpation), and cervical cancer are checked in adults between the ages of 35 and 65. A psychiatrist from the District General Hospital Nawalapitiya comes once a month to conduct a clinic. Dementia and other conditions are also examined once a month at this clinic. Surgical (trauma) care is provided for cases that require simple treatment or local anaesthesia, but serious cases that require general anaesthesia are transferred.

Patients who are not be able be treated at this hospital would be referred to the District General Hospital Nawalapitiya, the Base Hospital Dickoya, and the Teaching Hospital Kandy. There is no ENT and or ophthalmology department, so those patients are transferred to the District Hospital Nawalapitiya, the Base Hospital Dickoya, or the Teaching Hospital Kandy.

When transporting patients, an ambulance is used or, if no ambulance is available, police is contacted to request the dispatch of an ambulance. This ambulance system was started six months ago with the donation of ambulances by the Government of India.

Medical services and ambulance transport are free of charge. Drugs and other supplies are rarely out of stock.

A breakdown of the main diseases in the last year is as follows[100]. With regard to patient records, the statistical data reported to the MoH is entered and reported by one of the nurses using her smartphone. Diagnosis and treatment records were recorded on paper, but did not appear to be stored appropriately, as the data storage room was not organized at all.

[Situation Regarding Elderly Care]

- No inpatient facility for the elderly has been established. There was originally no elevator, but one was finally installed on the day of the visit.

[Challenges in Elderly Care recognized by Divisional Hospital Maskeliya]

- The most common diseases in the elderly are diabetes and hypertension, which are largely influenced by eating habits. Asthma is also common due to the influence of the climate. There is a high prevalence of alcoholism among the estate workers and injuries from fights and road accidents are also common.
- Training of health care personnel is needed. A rehabilitation centre is also needed and there is a desire to address this, but there is an extreme shortage of healthcare personnel to provide the necessary services.

[100] Hypertension, 478; Gastritis, 202,; Asthma, 188; Accidental injury, 147; Chronic wound: refer to here for the follow-up,137; Poisoning, 106; Diarrhea gastroentisis, 99; Viral fever, 88; Digestive miscellanies, 81+274; Diabetes Mi, 124, Infectious cellulitis, 54: Ischemic heart diseases, 55; Epilepsy, 53; Delivery, 45

c) Nuwara Eliya District, Central Province: PMCU Hatton

The areas covered by the facility are Hatton, Dickoya, Sinarim Pinamor Area and Kotagala.

The health care staff consists of one medical officer, one dentist, one pharmacy supervisor, and four support staff, with no nurse present. The outpatient service is available Monday to Friday from 8:00 AM to 4:00 PM with a half day on Saturdays, resulting in a daily outpatient capacity of about 180 cases.

[Health Care Services (including Elderly Care)]

- Adults between 35 and 65 years of age are screened for blood glucose, BMI, blood cholesterol (using sticks), hypertension, breast cancer (palpation), and cervical cancer.
- For cases that cannot be handled by this PMCU, the police are contacted, an ambulance is dispatched, and the patient is transported to General Hospital Kandy or Base Hospital Dickoya.
- Patients who can be treated with medication are back-referred by the upper levelled facilities and managed in this unit.
- Diagnosis will be made by stethoscope and sphygmomanometer, along with palpation.
- The most common diseases in the elderly are hypertension, dyslipidaemia, diabetes mellitus, and COPD.
- Shortages of medicines sometimes occur. The number of medicines and supplies is sent in advance to the regional MSD in the Nuwara Eliya, and based on this number, medicines and supplies are delivered once every three months. However, shortages occur since the number of medicines delivered is lower than the number requested. If there is a shortage, prescriptions are provided and patients purchase the drugs from private pharmacies.
- Follow-up patients are seen once a month.
- Patients are issued a patient number when they visit and recorded in the hospital's patient registration notebook. Two recording notebooks are also prepared for the patient and the unit to record the patient's diagnosis and treatment; one notebook is given to the patient and the other is kept in the unit. Patients bring their notes with them when they are seen.
- There is no nursing home in the district. There is also no coordination with social services staff.
- In terms of dentistry, about 10 people are seen on a daily basis. There are no specific check-ups and only patients with symptoms are examined and treated. Residents do not come to the hospital for routine check-ups if they have no symptoms.
- One of the support staff had a heart operation in Colombo two years ago. The cost of that operation was Rs. 1,200,000; Rs. 200,000 was self-paid and Rs. 1,000,000 was contributed by fund. The transportation to the required monthly visits after the surgery costs Rs. 4,000 for a tuk-tuk.

4) Rehabilitation Hospital

a) Kandy District, Central Province: Rehabilitation Hospital Digana

The hospital aims to support patients in regaining function and assist them in returning to the community by providing rehabilitation services. In addition to rehabilitation services, the hospital has an emergency

unit which is available for catheter removal, ultrasound, and general examinations. In addition to rehabilitation services, rheumatology clinics are held three times a week (Monday, Wednesday, and Thursday) and paediatric clinics are held on Wednesdays. The clinic serves approximately 300 patients per day (approximately 50 to 60 patients per physician), with initial diagnosis and treatment decisions being made by a consultant and subsequent medication and follow-up being carried out by a general practitioner. The emergency surgical unit and clinic services are from 8:00 AM to 4:00 PM.

There are four wards in the hospital, with 76 beds in total; each ward has around 20 beds. The wards are divided into male ward 1 (spinal diseases), male ward 2 (cerebral infarction, Guillain-Barre syndrome, rheumatism, tuberculosis, head injury, traffic injury, post-operative brain disease, poisoning, limb amputees, meningitis, etc.), female ward, and children's ward.

The staff consists of 21 nurses, 35 support staff, 8 general practitioners, two special doctors (rheumatologist and paediatric rehabilitation specialist), four external special doctors (psychiatrist twice a week, plastic surgeon, paediatric psychiatrist and neuro-paediatrician once a month each), two counsellors, eight physiotherapists, four occupational therapists, three speech therapists (one of whom is on maternity leave), one SSO, one pharmacist, three dispensers, one dentist, and a registered physician (based on 1.5 years of medical education). The medical officer manages the patient's medication and the rehabilitation process and treatment implementation is determined by the physical, occupational, and speech therapists. The MWCSS contributes funds to support disabled people and the SSO assists patients with vocational training, training programs, and offers job mediation when they are ready to be discharged from the hospital.

Since there are only two hospitals in Sri Lanka that provide rehabilitation services, this hospital receives a large number of patients. The length of stay of patients varies according to the severity of their illnesses, however there is no waiting list and patients are admitted within a few weeks at most even if the beds are full. This rehabilitation centre also caters to the elderly, however most of the patients are relatively young. In addition to the approximately 60 inpatients, approximately 1,500 outpatients receive rehabilitation services each month. Outpatient rehabilitation services are provided twice a week (Tuesdays and Fridays) and inpatient rehabilitation is provided on the other five days of the week. There is no computer system for patient information and each patient has a clinic book, maintained by a physician on one side and a physical therapist on the other. The most common scenario for the elderly is rehabilitation service after the onset of a stroke, but it is not possible to accurately identify the most common diseases in the elderly because the records are not summarized by age.

There are two physiotherapy rooms in the hospital, with five people working in one and four in the other. The rehabilitation services provided are as follows.

- Strengthening exercises
- Walking training
- Electrotherapy
- Suspension therapy
- Heat therapy

- Tilting bed
- Mat exercises
- Massage
- Mobilization exercises
- Mobilization by wheelchair

The facility is equipped with a relatively large amount of rehabilitation equipment for various services, but there is no hydrotherapy, laser therapy and shockwave therapy.

[Challenges of Rehabilitation Services recognized by Rehabilitation Hospital Digana]

- It is needed to increase the number of beds, rehabilitation space, and equipment to accommodate more patients.
- There are insufficient number of physiotherapists for the number of patients being admitted and shortage of equipment and personnel. There are no elevators installed.

B. Western Province

The following health care facilities were interviewed in Western Province

b) **C**olombo City, Western Province: The Elder Care Unit, Colombo South Teaching Hospital

This unit was established last year to provide geriatric outpatient and clinic services. Many elderly people are diagnosed and treated in health care facilities same as the ordinal people without a comprehensive diagnosis or treatment to check physical and mental functions necessary for elderly people. Therefore, potential physical challenges specific to elderly adults, such as range of motion in daily living, hearing, and vision have not been properly assessed. The nature of physical and mental challenges in the elderly is that symptoms are often fragmented and persistent and diagnosis and treatment should be based on this. The implementation of this service aims to identify the problems faced by the elderly and to identify and provide services to those who need treatment and support.

The unit's outpatient services for the elderly include a falls clinic on Mondays, general outpatient services for the elderly on Tuesdays, a memory clinic on Wednesdays, palliative care on Thursdays, and art and music therapy on Fridays, which also involves a SSOs. There are 15-20 cases per day in each clinic. Some of the most common conditions seen in the elderly in this unit are injuries from falls and dementia, which are referrals from other medical facilities. They also visit the inpatient wards to provide social services and support for walking.

Outreach services are also needed as some elderly patients may have difficulty visiting a doctor. Outreach clinics are conducted in target areas in conjunction with the in-hospital clinics. The outreach clinics are usually used by around 70-80 people, with 50 new patients a month. This clinic has been overcoming various difficulties in securing a location, materials, and equipment. The hospital's management department has been asked to open and implement the clinic but the process has taken time. Therefore, focus has been on research that can be done in a small space, such as the assessment of risk for the elderly, surrounding things like falls. The staff consists of one specialist, three medical officers with a diploma in

elder care, one nurse with a diploma in elder care, one assistant, one social services officer, and one physiotherapist. Transportation to and from the outreach clinic is difficult to coordinate, although a car is provided by the hospital.

There are relatively poor people living in the covering area and many people are still working over 60 years of age. Patients can contact healthcare professionals at any time. Training is conducted to improve skills needed to care for patients' families.

Mental health issues such as dementia and depression are identified as such.

With regard to rehabilitation, two programs are planned, one for fall prevention and the other for mental and memory security and recovery.

The clinic provides in-hospital services and home care in terminal cases. The medical officers have been trained in the first batch of palliative care and services began in September 2019. They are providing vigorous patient care and have handled 35 patients to date. They are currently caring for six to seven patients. If the patient is unable to come to the clinic, the physician will visit the patient at home. Regarding palliative care, it is necessary for a patient to think about how they want to end their life, what they want to do to end their life, how you they will spend the end of their life if they have no family or relatives, and whether they will spend that time at home or in an institution; this requires intervention before that time comes.

The consultant (specialist) of the unit is also the President of the Sri Lanka Association of Geriatric Medicine (SLAGM). The SLAGM has been holding scientific conferences, exhibitions, and events in public places. In the beginning, members were only medical doctors, however membership now includes nurses and other health care personnel who work in geriatric care. Currently, a specialist from the hospital is the chairman of the group. Prior to that, a neurologist served as chairperson for two years and published a newsletter and a book on elder care. Today, there are nearly 200 members.

[Situations and Challenges Regarding Elderly Care recognized by Colombo South Teaching Hospital]

- A framework for systematic assessment of the physical functioning of the elderly is needed.
- The Teaching Hospital Peradeniya also provides care for the elderly, however the methods are different from this hospital. Teaching Hospital Peradeniya has an inpatient ward for the elderly, but this hospital does not. Athurugiriya Hospital is in the process of being converted into a medical facility for intermediate care.
- There are only two rehabilitation centres in the country and there is no rehabilitation centre specializing in the elderly. A rehabilitation function will be established at Athurugiriya Hospital.
- With regard to elder care, in addition to the consultant there is a diploma system for nurses and doctors, and a diploma in nutrition is also a necessary component of elder care. As far as education is concerned, Sri Jayawardanapura General Hospital (the University of Sri Jayawardanapura) has conducted nine training sessions so far. In order to become a special doctor, one needs a total of four years of education, including one and a half years of overseas training and practical training at the Sri Jayawardanapura

General Hospital and Teaching Hospital Peradeniya.

- The hospital is considering the use of PHNOs and the second phase of training is about to be completed among them to provide home care for the elderly,
- The hospital is taking this proactive approach to elder care because of the understanding and cooperation of the director. The MoH has other priorities, including the YED which is not cooperating with this hospital on geriatric care. It is also very difficult to recruit medical doctors. In this regard, it would be very useful to develop a system of medical care for the elder based on technical cooperation from Japan.

c) Base Hospital Horana

The director of the National Institute of Health Sciences, Dr Kalbowira, who previously served as the director of the Base Hospital Horana in Kaluthara, Western Province, conducted a survey focusing on the current situation of the elderly, their health, and their utilization of medical services at the facility during his tenure. He summarized the issues with implementing the intervention measures for the elderly based on the results of survey. He has also been engaged in providing health care services and has collaborated with the community successfully. The activities have successfully conducted until now. Here is the information of the Project.

[Summary of Project INTRA3]

The above survey was carried out in 1999 as part of the project INTRA3 and the situation remains largely unchanged at this time. The main findings of the survey are as follows.

- Eighty-four percent of older participants (55 years and older) have at least one disease.
- Sixty-seven percent of them are being treated for two or more conditions.
- Twenty-four percent of the elderly have their own income. Their main source of income involves agricultural pursuits such as tea picking. Other sources include pensions for the elderly, funds for widows and orphans, low-income allowances by the Samurdhi sector, and social assistance by the NSE for low-income seniors aged 70 and above.
- Only 3% live alone.
- Seventy-two percent of older participants are taking care of their grandchildren to some extent. Some mainly look after their grandchildren because their parents are abroad to work. Although they should be in a position to receive support, they are in fact taking care of their families.
- Challenges regarding waiting times were identified in regard to health care facilities. Initial data showed that the average time required to receive a diagnosis and obtain medicines was approximately 12 hours. If a user visited the hospital in the afternoon, they would have to wait until the next day because of the already long queues. The next morning at 7:00 AM, registration would begin and they would have to wait in the next line to be seen by a doctor and then in another line to receive their medication. Patients have to wait everywhere.
- Doctors see patients not only in the outpatient clinic, but also in the inpatient clinic, which takes an average of two to three hours a day. Their stays are too short to have time to ask enough questions

about the health conditions of patients. In some cases, there is no time for blood tests. Doctors prioritize treatment of the most serious cases.

- This system of limited time for consultation and insufficient experiments and treatment leads to dissatisfaction on both sides (doctors and patients). When medicines are not in stock or tests cannot be performed, patients are asked to go to private pharmacies and laboratories, where they have to queue again. Staff is stressed out by too many tasks and unresolved problems to deal with.
- These lengthy appointment systems also have a negative impact on economic activity and productivity. Patients often lose their jobs and go into debt because of medical service visits.

In light of these circumstances, the outreach clinic service was started for health care staff in this facility to go to the community and offer services in order to increase the utilization of medical services. This outreach clinic has been successfully conducted with the Elders' Committees and other organizations as the primary sponsors. There are requests for these services not only in the target area, but in others as well.

Challenges in implementing the outreach clinics were identified in terms of transportation and securing medicines and health care personnel. There was also a need to secure a place and drinking water in the community for the service provision. Therefore, this activity was implemented with cooperation from the community and involving religious institutions such as temples and other institutions that people have respect for. This activity could easily incorporate as a community activity and made it accessible to patients in the community. By having temples or other religious institutions that community members use on a regular basis as the focal point of the activity, residents were able to recognize that this outreach clinic was part of their daily activities, and the that community will play a key role in managing this activity. Essentially, this activity will work based on respect of the community.

For the outreach clinic activities to be successful, there needs to be a suitable location to hold the clinic with knowledgeable volunteers with good management skills. The clinic has around 200 patients per day and the staff consists of medical officers (NCD), medical officers (public health), PHNOs, health education nurses and pharmacists. The outreach clinic service is held at each community clinic in the jurisdictional area once a month, for a total of 16 outreach clinics held per month.

One of the challenges of this initiative is the issue of funds. The MoH tends to avoid implementing change in the current policy and taking responsibility for it. In this context, Dr Champika, the head of DDG-NCD, has been supportive and understanding of the importance of these activities. Base Hospital Tangalle (Type A) located in Hambantota district in Southern Province is also going to start similar activities.

[Other Elderly Care Services]

- There are two types of services regarding palliative care: hospital-based services and services in which end-of-life teams visit patients' homes to change catheters, draw blood, and perform other procedures.
- The MoWCASS provides financial and other assistance to the elderly.
- There is other example that the hospitals and health insurance associations (NGOs) provide financial

support elder care services for purchasing medicines in other societies.

[Challenges in Elderly Care recognized by Base Hospital Horana]

- Transportation is needed for providing outreach services for the elderly.
  [Comment from the MoH] Transportation system for outreach services should be established in collaboration with MoWCASS in the community. Hospital ambulances are not adequate to cater all the services other than patient transportation.
- The current health system, which is divided into preventive and curative sectors, was created in 1926, when infectious diseases were the primary concern. Currently, NCD have become the major disease and treatment should be based on secondary prevention aspects, and so it is now impossible to make a clear distinction between prevention and treatment. Therefore, it is not efficient or effective to continue providing services under this system. Although the shortage of human resources is a problem, the biggest issue is not the lack of health care personnel, but rather the improper allocation and utilization thereof. The health care staff participating in this activity are motivated by the appreciation of their services from the community and their desire to meet the needs of their residents.

d) Divisional Hospital Athurugiriya

Divisional Hospital Athurugiriya is one of the underutilized hospitals in the Colombo District, Western Province, selected by the YED as one of the hospitals to develop under the Elderly Care Delivery Plan. From the budgetary allocations of government funds, YED started to renovate the hospital as the first ever Elderly Care and Rehabilitation Unit for intermediate care of elderly patients. Infrastructure developments and purchasing of equipment were done in 2019 to 2020. The landscaping and the improvements to the laboratory and occupational units were delayed due to the global pandemic of COVID-19.

Patients from Colombo South Teaching Hospital and Base Hospital Homagama will be transferred to Athurugiriya intermediate care unit for continuation of treatment plan of the apex hospital consultant. The Medical Officers at DH Athurugiriya will treat accordingly under the supervision of the Senior Regisras. A referral and back referral system will be introduced by the apex hospital.

C. Uva Province

The survey team could not visit Uva Province; however, it could conduct a questionnaire survey via e-mail.

Breakdown of medical facilities in Uva Province and the provision of services for the elderly

Table 4.3.18 shows the number of public medical facilities in Uva Province by category.

Table 4.3.18 Numbers of Health Facilities in Uva Province

Category	Number of health facilities
Provincial hospital	1
District general hospital	1
Base hospital	4

Category	Number of health facilities
Divisional Hospital	58
PMCU	26
HLC	86

Source: Answers from the Department of Health Services in Uva Province

Of the above medical facilities, the one that provides a focus on elderly care is Base Hospital Wellawaya, which has introduced priority cards for the elderly. Other facilities provide medical services for the elderly as needed. There has been no coordination yet among public medical facilities for providing elderly care services, and people living at elderly home care facilities go with the home care facility staff to nearby medical facilities for diagnosis and treatment. There is no coordination among private and public facilities for elderly care services. The number of services provided per year are 68,216 NCD examinations and 87,113 oral care examinations.

The activities of the preceding JICA project included TOT training, the establishment of outpatient clinics for the elderly in Kandaketiya Divisional Hospital, a community model plan, and a healthy village in Udawalawa; however, the situation regarding the continuation of these activities after the project has not been confirmed.

The issues and solutions regarding medical services for the elderly and the barriers to accessing the services, both of which the personnel in charge of the services recognize, are shown in Table 4.3.19 and Table 4.3.20, respectively. In addition, as necessary efforts to maintain and restore the health of the elderly, both (1) a review of medical examinations and referral mechanisms and (2) regular follow-ups were proposed.

Table 4.3.19 Issues to Provide Health Services for the Elderly and Possible Solutions

Issue / Challenge	Possible solution
No responsible government officer identified only for elderly care	Public health midwife can be identified as a responsible person.
Majority of medical clinic attending patients are more than 60 years of age, so it is difficult to give a priority number for them.	(No answers)
No identified screening program	Need a national program to screen elderly population

Source: Answers from the Department of Health Services in Uva Province

Table 4.3.20 Obstacles for the Elderly to Receive Health Services and Possible Solutions

Obstacle	Possible solution
Transport issues / long distance travelling	Improve primary care facilities (National health policy) to achieve UHC.
Long waiting time in clinics and OPD	(No answers)
Non availability of minor specialties in primary and secondary care institutions (Eye, ENT, rheumatology, psychiatry etc.)	Start out reached clinic services by minor specialties.

Source: Answers from the Department of Health Services in Uva Province

D. Medical Services for the Elderly Provided by Private Sector

In 2017, the MoH looked into the medical services provision in the private sector and published the report "Basement Report of the Institution Frame of Private Sector of Western Medicine and State Indigenous

Medicine Sector[101]".

Table 4.3.21 shows the nationwide distribution of the number of beds in the private sector in Sri Lanka according to this report.

Table 4.3.21 Beds Provided by Private Sector (per District/Province)

Province	District	# of beds per district	# of beds per province
Western Province	Colombo	2,314	3,197
	Gampaha	672	
	Kalutara	211	
Central Province	Kandy	331	360
	Matale	29	
	Nuwara Eliya	0	
Southern Province	Galle	120	248
	Matara	95	
	Hambantota	33	
Northern Province	Jaffna	241	256
	Vavuniya	15	
	Mannar	0	
	Kilinochchi	0	
	Mullaithivu	0	
Eastern Province	Batticaloa	43	111
	Ampara	44	
	Trincomalee	24	
North Western Province	Kurunegala	167	266
	Puttalam	99	
North Central Province	Anuradhapura	21	28
	Polonnaruwa	7	
Uva Province	Badulla	13	37
	Monaragala	24	
Sabaragamuwa Province	Ratnapura	137	183
	Kegalle	46	
Total		4,686	4,686

*The report lists 25 beds in Ampara and 19 beds in Kalmunai. Since Kalmunai is included in Ampara district, the number of beds in Kalmunai is combined as the number of beds in Ampara district.

Source: Basement Report of the Institution Frame of Private Sector of Western Medicine and State Indigenous Medicine Sector

The numbers of beds in private medical facilities vary widely, and the ones in Colombo account for more than half of the country's total. Gampaha and Kalutara (cities near Colombo) and Kandy and Jaffna (provincial capital cities) have beds in private medical facilities, but four districts (Nuwara Eliya, Mannar, Kilinochchi, and Mullaitivu) do not have them.

In addition, as mentioned previously, according to the Private Medical Institutions (Registration) Act No 21 passed by the congress in July 2006, all private medical facilities are obliged to register with PHSRC under the MoH. Table 4.3.22 shows the number of facilities registered annually from 2017 to 2020.

[101] "Basement Report of the Institution Frame of Private Sector of Western Medicine and State Indigenous Medicine Sector"

Table 4.3.22 Number of Private Health Facilities Registered with PHSRC (2017-2020)

Private health facilities	2017	2018	2019	2020
Private Hospitals, Nursing Homes & Maternity Homes	116	117	115	69
Medical Centres / Screening Centres / Day Care Medical Centres / Channel Consultations	191	182	186	107
Medical Laboratory	405	449	436	165
Other private medical institutions	40	45	60	35
Total	752	793	797	376

Based on Lists of Registered Institutes, PHSRC (http://www.phsrc.lk) - accessed on September 10, 2020

Source: JICA Survey Team

Of the 376 private medical facilities registered in 2020, eight have facility names containing "Nursing Home" and seven containing "Home Nursing" or "Nursing Care." There is only one facility that specializes in elderly people, Upeksha Elderly Care Home in Athurugiriya, in a suburb of Colombo city. Many of the facilities are concentrated in and around Colombo, Western Province. The names and locations of the facilities are shown in Table 4.3.23.

Table 4.3.23 Private Nursing Care Facilities Registered with PHSRC (2020)

Province	District	Name of facility
Nursing Home		
Western Province	Colombo	Kottawa Nursing Home
		Mahajana Nursing Home
		Channel Way Nursing Home
		Royal Nursing Home
	Gampaha	Central Nursing Home
		Manthiri Nursing Home
Northern Province	Jaffna	Evergreen Health Clinic and Nursing Home
Southern Province	Matara	Matara Nursing Home
Home Nursing / Nursing Care		
Western Province	Colombo	English Nursing Care Services
		Vibrant Home Nursing Service
		Certis Lanka Home Nursing & Swift Care (Pvt) Ltd
		Pearl Hospital Home Care Nursing Service
		Suwasahana Home Nursing Care
		Piyasa Home Nursing Care
Central Province	Kandy	Sadeepa Home Nursing Service
Elderly Care Home		
Western Province	Colombo	Upeksha Elderly Care Home

Lists of Registered Institutes, PHSRC (http://www.phsrc.lk) - accessed on September 10, 2020

Source: JICA Survey Team

While nursing homes in Sri Lanka are generally regarded as nursing care facilities, nursing homes in private medical facilities have a wide range of services. In some cases, the name "nursing home" is used for facilities that provide services similar to those of hospitals, such as medical examinations in internal medicine, surgery, obstetrics, and so on. Ambulances are also used for elderly care facilities with residential care homes. Hence, there are various forms of nursing homes.

Some nursing care facilities provide home-based nursing care as part of their service - with various names,

such as "home nursing" and "mobile nursing care". Nonetheless, the services are for people who need them at home. Specific service contents range from medical practice (e.g. tube feeding, injection, and wound care) to daily life support (e.g. providing meals and changes of clothes).

Due to the situation with COVID-19, the information on private medical facilities had to be collected via desk research, such as from the internet. Based on the information available online,

Table 4.3.24 shows the examples of the services for the elderly provided by private nursing care facilities.

Table 4.3.24 Examples of Services in Private Nursing Care Facilities

Example 1: English Nursing Colombo, Western Province *https://www.englishnursing.com/*
Home nursing service - Trained nurses are available to deliver a wide range of nursing services in home - Carry out initial health check when the service starts, conduct regular review meetings once the service has commenced - Carry out a rage of nursing procedures according to clients' needs **Eldercare** - Nurse Aids are trained in basic physio techniques and exercises to promote patient health and mobility. They are also trained in an overview of many age-related conditions such as dementia, stroke and diabetes. They have all undergone First Aid training and are certified First Aiders. **Diabetes Care** - Care provided by the nurse who knows well management of diabetes, diet therapy, action to take in the event of hypoglycaemia or hyperglycaemia and footcare - Health check, blood sugar monitoring, physio/exercise, diet therapy **Emergencies** - How to liaise with designated family members, your Consultant Physician and hospital preferences and clients' existing ambulance arrangements if clients have them **Support in Hospital** - Assist with feeding and trips to the bathroom, liaise with the Hospital Nursing team and Consultant Physicians to facilitate your early discharge from hospital when you wish, by putting in place arrangements for your discharge into a safe home environment **Managed Maid Eldercare** - Carry out a detailed care assessment at clients' home and draw up a bespoke training plan for clients' maid. This plan will be agreed with clients and delivered by visiting nurse
Example 2: Royal Nursing Home Colombo, Western Province *http://www.royalnursinghome.com/*
Home nursing service - Trained and Certified Care Nurse provides nursing service at home - Develop a care plan based on assessment and its implementation - Services cover patients suffering from; paralysis, Parkinson's care, all kinds of heart diseases, Alzheimer's care, dementia, Schizophrenia, cancer (terminal disease), depression, diabetes glaucoma, blindness, post operation recovery period, chronically ill care - Specialized paediatric and adult services, as well as: Nursing care, physiotherapy, occupational therapy, speech therapy, nutrition services, social services, specialized wound care, IV and chemotherapy, paediatric specialty care, daily monitoring of vital signs - Nurse Aides are specially trained on the following procedures. - Feeding (oral feeding, nasogastric feeding, gastronomy feeding, monitor iv infusion)

- Vigilant observations (blood pressure, temperature, pulse, respiration, blood glucose, monitoring & maintain fluid balance charts)
- Administration of oral medications, insulin injections, intramuscular injections
- Maintain personal hygiene (bed baths, shower baths, dressing of wounds, stoma care[102], catheter care)
- Prevention of complications like: bedsores, hypostatic pneumonia, diabetic gangrene, dehydration and constipation, accidental falls and fractures

Elders Home

- Nursing care
- Recreational activities (social and recreational activities, transportation on outing and luncheons)
- Rehabilitation (physiotherapy, occupational and speech therapy)
- Nutrition (meals supervised by a registered dietitian)

In addition to services mentioned above, services such as industrial nursing, ambulance service and medical equipment are provided.

Example 3: Vibrant Home Nursing Service

Colombo, Western Province *https://vibranthns.lk/*

Home nursing service

- Trained and Certified Care Nurse provides nursing service at home
- Develop a care plan based on assessment and its implementation
- Nurse aides are skilled on the following procedures
  - Feeding (Oral Feeding, Nasogastric Feeding, Gastronomy Feeding, Monitor I. V. Infusion)
  - Observations (Blood Pressure, Temperature, Pulse, Respiration, Blood Glucose Monitoring and Maintain Fluid Balance Charts)
  - Administration of Oral Medications and Insulin Injection
  - Medication reminder
  - Accompany to Doctor visit
  - Socializing activities
  - Keep the patients' room clean and management
  - Bathing the patient
  - Dress the patient
  - Prevention of Complications like Bed sores, Hypostatic Pneumonia, Diabetic Gangrene, Dehydration and Constipation, Accidental Falls and Fractures

24 hours doctor on call service

- regular check up with the doctors on a periodical basis (a doctor visit at home)

Age care equipment

- equipment
  - Medical equipment - nebulizers, sucker machines, glucometers, oxygen regulator etc.
  - Care product - bed, air mattress, wheelchairs, walking sticks, diapers etc.

In addition to services mentioned above, services such as babysitting, care for the pregnant mothers, industrial nursing service, 24 hours ambulance service and physiotherapy are provided.

Example 4: Certis Lanka Home Nursing

Colombo, Western Province *http://www.certislankanursing.com/*

Home nursing services

- Trained and Certified Care Nurse provides nursing service at home
- Develop a care plan based on assessment and its implementation
- Our Nurse Aides are specially trained on the following procedures
  - Feeding (oral feeding, nasogastric feeding, gastronomy feeding, monitor iv infusion)
  - Vigilant Observations (blood pressure, temperature, pulse, respiration, blood glucose monitoring and maintain fluid

[102] Stoma is an artificial outlet of body for intestines and bladder due to cancer surgery etc. There are digestive stomas such as colostomy bag and urinary stoma. Timing of egestion cannot be controlled and stoma apparatus must be installed around belly to receive bodily waste. Stoma apparatus consists of waste bag and platform to which the bag is attached. The waste received in the bag is disposed at toilet. Skin around stoma tends to decay due to the waste and apparatus. Therefore, proper stoma care such as skin cleaning, stoma apparatus change etc. Cancer Information service, National Cancer Center Japan (https://ganjoho.jp/public/dia_tre/rehabilitation/stoma_care.html)

balance charts)
- Administration of oral medications and insulin injections.
- Prevention of complications like bed sores, hypostatic Pneumonia, diabetic gangrene, dehydration and constipation, accidental falls and fractures
- Urinary catheters, bladder irrigations, insertion of iv cannula, drip facility
- Chest Physiotherapy

24 hours doctor on call service
- Check up with the doctors (a doctor visit at home)

In addition to services mentioned above, services such as babysitting, industrial nursing service, mobile health screening are provided.

Source: URLs under each facility's name in the table

Table 4.3.25 shows the costs and burden of the services in some of the above facilities.

Table 4.3.25 Fees and Obligations for Private Elderly Home Care Services

Facility	English nursing	Vibrant home nursing service	Royal nursing home
Fee for on demand	- Rs. 2,500 for a 12-hour shift per day (morning or night) - Rs. 4,500 per a full day of work (24 hours)	- Rs. 1,500 for a 12-hour shift per day (morning or night) - Rs. 2,800 per a full day of work (24 hours)	- Rs. 1,400 for a 10-hour shift per day (8:00-18:00) - Rs. 1,400 for a 12-hour shift per day (19:00-7:00) - Rs. 2,500 per a full day of work (24 hours)
Fee for monthly contract	Rs. 135,000	Rs. 84,000 + cost of meals	Rs. 75,000 + cost of meals
Food for the caregiver	No meals to the Caregiver to be provided by the client	For a 12-hour shift: twice, during the shift to be provided by the client For a full day's work: three meals to be provided by the client	Morning or night shift: twice, during the shift to be provided by the client For a full day's work: three meals to be given by the client
Accommodation for the caregiver	For a full day's work, accommodation to be provided by the client		
Duties of the caregiver	To be agreed between the company and the client		
Registration fee (for facility)	Rs. 3,500 per year to be renewed annually	Rs. 2,500 per year to be renewed annually	Rs. 3,500 when registering for the first time. If the client continues to engage the services of the company, they will not be charged the registration fee.
Invoicing / Deposits	- A refundable deposit equivalent to two weeks of full day fee must be paid at the time of registration. - Every two weeks, the Company will raise an invoice.	- A refundable deposit equivalent to one month of full day fee must be paid at the time of registration. - At the end of every month, the Company will raise an invoice.	- A refundable deposit equivalent to one month of full day fee must be paid at the time of registration. - At the end of every month, the Company will raise an invoice.

Source: ICA Data Collection Survey on Intermediate Care of Elderly Persons

For Royal Nursing Home in the above examples, the information on the fees has been updated on the website. While the registration fee is no longer required, there is a hike in the fees in general. In addition, the fees for the use of male nurses are slightly higher than those of female nurses. Table 4.3.26 shows the usage fees for home nursing services and home-based nursing care from Royal Nursing Home.

Table 4.3.26 Nursing Care and Facility Charge of Royal Nursing Home

Home nursing service		
Short term service (up to 24 hours)		・Day shift (10 hours, 8:00-18:00) Rs. 1,600 (Male Nurse Rs. 1,700) ・Night Shift (12 hours, 19:00-7:00) Rs. 1,600 (Male Nurse Rs. 1,700) ・24 hours shift Rs. 2,790 (Male Nurse Rs. 2,890)
Long term service (monthly)		Rs. 82,000 (Male Nurse Rs. 85,000)
Registration fee		Not necessary
Deposit		Before the commencement of the service, it is mandatory that at least the payment for 7 days be made.
Nursing home		
Ward Bed		Rs. 60,000 (Ward bed, Share Bathroom, Standard Facilities with Meal (Full Board) Including 24 Hour General Nursing Services & Resident Doctor Fees & Laundry Service Free)
High Care Unit		Rs. 65,000 (A/C Ward bed, Share Bathroom, Standard Facilities with Meal (Full Board) Including 24 Hour General Nursing Services & Resident Doctor Fees & Laundry Service Free)
Individual Room	Classic	Rs. 65,000 (Individual Room, Share Bathroom, Standard Facilities with Meal (Full Board) Including 24 Hour General Nursing Services & Resident Doctor Fees & Laundry Service Free
	Gold	Rs. 95,000 (Individual A/C Luxury Room, Standard Facilities with Meal (Full Board) Including 24 Hour General Nursing Services & Resident Doctor Fees & Laundry Service Free
	Premier	Rs. 120,000 (Individual Lage A/C Luxury Room Standard Facilities with Meal (Full Board) Including 24 Hour General Nursing Services & Resident Doctor Fees & Laundry Service, Transport 40km Per Month Free)
Registration fee		Rs. 50,000

Source: http://www.royalnursinghome.com/home-nursing , http://www.royalnursinghome.com/elders-home
accessed on September 24, 2020

4.3.4 Human Resources to Support Elderly Care Services

(1) Health Care Professionals for Elderly Care Services

The human resources to support medical care for the elderly are mainly those who work in health care facilities. Specialized technicians in elderly health care become relevant professionals through required curriculums stipulated by laws. On top of that, they are trained in their specialized skills. The University of Colombo is a major educational institution in Sri Lanka that trains specialists in geriatric medicine. The university provides specialized education at the Postgraduate Institute of Medicine. Its curriculum related to medical care for the elderly is as follows.

1) The Postgraduate Institute of Medicine, University of Colombo

Being financially and administratively independent and internationally recognized as a centre of excellence, the Postgraduate Institute of Medicine (PGIM) trains specialized medical doctors who support medical care for the elderly. The mission of the institute is to plan, implement, monitor, and evaluate postgraduate academic programs required to produce specialists of the highest quality, competence, and dedication in order to provide optimum humane health care to the people of Sri Lanka, whilst being mindful of wider responsibilities to the region and the world.

PGIM has graduate programs at the diploma, Master of Science (MSc), and Doctor of Medicine (MD) levels in the fields of medicine and dentistry. For those obtaining an MD, training is provided at the specialty and subspecialty levels, the latter of which is narrower than a specialist discipline. As of 2020, there are 28 diploma, 10 master's degree, 36 MD specialty, and 52 MD subspecialty courses provided. The duration of the diploma and master's degree education is one year, and the duration of the MD varies from three to eight years, depending on the field. While the diploma and master's degree courses are provided in domestic

institutions designated by PGIM, most MD courses require training abroad in addition to domestically.

The requirements for applying to the graduate school includes: 1) to hold a medical degree registered with the Sri Lanka Medical Council (SLMC), 2) to complete an internship recognized by the SLMC, 3) to complete one-year work experience in Sri Lanka, after internship, 4) to comply with any other PGIM regulations etc. The primary requirements are the completion of a degree in medicine or dentistry and the completion of one-year internship and one-year clinical experience. In addition, the requirement for Public Health course is the experience of working as a MOH.

The outlines of the courses related with healthcare for the elderly are shown in Table 4.3.27.

Table 4.3.27 Programs Specially Related with Healthcare for the Elderly

Category	Course
Diploma	Geriatric Medicine
	Palliative Medicine
Subspecialty	Rehabilitation Medicine
	Rheumatology & Rehabilitation Medicine
	Old Age Psychiatry
	Geriatric Medicine (in preparation)
Specialty/ MD	Geriatric Medicine

Source: Course of Academic Curriculum, PGIM (https://pgim.cmb.ac.lk/index.php/courses-new/)

Overview of the courses offered by PGIM, Colombo relevant to the elderly health care is given in Attachment-2.

(2) Current Status of Healthcare Personnel who Support Elderly Medical Care

Table 4.3.28 shows the number of specialty doctors in each province, the number of people per doctor per specialty, and the number of people per doctor per province. Medical fields in which many elders are likely to see a doctor are highlighted in light blue in the table. Overall, the number of specialist doctors is very limited, especially in the fields with high needs among the elderly, including respiratory surgery, neurology/neurosurgery, rheumatology, and others. The numbers of specialist doctors per capita is small; the estimated number of people covered by each doctor is about 500,000 to 1 million. The number of doctors who can provide specialized medical care in other fields is also limited, with the population covered by each doctor being about 300,000 in cardiology, ophthalmology, and orthopaedics - areas that are often needed by the elderly.

Regarding the number of specialists per province and the population per doctor, there are relatively more

specialists in Western Provinces, which include Colombo. In North Western, North Central, Uva, and Sabaragamuwa Provinces, doctors have to cover a larger population. Although the government aims for a system that can provide specialized medical care under the provinces, in clinical departments with limited numbers of specialist doctors, patients are transported to the facilities in Colombo or Kandy. There are plans to set up medical departments under each province for diseases that are common among the elderly, such as cardiovascular and cerebrovascular diseases. Nevertheless, the training of specialists is required because of the specialized skills needed for the diagnoses and treatments.

As mentioned above, training specialists takes time and financial resources - requiring about three to five years of education, including studying abroad. In addition to these MD programs, the government trains specialists through diploma programs. Under the guidance of specialists, diploma holders can also cooperate in providing specialized medical care.

Table 4.3.28 Number of Specialty Doctors and Population per Specialty Doctor

	Western Province	Central Province	Southern Province	Northern Province	Eastern Province	North Western Province	North Central Province	Uva Province	Sabaragamuwa Province	Sri Lanka	Population per one physician
General Physicians	88	27	32	18	23	20	14	14	21	257	79,220
General Surgeons	49	17	19	11	15	14	8	9	12	154	132,204
Obstetricians & Gynaecologists	45	18	17	7	13	15	8	10	14	147	138,500
Cardiologists	27	8	7	4	3	3	4	3	4	63	323,166
Chest Physicians	11	6	3	2	2	3	2	2	2	33	616,953
Thoracic Surgeons	10	2	2	1	1	1	0	1	1	19	1,071,549
Neurologists	14	5	5	2	1	1	3	1	2	34	598,807
Neurosurgeons	8	2	2	1	2	1	2	2	1	21	969,497
Dermatologists	22	10	9	4	3	6	4	5	7	70	290,849
Rheumatologists	12	6	3	2	3	2	2	1	2	33	616,953
Psychiatrists	30	9	11	4	7	9	4	5	8	87	234,017
Paediatricians	56	25	25	8	17	16	7	11	15	180	113,108
Paediatric Surgeons	5	5	3	0	1	1	1	0	2	18	1,131,080
ENT Surgeons	18	7	4	5	4	4	2	2	4	50	407,189
Eye Surgeons	27	10	9	3	5	6	2	3	3	68	299,404
Orthopaedic Surgeons	20	6	6	5	6	6	4	4	5	62	328,378
Plastic Surgeons	9	1	1	2	0	1	1	0	0	15	1,357,296
Genito Urinary Surgeons	8	3	4	2	2	2	2	2	1	26	783,055
Anaesthesiologists	60	20	18	7	7	10	5	8	9	144	141,385
Histo-Pathologists/Chemical Pathologists	37	9	9	4	7	7	5	5	7	90	226,216
Haematologists	22	7	6	4	3	5	3	2	3	55	370,172
Bacteriologists/Microbiologists	23	5	7	2	4	2	2	2	2	49	415,499
Oncologists/Radiotherapists*	16	4	6	4	4	3	2	3	3	45	452,432

	Western Province	Central Province	Southern Province	Northern Province	Eastern Province	North Western Province	North Central Province	Uva Province	Sabaragamuwa Province	Sri Lanka	Population per one physician
Oncology Surgeons	7	2	2	2	2	1	3	1	2	22	925,429
Radiologists	50	11	19	8	9	10	7	8	10	132	154,238
Venereologists	10	2	3	0	1	0	1	0	2	19	1,071,549
Judicial Medical Officers	12	4	4	3	1	5	2	2	6	39	522,037
Public Health/Community Health Physicians	61	5	8	0	5	2	2	0	0	83	245,294
Endocrinologists	8	1	2	2	2	2	1	1	1	20	1,017,972
Gastroenterologists	3	1	2	1	3	2	2	2	1	17	1,197,614
Nephrologists	8	4	4	2	1	1	4	1	1	26	783,055
Specialist Dental Surgeons-Orthodontists	10	4	2	2	1	3	2	1	2	27	754,053
Specialist Dental Surgeons-Maxillofacial/Restorative	13	3	3	2	2	2	2	1	3	31	656,756
Specialist Dental Surgeons-Restorative	5	1	1	0	1	1	1	1	1	12	1,696,620
Others	77	24	18	3	4	4	9	2	4	145	140,410
Total	881	274	276	127	165	171	123	115	161	2,293	8,879
population per one physician	6,641	9,385	8,976	8,357	9,427	13,923	10,298	11,013	11,979	8,879	79,220

Source: Medical Statistics Unit

4.3.5 Studies on Healthcare for the Elderly

The followings are examples of studies and reported factors related to the health of the elderly in Sri Lanka according to a literature search of PubMed.[103]

(1) Non-communicable Diseases in General

Title	Social participation and healthy ageing: a neglected, significant protective factor for chronic non communicable conditions
Journal	Globalization and Health 2011, 7:43
Author's institution	Healthy Ageing at the Burnet Institute for Medical Research and Public Health, Melbourne, Australia. Healthy Ageing Project at PALM Foundation, Nuwara Eliya.
Main author(s)	Dr Wendy Holmes

Reviewing eating habits and lifestyles (e.g., exercising, smoking, and drinking) are the ongoing measures to prevent NCD. However, sufficient steps are not being taken to address social isolation and loneliness, despite their importance as risk factors for chronic diseases. The formation of a senior citizens' club by retired tea plantation workers in Nuwara Eliya with the support of AusAID increased seniors' access to social support, interaction with other generations, health promotion activities, and health/medical and social welfare services - all promoting social connections for the elderly and bringing many benefits that lead to the prevention of NCD.

[103] PubMed is a database created by National Center for Biotechnology Information, National Library of Medicine in the United States where documents released on world major medical journals and so on can be searched.

(2) Hypertension

Title	Aging and obesity are associated with undiagnosed hypertension in a cohort of males in the Central Province of Sri Lanka: a cross-sectional descriptive study
Journal	BMC Cardiovascular Disorders (2017) 17:165
Author's institution	1) Department of Animal and Food Sciences, Faculty of Agriculture, Rajarata University of Sri Lanka, Anuradhapura, Sri Lanka. 2) Department of Medicine, Faculty of Medicine, University of Peradeniya, Peradeniya, Sri Lanka. 3) Department of Food Science and Technology, Faculty of Agriculture, University of Peradeniya, Peradeniya, Sri Lanka. 4) National Transport Medical Institute, Kandy, Sri Lanka. 5) Department of Agricultural Systems, Faculty of Agriculture, Rajarata University of Sri Lanka, Anuradhapura, Sri Lanka. 6) Department of Physiology, Faculty of Medicine, University of Peradeniya, Peradeniya, Sri Lanka.
Main author(s)	N. W. I. A. Jayawardana1

(3) Cerebrovascular Disease

Title	Cerebrovascular disease in South Asia – Part I: A burning problem
Journal	J R Soc Med Cardiovasc Dis 2012;1:20
Author's institution	Department of Neurology, Neurosciences Centre, All India Institute of Medical Sciences, New Delhi, India
Main author(s)	Kameshwar Prasad

According to a community-based study of 2,313 adults in Colombo, the risk factors for stroke were hypertension (62.5%), smoking (50%), excess alcohol (45.8%), diabetes (33.3%), transient ischemic attack (29.2%), and family history (20.8%). Further CT scanning revealed cerebral infarction in 74.7%, intracerebral haemorrhage in 19.1%, and subarachnoid haemorrhage in 62.2% of the cases. The prevalence of stroke per 100,000 people in the neighbouring region is 44-843 in India, 500-2000 in Bangladesh, 218 in Pakistan, and 1000 in Sri Lanka, although detailed information was not provided.

(4) Eye Diseases

Reference 1)

Title	Cataract Services are Leaving Widows Behind: Examples from National Cross-Sectional Surveys in Nigeria and Sri Lanka
Journal	Int. J. Environ. Res. Public Health 2019, 16, 3854
Author's institution	1) International Centre for Eye Health, London School of Hygiene and Tropical Medicine, London WC1E 7HT, UK 2) School of Optometry and Vision Science, University of Auckland, Auckland 1010, New Zealand 3) College of Health Sciences, Baze University, Abuja 900108, Nigeria 4) Department of Clinical Medicine, Kenya Medical Training College, Nairobi 00100, Kenya 5) Ministry of Health, Indigenous Medicine and Nutrition, Policy Analysis and Development Unit, Colombo 10, Sri Lanka 6) Public Health Foundation of India, Hyderabad, Telangana 122002, India
Main author(s)	Jacqueline Ramke [1,2]

Of the 5,779 cases from the national cross-sectional blindness surveys conducted from 2012 to 2014 in Sri Lanka, non-married women, including widows, accounted for 18% of the sample and 54% of those with cataract blindness. Cataract surgical coverage for rural non-married women was 68.5%, which was lower than for the wealthiest group of people. Regarding the service quality, the coverage for effective cataract surgery was low among rural non-married women (37.0%). In this way, rural non-married women tend to have poor access to cataract services and are at a higher risk of cataract blindness than other groups. Multi-faceted strategies are needed to eliminate these disparities.

Reference 2)

Title	Barriers for Cataract Treatment among Elderly in Sri Lanka
Journal	Current Gerontology and Geriatrics Research Volume 2019, 6 pages
Author's institution	1) Teaching Hospital, Batticaloa, Sri Lanka 2) Postgraduate Institute of Medicine, University of Colombo, Sri Lanka 3) Radiant Eye Hospital, Ja-ela, Sri Lanka 4) Teaching Hospital, Kandy, Sri Lanka 5) Department of Public Health, Faculty of Medicine, University of Kelaniya, Sri Lanka
Main author(s)	Nilanga Nishad [1)]

A study of 470 elders in Gampaha District in Western Province showed that the prevalence of any cataract was 80.6% (including in eyes that had been operated on), and 73.6% of those had not been treated with operation. It also demonstrated a lack of knowledge and awareness of the disease and its treatment and operation. Of the cataract cases without operation, most people were not aware of the disease, and 40% did not know that it was curable by operation. On the other hand, 60% of interviewees thought that they would experience post-operative behavioural restrictions. Other concerns identified were about surgery costs, postponement due to family circumstances, fear of surgery, and concerns about long waiting times before surgery. These concerns were apparent in lower-education and lower-income groups. This study demonstrated lack of awareness and knowledge, socioeconomic factors, and misconceptions as the main barriers for cataract treatment which has led to a lower cataract surgery rate irrespective of the high cataract prevalence reported. Findings of this study highlight the importance of cataract as a common health problem in elderly and need for removal of the barriers for its treatment which should be given due prominence in the formulation of public health policy in Sri Lanka at the earliest.

Reference 3)

Title	Impact of vision impairment and self-reported barriers to vision care: The views of elders in Nuwara Eliya district, Sri Lanka
Journal	GLOBAL PUBLIC HEALTH, 2018 VOL. 13, NO. 5, 642–655
Author's institution	1) Centre for International Health, Burnet Institute, Melbourne, Victoria, Australia 2) PALM Foundation, Nuwara Eliya, Sri Lanka 3) Berendina, Colombo, Sri Lanka 4) Plantation Human Development Trust, Colombo, Sri Lanka 5) Central Province Health Department, Kandy, Sri Lanka 6) Department of Obstetrics and Gynaecology, International Centre for Reproductive Health, Ghent University, Belgium 7) Department of Epidemiology and Preventive Medicine, School of Public Health and Preventive Medicine, Monash University, Victoria, Australia
Main author(s)	Nilanga Nishad [1)]

This study conducted focus group discussions with retired Tamil and Sinhala elders in Nuwara Eliya District. Many worried that vision impairment would made them dependent on their families, restricting their ability to contribute to their families and communities, access information, socialize, maintain their health, and earn income. Barriers to eye care services included transportation, costs of treatment, fear, lack of knowledge, waiting times, and health staff attitudes. Eye care services need to be integrated into the PHC system and provided equally to elders; they should be provided with consultation to overcome the economic, social, and cultural barriers to access to eye care.

(5) Cognition and Cognitive Function

Title	Associated factors for cognition of physically independent elderly people living in residential care facilities for the aged in Sri Lanka
Journal	BMC Psychiatry (2019) 19:10
Author's institution	1) Department of Nursing, Faculty of Allied Health Sciences, University of Ruhuna, Galle, Sri Lanka. 2) Department of Physiology, Faculty of Medical Sciences, University of Sri Jayewardenepura, Gangodawila, Nugegoda, Sri Lanka. 3) Department of Medicine, Faculty of Medicine, University of Ruhuna, Galle, Sri Lanka.
Main author(s)	Madushika Wishvanie Kodagoda Gamage[1]

This survey assessed the cognition of 421 elderly people dwelling in residential care facilities for the aged in Southern Province. Factors such as the completion of higher education, marital status, voluntary attending of the facility, visits by family members, higher physical activity levels, and engagement in social/leisure activities were associated with the level of cognition and could be predictors of future decline in cognitive function.

(6) Abuse

Title	Elder abuse among outpatient department attendees in a tertiary care hospital in Sri Lanka
Journal	Ceylon Medical Journal 2014; 59: 84-89
Author's institution	Departments of [1]Forensic Medicine and [2]Psychiatry, Faculty of Medicine, University of Kelaniya, Sri Lanka
Main author(s)	P A S Edirisinghe[1]

Abuse, whether physical, psychological, neglect, or otherwise, was reported by 45% of the elders on a questionnaire survey of 530 adults above 60 years of age attending the out-patient department at the North Colombo Teaching Hospital. The total overall rate of abuse was 38.5%, with physical abuse at 5.6% and loneliness at 26%. Having more than three children was a risk factor for psychological and financial abuse and being single was a risk factor for psychological abuse.

(7) Social Participation

Title	Factors associated with social participation amongst elders in rural Sri Lanka: a cross-sectional mixed methods analysis
Journal	BMC Public Health (2018) 18:636
Author's institution	1) Burnet Institute, Melbourne, Australia. 2) Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Australia. 3) Judith Lumley Centre, La Trobe University, Melbourne, Australia. 4) International Centre for Reproductive Health, Department of Obstetrics and Gynecology, Ghent University, Ghent, Belgium. 5) Central Province Health Department, Kandy, Sri Lanka. 6) PALM Foundation, Nuwara Eliya, Sri Lanka.
Main author(s)	Celeste Marsh[1)]

A study of 1200 elders aged over 60 years residing in two divisions in Nuwara Eliya District revealed that social participation in poor, geographically isolated communities was low. Being younger, male, Sinhala, married, employed, and satisfied with one's health were the factors that were significantly associated with higher social participation. Domestic work and cultural constraints often prevented elderly women from participating in society.

Thus, being older women, particularly the oldest of the old, having physical and mental problems, and other

factors were barriers to social participation. It is necessary to understand these issues and consider measures that take into account cultural, social, and environmental factors - for example, creating opportunities for both informal and formal social participation by working with elders' homes, setting up consultation desks for the elderly, improving physical access, advocating with elders' families and religious leaders, and encouraging mutual support and inter-generational activities.

CHAPTER 5 Activities by Related Development Partners

This chapter summarizes developments by partners that support Sri Lanka's aging population in various ways.

5.1 Partner Types, Features and Major Projects

5.1.1 National Institutions

- University of Colombo

University of Colombo is one of the oldest and largest national universities in Sri Lanka with many research fields. Especially, the aging research advances in the demographic statistics department which belongs to the liberal arts department. The department was established in 1973 with UNFPA support as a unit for demographic education and research. To date, they have made a demographic analysis of Sri Lankan people on a variety of topics. "Actual situation of the elderly" is one of the subjects of the department's research. Lakshman Dyssayanaka led the publication of a report entitled "Older Persons in Sri Lanka: Burden or Resource?" (2014).

In addition, as a measure to improve the quality and social status of current caregivers, the establishment of a course of care for the elderly is being planned at University of Colombo. The aim is for Colombo University to provide high-quality care education in cooperation with domestic and international partners, including private sectors, with the participation of existing caregivers as well as those who are newly employed. The aim is to make caregivers' job attractive, provide employment opportunities for many job seekers, and provide high-quality services. The outline of the plan is as follows.

・Conducted courses in cooperation with vocational training institutions (VTA)
・Night course of less than 1 year (10 months) (so that workers can participate), 2 semester system
・Expect external support and cooperation from Japan and other countries in curriculum development, selection of trainees, and ICT utilization
・Training for course teachers (TOT) is also assumed.
・Assuming a course program involving private facilities for the elderly with equipment and environment

5.1.2 International Organizations

- Asian Development Bank (ADB)

ADB is a financial organization that promotes international development in Asia and the Pacific. While the main themes of their activities in Sri Lanka are infrastructure construction, transport, energy, and urban development, project themes such as job creation, living standard improvement and rural development are also included in their project themes. There are projects related to elderly people. In December 2019, ADB published the "Growing Old Before Becoming Rich Challenges of an Aging Population In Sri Lanka " report. In addition, capacity building related to the care of the elderly in the following 6 countries is being

implemented in cooperation with HelpAge.

Project name	Capacity Building for Elderly Care
Summary	Technical cooperation through "Japan Fund for Poverty Reduction" Technical cooperation in geriatric care in -6 countries (Mongolia, Indonesia, Sri Lanka, Vietnam, Thailand, Tonga). In Sri Lanka, the NSE acted as the coordinator, and in 2018, a workshop was held with 30 participants from the MoH, Ministry of Planning, and relevant organizations. They also conducted study tours to Japan and Singapore.
Progress	A follow-up program was planned but was not implemented due to NSE issues. The theme of future technical cooperation is the development of human resources in nursing care, but it is necessary to advance discussions with related organizations.
Learnings	As a prerequisite to implement future projects effectively, it is necessary to strengthen the functions of implementing system of related organizations such as NSE.

- International Labour Organization (ILO)

The ILO is an international organization that conducts research, studies and recommendations on labour issues worldwide and in countries around the world. According to the ILO's "Rewarding decent Work Sri Lanka Program 2013 -2017" (2013), Sri Lanka is tackling the following 3 priority themes.

1. Promoting formal, rewarding and productive employment and creating an environment that enables competitive and sustainable corporate growth
2. Strengthening Democratic Governance in the Labour Market
3. Social Inclusion and the Establishment of a Social Security Community

Project name	Social inclusion project
Summary	This project proposes the expansion of work related to the care industry, tourism, and environment related to the aging sector.
Progress	It remains in the proposal of the extension. The care industry includes not only health care workers and caregivers, but also various elements such as cleaning, child care, Ayurveda, household service providers, massage services, equipment and materials for the disabled, and life support for the elderly after retirement.
Learnings	From the view point of promotion of protection of the rights of the weak, it is important to promote participation of the elderly in society, raising the retirement age, participation of women in labour, etc.

[Challenges Recognized]

One of the reasons for the low social status of caregivers is that helpers and maids are regarded as simple jobs and are not recognized as specialists. As part of an effort to increase the attractiveness of the caregiver, career path to work overseas may be a good idea. For example, nurse can work overseas to gain experience and gain better job and status after returning home.It is necessary to provide work place after overseas experience while mitigating working overseas risks (For example, there are casese in the Middle East that some people were deceived and returned to their home countries without making deposits, resulting in poverty.). On the other hand, although family care is an important concept, attention must also be paid to the problem of abuse by families.

- United Nations Population Fund (UNFPA)

UNFPA is an international organization that focuses on maternal and reproductive health to address the world's population problems. On its website, UNFPA states that the number of people aged 60 or older in

the world will rise to 12.3%, and in 2050 it will increase to 22%.[104] It is also active in Sri Lanka. It publishes "Older people in Sri Lanka" (2012) and other reports, and holds various seminars such as "feminization of aging" (2019) and "realise an active aging of society" (2018) to raise awareness about aging issues in Japan from the perspectives of cases in Japan and Malaysia and consideration for women. Future activities with NSE, etc., are assumed.[105]

Project name	Support for the implementation of the Sri Lankan census
Summary	Support the implementation of the national census, including the elderly, and analyze and utilize data, including the elderly.
Progress	It will be implemented by the Statistics Division in March 2021 and will be supported by UNFPA. The ministry had planned to conduct the survey in cooperation with professors at Columbia University in order to assess the economic impact of the 2020 generation, but the decision has yet to be made due to the impact of COVID -19. The results of the analysis are important in policy dialogue and policy formulation. Policy dialogue partners include the Central Bank of Sri Lanka, the National Planning Unit, and the Census Statistics Unit.
Learnings	In addition to the perspective of care for the elderly, demographic and economic analyses (Income, consumption, markets, etc.) of the elderly are also important. On the economic front, the agenda will include raising the retirement age, reducing the burden of the government's pension program and improving the nongovernment pension program.

- World Bank

World Bank has carried out elderly people related projects in Sri Lanka in social secuirty, rural development and primary health care. In February 2019, World Bank published a report entitled "Sri Lanka Development Update Changes in Sri Lanka's Population Dynamics."

In the elderly sector, the following projects are planned (in the chart below) for adaptation of the needs of facility care for the elderly, transitional care[106] and community care.[107]

Component	Overview
Elderly facility development	Facility development (stay type) for 1,000 beds, targeting mainly dementia and bedridden elderly people. Coordination with hospitals (facility: dosing, daily exercise at the facility / hospital: further medical treatment at the hospital when required) [Background] While there is a high demand for stay type elderly care including dementia and bedridden people, government-run facilities are limited. Many non-government facilities cannot accept dementia and bedridden elderly people from financial point of view.
Standard improvement / implementation for elderly facilities	Standard for the elderly facilities is in place but improvement is needed. At the same time, support for substandard facilities and NSE monitoring capacity support. For example, unlike restaurants, it is difficult to suspend their business for breaching the standard as there are elderly people living there. With reference to the other counties' cases, it should be implemented in Sri Lankan context. [Background] Main problem is implementation and enforcement of the standard and it is thought to be difficult.
Enhancing community home elderly care services	A priority is given to the elderly living alone, those with bad health conditions and so on. Elderly care education to their families, awareness program of government services (health care, social security etc.) are also implemented. Home elderly services in an affordable manner is envisaged by utilizing volunteers. Target for such volunteers are, relatively young, age 60-70 year-old members of elderly committee. [Background] There is a need for home elderly care. However, private home elderly care services are expensive and not affordable for majority of the people. Filling this supply and monetary gap is the purpose of this support.

[104] https://www.unfpa.org/ageing
[105] Based on January 2020 hearing. There was a statement that it was thought that preparation for implementation was yet to start due to capacity shortage of NSE.
[106] Transitional care: Transitional care means care to be provided when a place of service provision has changed or levels of care or care givers have changed. Ref. Journal of Japan Geriatric Society, Vol. 54, No. 1 P41)
[107] Based on JICA survey in August 2019 and hearing in February 2020.

Caregiver development	Training on about 1,000 caregivers including in-service staff. Support for migrant work. Through 2-year work experience at facility, obtaining NVQ level 4 is envisaged. [Background] It is necessary to improve career development motivation as caregiver.
Day care centre development	Development of regular clinics (visit by doctor and nurse etc.) and facilities with easy rehabilitation functions, for both public and private. Plus, delegating operations to elderly committee is also studied. [Background] Elderly people's family members may work or go to school for their kids during day time. If their elderly member is kept at facility during day time, they can work. Seeing a doctor also takes a long time as lengthy waiting time at hospital.
NSE functionality enhancement, information system development	No concrete plan is fixed yet. One of support targets is legal system application / implementation. On top of human resources, information registration, monitoring and certification systems are either weak or non-existent. Support in system development for these areas is also envisaged.
Transitional care support	At the beginning, support for transitional care was considered. However, the MoH has secured support from another donor in the area, World Bank decided delist this item from their support list.

[Challenges Recognized]

Among the challenges facing facilities for the elderly are the lack of NSE personnel, the lack of implementation of standards, the lack of coordination with the MoH, etc., and the lack of government oversight of private facilities for the elderly. Facilities for the elderly are homes for the elderly, and even if the facilities do not meet the standards, they cannot be suspended. The systematization related to registration and management of facilities for the elderly has not advanced.

Challenges for day care centers include lack of services, lack of organization, and no visits by nurses or doctors.

- World Health Organization (WHO)

World Health Organization is an international organization working on global health issues. The issue of the elderly is one of the themes of the WHO. In particular, Japan has deepened its cooperation with the MoH in the field of medical care, and cooperated in the compilation of health policy statistics in 2017. Although it was planned due to its relationship with the MoH, it has not been implemented. The WHO explained at the interview in February 2020 that it planned to hold a meeting with relevant stakeholders to share results of the survey conducted by consultants and start to support the MoH for the formulation of the strategy, but it seemed not started yet due to COVID-19 pandemic in the world.

Besides, the YED explained that there is a plan with the WHO to introduce the new Programme of Integrated Care for Older People Approach (ICOPE), which the older people will be screened annually for impairments of nutrition, mobility, vision, hearing and mental status and will receive timely correction of any impairment detected.

Project name	Formulation of senior strategy framework and strategy
Summary	With the aim of formulating a strategy for solving elderly issues in Sri Lanka, the MoH, other donors, and the elderly group will be consulted based on environmental analysis.
Progress	It was scheduled to take about 1 year, but it has not been decided yet due to COVID -19.
Learnings	It is important to deal with the issues of the elderly mainly from the theme of health and medical care, and to consult and cooperate with various parties concerned.

5.1.3 NGOs

- HelpAge

HelpAge is an international NGO working for the elderly around the world. The HelpAge Sri Lanka) is based in Sri Lanka and is aware of and knowledgeable about the challenges facing the elderly in Sri Lanka. For example, in the background of the recent aging of society, the government's population control measures in the 1970s based on the concept of "Small families are great (small family is golden)", a decrease in family care caused by women's social advancement, and the trend toward nuclear families are analyzed. In Sri Lanka, people over the age of 60 cannot borrow loans from financial institutions. We are urging the government to rectify this policy.

Specific activities at present are as follows.

1) Provision of Mobile Ophthalmology Clinic Services

Public ophthalmic hospitals are free of charge, but residents, especially in rural areas, often do not go to hospitals without knowing that they are free. Even if you want to go to the hospital, there is no transportation, you have to wait in line even if you can go to the hospital, and you have to wait even if you need an operation. Against this background, HelpAge started a mobile clinic. They provide about 20 treatments a day and about 37,000 treatments so far.

2) Caregiver Training

HelpAge has been training caregivers since 1986. From 2015, training corresponding to NVQ levels 3 to 4 was started, and by 2019, 5 programs were implemented. In the past, students who did not do well in Ordinary Level exam were subsequently not eligible to take the Advanced Level exam, but now they have another option. It's going to technical and vocational education institutions. Care for the elderly is one of the majors of technical and vocational education institutions, and it is possible to advance to diploma.[108]

3) Volunteer Programmes

55 -65 year old (Up to 70 years old) healthy, literate elders are selected from the village elders committee and given 5 days of training. The purpose is to care for the elderly in the village. After that, they work in the village as volunteers. Training and accommodation fees are also provided free of charge, and approximately 3,000 people have completed training so far. Currently, it is training 100 ~ 200 students a year, and it is asking WB for support in order to double the number.

One of the problems with families with elderly people in Sri Lanka is that they do not receive proper care,

[108] The National Institution for Academic Degrees and University Reform (2020) is an independent administrative institution that specializes in Sri Lanka's education system. It is roughly divided into preschool education, middle school education such as first year [a school such as the first semester (5 years), a school such as the first semester (4 years), and a school such as the second semester (4 years)], technical and vocational education, and high school education, and compulsory education is until the 2nd year of a school such as the second semester, and students take the O examination at the end of the 2nd year. During the second two years of school, including the second half of the semester, students receive a college preparatory education as part of the college curriculum. Students take the A exam at the end of school, such as in the middle of the second semester, which affects their ability to enter university. The overall picture is the same on page 5.

such as not cleaning their rooms and confining them in the back. Volunteers visit families that do not care for the elderly and tell them about the need for care. There are also many Sri Lankans who cannot say, "they do not care for the elderly" and who do not want others to see them without care. In one case, a family member actually took care of an elderly person after volunteers visited.

4) Home Care Programme

Training young people to care the elderly and match them with those who need care. The object of this matching is the wealthy class in Colombo (Mainly Colombo accounts for about 95%). Recruit in the area and train when enough people gather. The frequency is about once every three months, and the cost of training and matching is jointly borne by HelpAge and vocational training institutions. Young people can take the course free of charge, and it is a one-week classroom study, two-week practical training of care, and then an OJT program at an elderly facility for three months. Training levels are NVQ2 and 3 and are determined by the student. During OJT, elderly facilities require participants to pay 30,000 rupees per month. So far, about 200 people have completed the course, and the career paths are for government-affiliated, private and overseas facilities for the elderly.

5) School Education

Education on family elderly careis carried out in schools. Both men and women are eligible, and in addition to students, teachers are also eligible.

5.1.4 Japan's Aid

From 2014 to 2019, JICA implemented a Training on Specific Issues "Strengthening Policy for Aging in Asia: Challenges and Responses to the Aging Society" and 2 government officials from Sri Lanka participated in the training every year. A grassroots technical cooperation project "Sri Lanka Elderly Care Health Policy Model Forming Project (2015-2017)" was also implemented. The following activities were undertaken.

(1) Formulation of basic policy and plan for health care for the elderly with reference to measures for aging in Japan and so on.

(2) Based on the Basic Policy on Elderly Care fromulated in (1), the MoH YED formulated the Elderly Care Delivery Plan (Elderly Healthcare Delivery Plan).

(3) Formulation of national guidelines for elderly care training as well as training for elderly care instructors (Training of Trainers: TOT)

As for the private sector, the Koshikai Social Welfare Corporation entered the Sri Lankan nursing home market in June 2016, and established and operated "NAGAI" a high-grade elder facility in Colombo City, in which Japanese citizens also invested (Introduced on September 9, 2016 "JETRO Business Brief" and October 17, 2016 "Toyoshin Overseas Trade and Investment News").

NAGAI is a hybrid service that combines medical care and nursing care, taking advantage of Japanese hospitality and Sri Lanka's hospitality, and is aimed at attracting wealthy people living in the aging society. The ministry also plans to train nursing care workers there and dispatch them to Japan. "NAGAI" was established by Hiromitsu Takahashi, president of Koshikai, a social welfare corporation that operates Rengeso (Takatsuki City, Osaka), and local Nawaloka Holdings Co., with 49% and 51% investment, respectively. Operated by a joint venture between the two companies, Nawaloka Guardian International. The 7th floor of Nawaloka Hospital, which was operated by Nawaloka Holdings Co., will be renovated and 9 new private rooms with living rooms will be installed to fully support the residents with all meals provided 24 hours a day. With the aim of creating a living space and providing services similar to those offered by luxury hotels, the company has introduced Japanese products for the beds and mattresses used in the rooms, and has used Japanese technology to renovate barrier-free facilities.

CHAPTER 6 Analysis of Japanese Companies and Their Technologies

6.1 Japan's Aging Sector Market

The Mizuho Industrial Survey (2012) predicts that elderly businesses will be around 101.3 trillion yen consumer market, if they are defined as the 3 industrial sectors or "medical and pharmaceutical industries", "care industry" and "consumer products industry" based on the growth of elderly population and demand for elderly people by 2025. This amount exceeds 97.5 trillion yen nominal domestic product of infromation and communication industy in 2017 according to 2019 edition of the Ministry of Internal Affairs and Communications' White Paper on Information and Communications,' making the elderly industry an attractive market for entry. Public funds such as insurance and subsidies are closely related to the business for the elderly in Japan, and it is necessary to consider how to develop the business based on these aspects.

On the other hand, when considering the elderly industry in Sri Lanka where designing of future elderly care system design hass just started, the viewpoints of "medical and pharmaceutical industries" "care industry" and "consumer products industry" are helpful as an example, taking into account that the public expenditure systems (Medical Insurance System and Long-TermCare Insurance System) are different from those in Japan.

On the other hand, when considering the elderly industry in Sri Lanka where designing of future elderly care system design hass just started, the viewpoints of "medical and pharmaceutical industries" "care industry" and "consumer products industry" are helpful to understand progress of investigation in each sector, identify specific areas to be strengthened and enhance utilization and coordination of private services, with taking into account that the public expenditure systems (Medical Insurance System and Long-TermCare Insurance System) are different from those in Japan.

Source: Mizuho Corporate Bank "Mizuho Industrial Survey 2012" p.50

Figure 6.1.1 Domain of Elderly Care Market

It is necessary to define customers in provision of products and services to the elderly by private companies. In Japan, various service products for the elderly such as "preventative exercise," "rehabilitation" and "dementia care," and other service products such as "beauty, barber, and cosmetic" "support for travel and outings" and "monitoring" are developed. In order to provide optimum products and services for Sri Lankan elderly people, it is necessary to collect and analyze data on the health conditions of the elderly, information related to long-term care needs, and living conditions, and present them to the government and private parties concerned.

Source: Source: Japan Research Institute, Ltd. (March 2016) "Research and Survey Project Report on the Development of Healthcare Business for the Elderly by Private Sector for the Establishment of a Community-Based Integrated Care System p.3

Figure 6.1.2 Needs and Services for the Elderly

6.2 Business Potentials in Sri Lanka's Aging Sector

In general, Sri Lanka's ageing sector market is still under development, and private sector service development is lagging. This is because public-private partnerships in the provision of services in the sector, which have been led by the government, have not yet been fully achieved, there are few players (local and overseas companies) who have the experience and know-how to provide the necessary services, and there are few middle-income or wealthy customers. However, with the aging of society, the needs for these services are increasing, and the market potential in the future is large. However, it seems foreign elderly care businesses are yet to embark in the country.[109] In this section, the medical and nursing care sectors are

[109] There was no information available about the number of foreign businesses in the elderly businesses. Online research outcome of little foreign business suggests not many foreign companies have entered in Sri Lankan elderly market.

focused, which are in great demand among the various aging market sectors.

(1) Medical Sector

Public hospitals account for approximately 73% of the total number of hospitals and 93% of the number of beds in Sri Lanka, and medical services, including medical care for the elderly, are heavily dependent on public services.[110] For this reason, it is important for Japanese companies to develop businesses that enhance and complement public services, taking into account the needs and trends of public medical institutions, when they enter the host country.

- Remote and Mobile Medical Care

According to the Annual Health Bulletin 2017, the number of beds in rural areas is smaller than in urban areas, with 14,230 beds in Colombo compared to 492 beds in Mullitteevu, the smallest district in rural area, with an average of around 1,000 beds across the county.[111] According to the "Sri Lanka Health Service Improvement Project Preparation Final Report" (2017), the number of doctors assigned to each region was 231 (Per 100,000) in Colombo, but less than 100 in all other regions. Unlike urban areas, rural areas have fewer hospitals and limited means of transportation, so access to hospitals is a challenge. In mountainous areas, it has been reported that, on average, patients spend as much as 76.7 minutes to visit a hospital one way, and in some cases, patients spend more than 2/3 of their monthly income on transportation when choosing a medical institution located far away from their homes.[112]

Under these circumstances, mobile medical care and telemedicine are required in order to solve problems such as insufficient medical facilities and the burden of moving elderly people, especially in rural areas. Currently in Sri Lanka, telemedicine is mainly provided for young workers in urban areas such as Colombo, Gampaha and Kandy, while rural services for the elderly are not common.[113]

Professor Lakshman Dissanayake, Senior Professor of Department of Demography, University of Colombo views[114] the reasons why services for the elderly are not widespread in rural areas as follows:

- Market Size
  - ✓ In rural areas, the number of potential customers is small and the market size is small.
  - ✓ In businesses (To B), existing service providers target private hospitals and the number of such hospitals is limited in rural areas.
  - ✓ Due to low income levels in rural areas, the elderly population with access to private hospitals is limited.
- Users' IT literacy
  - ✓ Elderly people have relatively low IT literacy, making it difficult to use services using smartphones and PCs.

[110] Data as of 2014. https://openjicareport.jica.go.jp/pdf/12292959.pdf
[111] Annual Health Bulletin 2017, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.
[112] http://www.trip.t.u-tokyo.ac.jp/kato/WP/2011/2011wp_6.pdf
[113] For example, Sri Lanka's Remote Diagnosis Service "mydoctor", introduced in 2017, is a platform that connects patients and doctors. Doctors clustered in Sri Lanka are basically doctors from the Colombo area, and patients of all ages use the service.
[114] Based on hearing in October 2020.

- English Ability
  - ✓ English speakers are limited in rural areas compared to urban areas, and it is essential to provide services in Sinhala and Tamil.
- Healthcare Professional's Motivation
  - ✓ In general, medical institutions in rural areas lack resources such as equipment and personnel, and their attractiveness as a place of work is weak, so it is difficult to assign highly motivated and excellent human resources, and to introduce new services or improve existing systems.

There are multiple reasons for digitizing of healthcare services in Sri Lanka is lagging behind especially in rural areas. One is related to lack of internet infrastructure coverage. Compared to urban areas, in rural areas internet coverage is either weak or completely absent. For this reason, service providers are unable to introduce reliable digital health services. The flip side of this problem is that due to lack of internet infrastructure, the rate of people that is digitally literate are also low in rural areas. Studies show that digital literacy in urban areas are 61.7&% whereas in rural areas the rates goes as low as 43%. (*Department of Census and Statistics Sri Lanka, 2019)

Another reason for low healthcare service digitization in rural areas is related to the low-income level of the people in these areas. Service providers find it difficult to generate revenues of digital health service provisioning as people are unable to pay for it.

HelpAge Sri Lanka, an NGO operating in Sri Lanka to support the elderly community in Sri Lanka, conduct mobile clinics in rural areas where there are difficulties in accessing medical services. According to a hearing with HelpAge, currently there are only two mobile health clinics and they lack funding and resource for their services. HelpAge lacks funds and resources to strengthen the mobile clinic unit even though the demand is high. This is an opportunity for Japanese companies who have experience and expertise in mobile healthcare service provision in Japan or other countries.

Regarding barriers to entry by foreign companies in this field, this field does not fall under the regulation or prohibited industries set by the Sri Lankan government. On the other hand, according to JETRO's "2017 Survey of Japanese Companies Expanding into Asia and Oceania," Japanese companies expanding into Sri Lanka raised the difficulty of quality control, the quality of employees, and the rise in wages as management issues. In addition, 67% of the companies mentioned that local companies become competitors, so it is considered that the difficulty of worker and labour management may be a barrier to entry for foreign companies. The survey also shows that Sri Lankan consumers tend to value price over quality, which may be a factor that makes it difficult for Japanese companies to enter the market.

With regard to telemedicine in Japan, introduction and demonstration of telemedicine for the elderly are advancing, including an online medical care model such as the visiting nurse model promoted mainly by the Telemedicine Promotion Network, a specified nonprofit corporation in Tsukuba City, Ibaraki Prefecture, and Tsukuba Heart Clinic.

- Rehabilitation Service Follow-up

According to data on national hospitals from the Annual Health Bulletin 2017[115], the number of bed in the Colombo area was 14,230, and the number of doctors and related medical officers was 4,725. Large private hospitals are also concentrated in Colombo, Gampaja and Kandy, indicating that there is a relatively high level of treatment-based medical services in urban areas.[116] On the other hand, facilities and services for post-treatment rehabilitation and after-care are in short supply, and the Sri Lankan government has promoted the provision of high-quality and equitable rehabilitation services as one of the 7 basic policies of "NATIONAL HEALTH POLICY 2016 -2025". At present, families of elderly persons who do not have specialized knowledge are often in charge of these care, hampering early recovery and increasing the number of cases requiring revisits to hospitals.

The opportunities for elderly people to receive rehabilitation and after-care services, such as at some private nursing homes, are limited, and many elderly people cannot receive satisfactory care in nursing homes or at home where they spend time after being discharged from the hospital. For this reason, it is required to provide services in cooperation with a home for the aged or to provide some kind of care at home.

According HealpAge, Sri Lanka home visiting care givers or nurses that can provide rehabilitaion and aftercare services are short in supply and only less than 3/1 of the demand is met in the market. Private elder care services provider, Nobel Aged Inc. also highlighted that need for the home visiting care givers is very high but it is difficult to find qualified personnel in the market.

Lack of training system is also a problem behind this problem. Due to the absence of training and skill validation system, care givers are not able to acquire the required skills for providing visiting services and due to the same reason, they are not paid a decent salary. This is directly connected to the lower job satisfaction in care givers and this is one of the main reasons behind the low job retention rates.In this regard, in Japan, services that enable people to easily receive rehabilitation and after-care at home or at nursing facilities have been developed and introduced on a trial basis, such as the online remote rehabilitation service provided by an AI venture company Exawizards and Kitahara Hospital Group, and the rehabilitation support service utilizing IoT and apps provided by Moff, a startup and are expected to meet local needs.[117] [118]

- Digitization of Medical Data of the Elderly

In Sri Lankan hospitals, patients' medical records generally exist in the form of paper, but they are not stored as electronic data, and a system for efficiently sharing the patient's health status, medical history, and treatment history among healthcare professionals has not been established. Especially in the case of elderly people, there is a great need for digitization of medical data, including medical records, because there are many cases where the patients themselves do not correctly remember or understand their past medical and treatment histories, and current health conditions.

[115] The Department of Census and Statistics, Sri Lanka (2019)
[116] Annual Health Bulletin 2017, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka.
[117] https://www.pt-ot-st.net/index.php/topics/detail/1093
[118] https://jp.moff.mobi/news/20031001/

Specifically, introduction of electronic medical record systems is conceivable, but in Sri Lanka, it has not progressed at both public and private hospitals.

In this regard, various systems integrated with electronic medical records and statement of medical expense have been developed in Japan and they may meet some local needs. For example, HOPE LifeMark-HX developed by Fujitsu targets large hospitals. CLINICS medical records developed by Medley and QUALIS developed by BML Co., Ltd., for medium-sized hospitals, free hospitals, and home care may be helpful to some Sri Lankan medical data digitization needs.[119] [120]

(2) **Elderly Care Sector**

With regard to the nursing care sector, there is a great need for products and services related to nursing facility management and human resources shortage. Those techonologies lead to nursing care human resource development and the saving of nursing care human resource are badly needed As Japan's long-term care business opportunities were opened to the private sector, various originalities and ingenuities have been innovated across the whole elderly care businesses, it is thought that the private sector has certain comparative advantage in comparison with sole public sector implementation. Especially, in terms of provision of elderly care services based on individual's needs, there is a member of creative technical innovations mainly in ICT area.

- Management Knowhow of Eelder Homes

As elderly facility operation support software, there are services for elderly people's health condition record keeping, care plan development, care record keeping, invoice management, nutrition planning. For example, Logic Inc. offers "Care-wing" service which improves home-visit type service (elderly care / medical nursing) through utilization of smartphones and IC tags. It helps service staff shift management, care record keeping, insurance application documentation, service log keeping and so on. By reducing transcribing / checking paperwork, staff shift communication mistakes and telephone communication cost, the service concentrates much-needed business human resources on care services.

Regarding foods provided at elderly care facilities, a variety of external food supply services are available. They offer completed foods which can be easily made ready for eating with hot water, reducing food cost, labour cost, menu development task, at the same time improving satisfaction of the facility users. The foods provided include "event-meal" for seasonal events, "select meal" which enables users to choose main dish based on their appetite on the day. From functional (chewing, swallowing, digesting and absorption) point of view, functional meals such as "minced meal", "soft meal" and "mixer meal" are offered under supervision of managerial dietitian, in pursuit of joy of eating.

- Services Utilized by the Elderly and Their Families

As for services utilized by the elderly by themselves and or their families, there are some applications utilized in health record keeping, nutrition management and dementia prevention. There are also services

[119] https://www.biz.ne.jp/matome/2003023/
[120] https://it-trend.jp/emr/article/resekon

for solitary elderly safety confirmation application, combined with installed sensors on daily life movement lines, pendant type communication device for medical emergency service, and loitering

- Japanese Elderly Care Businesses in Sri Lanka

In Sri Lanka, the private sector plays a major role in the management of nursing homes and other care facilities. Currently, the number of private elder homes registered with the NSE is 327, far exceeding the number of government-run elder homes of 6. The government is providing financial support for the operation and expansion of private nursing homes, but supply has not kept up with demand. In fact, there is a waiting list of applicants at each elder home that was visited during the field survey, and some elders have to wait for more than six months before moving in.[121]

Table 6.2.1 Number of Nursing Homes for the Elderly in Sri Lanka

Province	Number of nursing homes
Western	161
Southern	46
Northwest	37
Uva	29
Sabaragamwa	28
Central	22
Northern	9
Eastern	9
North Central	6
Total	327

Based on NSE (2019) and additional investigation by JICA Survey Team

Source: JICA Survey Team

NobelAged Inc provides elder care services at a fee targeting middle to upper level market. Even if they make a profit in elder care business it has been difficult to them to maintain service standards mainly for two reasons. First, there is no evaluation or monitoring system on the government side to ensure operations and management standards in paid eldercare service providers. Secondly, there are no success stories or examples in the market for incentivising service improvements in the paid eldercare service sector.

On the other hand, many of the private sector nursing homes today are operated on more of a charity based, by government grants and community donations, rather than for business purposes, and many of these homes are poor in service qualities.

According to the ERPO, which regularly evaluates operation of nursing homes, the lack of a system for constant monitoring of nursing homes also contributes to poor quality of service.

In this regard, in Japan, there are some businesses, such as Smile Ichiban Co., Ltd., that are developing servivces for improving the services of nursing homes and monitoring and evaluation systems, which can contribute to solve local problems. In this field, there are some Japanese companies, such as the Social Welfare Corporation Koshikai, which operates "NAGAI" a home for the elderly aimed at high-income earners in Sri Lanka, that have already been expanding their business overseas.

[121] Interviews with Janadhara Elder Home Moratuwa (2020), Irine Thilakarathne Wedehiti Niwasaya, and Kadawatha (2020).

There is a case a Japanese manufacturing company operating in Sri Lanka embarked on elderly care business. Kure, Hiroshima based Daiki has been engaged in various manufacturing businesses before World War 2 in the area of ship building and bridge construction based on their welding technique. The company started elderly care business for wealthy locals in 2018 through its Sri Lankan subsidiary Daiki Lanka at Katunayake, in an outskirt of Colombo. According to the company, the facility was originally intended for international tourists. However, currently the facility is occupied with Sri Lankans as stay-type nursing home. Due to the country's highly educated human resources, pro-Japan, English speaking environment, the company decided to expand into Sri Lanka as their third overseas expansion after the Philippines and Vietnam. Combined with their base business in manufacturing, the company is expanding businesses in Sri Lanka.

- Nursing Care Personnel Development and Labour Saving

The shortage of human resources is a national problem in the nursing field in Sri Lanka. Caregivers are, in the first place, unpopular career because of their low social status and low salary levels. Reflecting this unpopularity, the NSE's 2019 program to train 1,000 caregivers did not attract enough applicants. In addition, there is a problem that many existing nursing care workers do not have high expertise. There is a qualification for careworkers defined by law in the country. The national qualification requires caregivers with 3 month training and accreditment of level II certification of the National Vocational Qualification (NVQ). However, in some cases, the content of education has become a mere formality, and the quality of education has been pointed out as a problem.[122]

In addition, the elderly used to be generally cared by their family members. With the advancement of the aging of the society, women's participation in society and the mainstreaming of overseas migration, shortage of non-professional nursing caregivers also has become a serious issue.[123] As a result, there is a strong demand for services and products that enable the development of specialized human resources as well as reduction of nursing labour.

In Japan, the Ministry of Health, Labour and Welfare has established a certification evaluation system for nursing care providers engaged in human resource development. In addition to universities and educational institutions, nursing care providers themselves are actively engaged in human resource development. In fact, the aforementioned Koshikai, which operates a nursing care business in Sri Lanka, focuses on nurturing local nursing care personnel. In Japan, assistance devices such as muscle suits by Innophys and Honda's walking assists are actively being introduced in the field of nursing care, and such technology is expected to contribute to solving local problems by making up for the shortage of human resources in the field of nursing care.[124] [125]

[122] https://www.niph.go.jp/journal/data/67-2/201867020010.pdf
[123] Long Term Care for Older Persons in Sri Lanka, UN ESCAP 2016 P. 29 -31.
[124] https://innophys.jp/news/%E4%BB%8B%E8%AD%B7%E4%BA%8B%E6%A5%AD%E8%80%85%E3%83%BB%E4%BB%8B%E8%AD%B7%E6%96%BD%E8%A8%AD%E9%99%90%E5%AE%9A%E3%80%8C-%E3%83%9E%E3%83%83%E3%82%B9%E3%83%AB%E3%82%B9%E3%83%BC%E3%83%84-every%E3%80%8D/,
[125] https://www.honda.co.jp/walking-assist/

CHAPTER 7 Challenges of the Measures for Aging in Sri Lanka

Throughout the survey, it was confirmed that aging of the society is progressing quickly in Sri Lanka, the number of elderly-only household is increasing, and facilities and services for the elderly are not sufficient yet and household care is still mainstream. Given these conditions, it is desirable to establish a system where the eldery can continue self-reliant life in the community they are familiar with.

In addition, tight budgetary constraint for the elderly care and regional difference in the degree of aging of the society were observed. These make it necessary to conduct medical and care precention activities, coordination among healthcare, elderly care and community considering unique characteristic of each commynity.

Based on the discussions so far, this chapter comprehensively identifies issues related to measures for aging in Sri Lanka and proposes solutions in the next chapter.

7.1 Cross Sectoral Issues

- Cooperation between/among/inside National/Local Governments

Absence of an integrated legal and policy system to deal with the aging of society has led to the implementation of individual programs by the MoWCASS, MoH, other ministerial organizations, and international organizations, but not to the implementation of activities based on clear priorities. The main ministries involved in measures for the elderly are the MoWCASS and the MoH, but there has been no discussion on the status of efforts by both sides for possibile cooperation or collaboration. At the field level, relatively more collaborations can be observed than those at the national level, such as regular visits by healthcare professionals to medical facilities and visits by SSO to medical facilities to provide social security services to hospitalized elderly people. These collaborations, however, are more of personal and not standardized practice effective in all regions.

Cooperation within the ministries is not sufficient either. For example, in the case of the MoH, the YED Division is in charge of measures for the elderly, but the YED Division does not have a system in place to implement measures for the aging in constant cooperation with other special divisions. Although department directors in charge of divisions other than the YED Division may have some ideas for activities that should be addressed as measures for the aging even though they are not direct implementing department. There is not much opportunity for them to share these ideas and consider specific measures to improve medical care for the elderly due to the lack of opportunities for consultation between departments.

In addition, not only between ministries and agencies, but also between central and local governments, there is overlap in the provision of similar services, and there is a lack of role-and information sharing, and cooperation. In the case of health care, the MoH does not have enough opportunity to share the policies and plans related to medical care for the elderly with local governments under each province, and each province has its own plans and activities. Thus, the cooperation between the national government and local governments is not sufficient.

- No Regular and Sustainable Budgetary Provisions for Measures for the Elderly

As Sri Lanka's population ages, the budget for social welfare and medical services for the elderly is expected to increase significantly. At present, social welfare services are not provided to all elderly people, and services are provided to self-reported and occasionally confirmed elderly people. In the future, however, if the number of elderly people increases, services for elderly people will expand, and services must be provided to all target people and budget requirement is also expected to increase significantly. The NSE recognizes the need for facilities such as nursing homes and day centers, as well as the need for caregivers and other human resources to provide care to the elderly in order to expand and enhance care services for the elderly. At the present stage, however, the budgetary measure is rather ad hoc based at the time of budget allocation.

With regard to medical services, public medical institutions offer free services, but the increase in the number of NCD patients, the increasing complexity of diseases, and the introduction of highly advanced medical care have led to an increase in the cost of diagnosis and treatment, and this trend is expected to continue. In addition, the number of patients who visit public hospitals is large and the waiting time is long, so it takes time for patients to receive medical examinations and treatment. Moreover, patients have to purchase drugs and equipment that are not available at such medical facilities, resulting in more medical expense as a whole society. In light of this situation, measures to secure financial resources, such as collection of medical and social security expenses as well as tax revenues such as sepcial tax and special fiscal resource, are necessary in preparation for the future aging of society.

- Inadequate Data on Measures for the Aging of Society

ERPOs and SSOs, which are under the jurisdiction of the MoWCASS, have some partial information on some elderly facilities, caregivers and the elderly such as name and address, household situation in the areas of their responsibility. However comprehensive figures are not well known. Data required to consider measures for the aging of society, including elderly facilities, caregivers, and the elderly themselves are not collected sufficiently. Classification of elderly people, measures for each needs and their scale and duration are unclear.

Similarly, HLCs and MOH offices, which provide primary health services under the jurisdiction of the MoH, do not have adequate lists or information of elderly people living in their jurisdictions.

As a service for the elderly, elderly service guidance and mediation are provided upon inquiry to an administrative organization, facilities for the elderly, or medical facilities. However, there is no mechanism to systematically comprehend actual condition of the elderly, to specify the elderly in need of support, and to reliably provide services to those in need. In addition, there is not sufficient mechanism for the elderly to obtain information on elderly services. In this way, necessary information on measures for the aging of society and the provision of services has not been accumulated in administrative organisations.

- No Streamlined Mechanism to Promote Private Sector Services and Ensure Quality

A mechanism to fully utilize private services related to elderly care has not been established yet. For

example, the government may ask the private sector for a cooperation to transfer disabled elderly into private-sector operated facilities. However, the government does not fund operating cost for compensation. The government has been the regulator of the private sector services and the mechanism to utilize private sector services has not been well studied. Current elderly care services are insufficient in terms of the type, quantity, and quality of services. It is thought to be difficult to fill the shortfall only with public services, and the utilization of private services should be considered. It is desirable that a mechanism to promote the systematical involvement of private services will be established.

In addition, it has been pointed out that some private services in Sri Lanka do not meet the required quality of services, due to inadequate establishment and supervision of standards and qualifications for elderly care facilities, day centers, and caregivers.

Furthermore, the government does not fully control the situation of private services, and there are many private business operators who do not wish to register their services with the government. As for the reason not to get registered, there is no problem to conduct business without registration and there is no merit of registration.

Regarding the health sector, service provision mechanism is already established from community to tertiary level for free of charge. Therefore, private sector utilization is not considered in the public health services. The cases people resort to private medical facilities include when 1) high quality medial service is needed, 2) required medicine/examination was not available at public institutions, 3) timely service provision was not available at public medical institutions due to congestion, and 4) business hour is over at public medical institutions. The registration system for private medical facilities has been established. However, as pointed out before, the conditions for registration are not sufficient to ensure the quality and safety of medical services. There are cases where medical services are provided without registration in this system and the medical association opposes this registration system on the ground that private sector business should not be regulated and monitored, so the supervisory function is not thorough.

- Housing Environment

In Sri Lanka, barrier-free facilities for the elderly and the disabled have not yet been fully implemented. In particular, elderly people living in mountain areas and estate areas need to use stairs and walk uphill/downhill in their daily lives. In fact, it is suggested that living conditions that are not suitable for elderly people, such as elderly people being hospitalized due to injuries resulting from falls, may have an impact on the health of elderly people at medical facilities they visited.

- Estate Areas

The estate area is heavily populated by Tamils and differs from other areas in social characteristics such as culture and religion. Historically, unique medical services has been provided in the area and not much improvement has been made despite repeated intervention attempts by the MoH. With regard to medical facilities, there are estate-owned clinics within the estate area but these clinics do not follow national laws and regulations and it is difficult to enforce them. Therefore, quality of medical services and treatments are

not guaranteed. In addition, according to past customs, the Tamils have many consanguineous marriages, have inherited genetic diseases, develop eye diseases due to aging, and have low immunity and are susceptible to infectious diseases. Chewing tobacco, alcohol and smoking rates are particularly high in estate areas, which have also affected NCD and oral diseases, but these cultures and lifestyles have been in place for a long time and are not easy to improve.

7.2 Issues under the Jurisdiction of the MoWCASS

- NSE Functionality

In Sri Lanka, the NSE has been established as an organization that can comprehensively and professionally deal with the issue of the elderly. The function of drafting policies and policies for the elderly has been delegated to the NSE, not to the MoWCASS. The NSE has established and operated facilities for the elderly and has provided support for them. Even though all such NSE programs and activities have been developed base on the elderly act and 2006 elderly policy, the NSE has not yet taken a further strategic approach in anticipation of the aging of society due to chronic budget shortage, lack of human resources and detailed data on the elderly and facilities for the elderly.

The NSE does not have a long-term plan, but plans to spend immediate fiscal year (financial support for elderly facilities, allowances for the elderly aged 70 and over, etc.) based on the results of the previous fiscal year. In principle, when implementing national programs, it is necessary to formulate plans for each program, considering priorities, based on target figures and time, to implement and monitor/evaluate activity plans, and to formulate plans for the following fiscal year based on annual performance. However, the NSE has not yet implemented programs under such system.

In addition, in some areas, the number of ERPOs is insufficient and they are not allocated to districts or divisional secretariats, and support to the field work is not provided. Although the shortage of ERPO has been covered at the field level by SSO and other development officers of the central and provincial governments, the support that ERPO should provide has not been sufficiently implemented. In fact, there was a plan to implement a caregiver development project, but the project was not implemented due to political instability.

7.2.1 Social Security Issues

- Preparation for Aging

In Sri Lanka, families used to care for the elderly, but the situation is changing due to the prolonged care of the elderly, nuclear families, and migration to urban areas.

As elderly people live longer, the length of time they spend as elderly people has increased. Therefore, it is assumed that the proportion of elderly people who require high levels of care will increase. In addition, elderly people tend to live alone or as a married couple for a longer period of time, especially for women. In order to cope with such a situation, it is necessary to be economically prepared, such as savings, and efforts to stay healthy. However, for both government and people, such preparation is not sufficient due to

lack of awareness of the necessity of preparation for their old age, lack of fiscal and economic leeway, and inadequate social security systems such as pensions and long-term elderly care system for genereal public.

- Social Security System

In Sri Lanka, public hospitals offer free medical services. This medical care system is desirable for elderly people, because elderly people are more likely to have higher health risks and to visit hospital more frequently. However, the provision of free medical services has the following problems: (1) hospital congestion caused by easy access to medical services, (2) long waiting time, (3) increased burdens on medical staff, (4) difficulty in attracting residents' interest in disease prevention, and (4) pressure on national financial resources. On the other hand, the market for private medical insurance also exists, and high-income earners tend to utilize private medical services except for public medical services when advanced medical care is necessary.

As an income security system for the elderly, a sufficient livelihood security through pensions has been established for public servants, but the livelihood security through funds provided by private enterprises is not sufficient. In addition, some elderly people are not enrolled in any of the livelihood security systems. Older people and their families who do not have sufficient savings need to work during their old age to make a living, but those who do not have employment opportunities and their families do not have income or security and are financially troubled. Similar to the welfare system in Japan, the Samurdhi sector provides support to low-income earners, but the amount of support is small and cannot adequately guarantee the livelihood of the elderly.

7.2.2 Social Welfare Issues

- Support (Services) According to the Situation of the Elderly

Currently, related organizations, such as ERPO and SSO, are cooperating in the field to support elderly people who have no relatives. However, due to lack of mechanism to objectively evaluate eldery people’s health condition and shortage of human resources, combined with a limited variety of elderly care services both in public and private sectors, it is difficult to say that the current support system is suited and customized to the situation of individual elderly people.

- In addtion to the limited care available in nursing homes where there are few options for support menus, there is a lack of human resources and systems to provide appropriate support taking into account the situation of the elderly, such as care managers in Japan, and the wishes of the elderly and their families.Caregivers and Service Quality

In Sri Lanka, the primary non-medical staff involved in the care of the elderly is caregiver, and it is expected that caregiver will continue to play a central role in the future.

Both the MoWCASS and the MoH understand the need for caregivers, and the MoWCASS is considering requirements for qualification of caregivers and training institutions. However, cooperation and consultation with the MoH have not been made, and the activities are not based on mutual agreement. The

NSE recognizes that the number and quality of caregivers is not sufficient for current and future needs.

While NVQ level 2 is established as a national qualification for caregivers, Sri Lanka currently has no mandatory qualification requirements for caregivers, and it is possible to provide services to the elderly without qualification. Caregivers working at the nursing homes visited in this study received only on-the-job training at the facility and did not receive specialized education. The elderly were left lying in bed, and rehabilitation necessary for maintaining their mental and physical functions was not provided, indicating that appropriate care was not provided. At the present time, the poor quality of care is not a major problem because elderly people with a high level of care need does not exist in elderly facilities becuase such people do not reside in such facilities. However, it is expected that the number of elderly people in need of long-term care will increase steadily in the future, and the government will be forced to accept elderly people in need of long-term care. Improvement of the quality of caregivers is an urgent issue because appropriate care is required to prevent deterioration in the level of care needed. At the same time, it is suggested that the low quality of care for the elderly leads to the possibility of avoiding the use of facilities for the elderly and hinders the entry of the private sector into the elderly care market.

With regard to the nurturing of caregivers, in addition to the problems of caregiver nurturing institutions and raising funds, it is also a problem that there are few applicants for caregivers. Caregiver is not a popular profession in Sri Lanka, and it is difficult to find applicants. The reasons for this are believed to be the poor treatment and low social status of caregivers. Caregivers are not only poorly paid, work long hours, and have little time off, but they also have a bad working environment, sometimes working overnight. However, the current facilities for the elderly home caregivers who have been trained at their own facilities at low wages, and it is difficult to improve their working conditions without subsidies or budget allocations. It was also pointed out that some people in Sri Lanka view some careers as dishonorable work.

Although the caregivers in the nursing home visited in this study were unqualified, the manager of the facility said that the heart was important in the caresgivers. Although it does not deny the importance of the mind of the caregiver in caring for the elderly, related knowledge and skills are very important. This kind of awareness on the part of service providers is one of the reasons that caregivers have less social recognition as professionals.

Another reason for the low popularity of caregivers in Sri Lanka is the lack of clear career paths.

- Care Quality Standard

The Sri Lankan Organization for Standardization has set detailed operating standards for facilities for the elderly. These standards are based on the British Standards for the Management of Nursing Care Facilities (Care Homes Regulations 2001) and are guidelines for the environment in which facilities for the elderly are located, facilities in elder homes, and the system for nursing care services. However, as for the facilities for the elderly themselves, many of them are renovating existing facilities and using donated facilities, and sometimes they do not meet the standards. This is supposedly due to financial problems of charity/NGO run facilities and lack of monitoring by the government on them. In addition, the quality of care provided

at each facility for the elderly varies because the management of nursing care services in accordance with the standards is not mandatory.

- Fcilities and Services for the Elderly Requiring Long-Term Care

Under the current system, only a small number of public facilities for the elderly are available due to budget constraint and shortage of human resources, and they must be able to live independently. In the private sector, there are facilities for the elderly that accept elderly people in need of long-term care, but these facilities have high occupancy costs, and there is no place for elderly people with low income and no relatives to go. At present, nursing care services such as home care and home visits are limited.

The lack of services for the elderly requiring long-term care also affects the medical side. Among elderly in-patients who are supposed to be able to leave the hospital, if they have no relatives and no home, they contact SSO and look for a place to live, but if there is no place to accept them, there are cases where they stay at a medical institution as in-patients until they find a place to accept them. According to ERPO, there are an average of five elderly people in urban towns who have no relatives stay in hospitals for several months because there are no facilities to accept disabled elderly people.

- Family Burden

In Sri Lanka, public and private services such as facilities for the elderly, day centers, and in-home services are also provided, but in principle, the main focus is of elderly care is placed on family members. Suppression of physical and mental burden and social participation of the family by the care of the elderly are assumed.

Public services in Sri Lanka do not provide care for the elderly who are bedridden or have dementia, which is physically or mentally burdensome. Private services are limited in number and expensive, and in most cases the family members provide them. In many cases, women are in charge of such nursing care, and there is concern that the burden of nursing care may discourage participation in society, such as work. There is no support or service such as respite care, and there are no measures for family members to discuss problems in nursing care or to reduce their own burden. From the family's point of view, it is difficult to use external services due to the difficulty of using external services from a geographical and economic perspective and the lack of services that meet the needs of the family.

7.3 Challenge of the MoH

In the health sector, utilization of private sector facilities is not assumed and public medical facilities play the central role in health services. In this chapter, issues related to elderly people in public medical facilities are presented (issues related to private medical facilities are presented in 7.1).

- Functionality for elderly health

The YED mentioned that Medical Administrative Grade director posts are vacant in the MoH and Director of the YED is also vacant at the moment.

The YED collaborates with other directorates providing technical advises for implementation of activities related to elderly services. For further improvement of the health care for the elderly, the YED is expected to take further initiative in implementing the action plan and strengthen coordination of the services to the elderly.

- Lack of financial resources for elderly services

The YED described that it is not allocated necessary budget to to implement activities for elderly services scheduled in its annual action plan.

- Vertical Organization (Prevention and Treatment)

The health sector is divided into the prevention and treatment sectors, from the central to the peripheral community level, and is characterized by vertical service delivery in personnel and facility systems. This system was constructed in the 1920s, when the disease structure was mainly infectious diseases. The intervention methods were different between "prevention" by vaccination and health education, etc., and "therapy" after the disease was contracted, and there were almost no cases that required the continuation of treatment after complete recovery. On the other hand, in recent years, where NCD and psychiatric disorders are central to the disease structure, there is a need for services that combine prevention and treatment because treatment is secondary prevention, and medical services cannot be clearly distinguished between prevention and treatment, such as the combination of treatment and health education, such as the medication treatment of NCD. With regard to maternal and child health services, which are the main services of the prevention sector, the situation is different from that in the past when the maternal mortality rate, infant mortality rate, and total fertility rate were high, and it can be said that it is time to review the system for an aging society.

- Gaps in Communication and Health Education

Introduction of systematic health education for the elderly is recommended to increase awareness on maintenance of good health, early identification of illnessess, diagnosis and correct treatment[126]. The MoH provides NCD screening services through the HLC, thus, if health education is combined with the services and utilization rate of the screening services is increased, it is expected to improve health condition among elderly people.

The MoH starts to training and allocation of the public health nurses in the HLC in order to provide new medical care for the elderly, NCD measures, and palliative care services. It is reccomended to effectively utilize the public health nurses by increasing its number and strengthening capacity of health education for the elderly to prepare for the aging of society and to improve lifestyle habits that pose health risks, such as smoking, drinking, and chewing tobacco.

- Consumption of Unbalanced Diet

[126] The YED explained health education programmes including medical discuusions, nutrition at old age, physical activity and importance of sustaining good mental health are very much advisable as they will be directly accentuate Active Healthy Ageing.

Main meals in the Sri Lankan communities are consist of considerable amount of carbohydrates such as rice, thosai, roti and so on and confirmed that nutritional education such as dietary education by nutritionists and diet for diabetes is necessary. The nutritional Unit of MoH is on the process of developing guidelines on Elderly Nutrition in collaboration with YED. Awareness programmes will be arranged accordingly to health non health service providers. Using this guideline, it is suggested to strengthen nutritional education for the elderly on avoiding excessive intake of lipids, salts, and carbohydrates, weight management, adequate intake of fluids, and cooking methods.

- Inadequate Utilization of Screening Facilities

As part of the NCD strategy, the MoH has established HLCs at district hospitals and PMCUs to provide NCD diagnosis and treatment services. This service is for adults 35 years old or older. However, 1) the service is provided during the day and the target people need to go to the facility. It is very difficult for working adults to visit medical facilities in order to take time off from work to receive these services. Especially for those working in informal sectors, they are employed on a daily basis and skipping job is directly connected to reduced revenue. Another factor contributing to the low utilization rate is 2) low awareness on preventive care because public medical services are provided for free. These result in inadequate utilization rate of screening services. In order to improve service provision and mechnism, recently, in addition to HLC, public health midwives (PHMW) play a central role in MOH offices to provide medical examination services in communities (PHMW Area). However, the central role of public health midwives is still thought to provide maternal and child health services and screening services have not been actively provided.

- No Maintenance of Uniformity across the Districts

The MoH points out an issue that even though people can be provided basic treatments at Public Health Care Institutes including Emergency and Trauma Unit facilities, most people are bypassing them to go to large hospitals in secondary or tertiary care.

The survey team got information that among the many cases of NCD in the elderly, the disease can be controlled by patient compliance instruction if it is mild, but the health facilities which can deal with the treatment when it becomes severe are limited. In particular, highly advanced diagnostic and therapeutic techniques, such as for severe cardiovascular and neurological diseases are mainly provided in Colombo and Kandy. Patients explained that even if he or she survives by appropriate treatment, he or she is required to visit Kandy or Colombo medical facilities regularly for follow-up, which needs trasportation cost. The MOH plans to establish stroke units in the tertially hospitals in each province, thus this issue might be improved.

- Limited Number of Elderly Healthcare Practitioners

There are 4 senior registrars in geriatric medicine who need to complete foreign training[127] to become Consultants. Until then, the visiting physicians are covering the gerontology as well. Some nurses and minor

[127] Sri Lankan gerontologists are rquired specialized education including four to five years of overseas study experience for

categories of staff in selected hospitals get training for elderly care. Caregiver training is conducted by social services and YED of MoH at vocational training centers[128].

Physical, occupational, and speech therapists who provide rehabilitation services significantly related to the maintenance and improvement of activities of daily living are placed in medical institutions. According to the MoH, the necessary number of physical and speech therapists has been secured, but there is a shortage of qualified occupational therapists. Many health-care facilities lack a rehabilitation function and are only teaching how to perform rehabilitation after discharge, but if these facilities begin to provide rehabilitation services to hospitalized patients, a shortage of people is expected.

- Limited Specialized Clinical Services where Improvement Needed

In Sri Lanka, the elderly are treated in the same way as general patients, and there is limiedt provision of attentive and specialized public medical services for the elderly. The problems identified by the survey are as follows.

1) Ophthalmology

There are about 70 ophthalmologists throughout Sri Lanka, 30 of whom work in private institutions, and only about 40 in public institutions. In other words, 1 ophthalmologist in a public hospital has about 540,000 population, and 1 ophthalmologist in total has about 310,000 population, making it extremely difficult to provide the necessary ophthalmic services. Ophthalmologists are burdened by cataract, which accounts for 90% of all eye surgeries. Ophthalmologists in Nuwara Eliya, Central Province, handle 20 cataract surgeries a day. When there is no anesthesia or equipment, patients are referred to other hospitals. Glaucoma is a problem, but patients have not been treated because they cannot recognize the eye disease.

2) Dentistry

In Sri Lanka, bad oral hygiene habits, such as smoking and chewing tobacco, have been reported. As people get older, the use of dentistry decreases, and the number of periodontal diseases and missing teeth increases. A breakdown of treatment is reported to be tooth extraction, suggesting that there may also be problems with the level of skill of dentists. These results suggest that the elderly may not be able to receive proper oral care and dental examinations, and that there may be problems with proper methods of tooth brushing and oral care, health education for maintenance and management of oral hygiene such as habituation of tooth brushing and prevention of risk-taking behaviours, lack of knowledge of residents about opportunities and necessity of regular dental examinations, and problems with the level of skill of dentists and dental technicians.

- Palliative Care Services

consultants and one year of specialized education for diploma.

[128] Here is the perspective of the Japanese survey team that "Similarly, there are very few nurses with specialized training in geriatric nursing, and the number of training programs for the elderly is limited, and there are no staff members with expertise in geriatric care. In addition, as mentioned above, there is no definition or training method for caregivers. Although the MoWCASS and the MoH have each referred to the need to identify and nurture caregivers, they have yet to reach a consensus on the definition of caregivers and which one should be in charge.

With regard to palliative care, Sri Lanka is in the process of taking concrete measures based on policies and plans. One of the responsibilities of the public health nurses assigned to the HLC is palliative care. From now on, the public health nurses will play a central role in providing home palliative care, but equipment and transportation necessary for home palliative care have not yet been provided. At the central government level, a plan has been developed for palliative care. However, implementation has just begun and budget allocation is insufficient, policy and guidance for actual provsion of services are insufficient.

- Rehabilitation

Sri Lanka has only two public medical facilities in the country that provide rehabilitation services. Physical therapists, occupational therapists, and speech and language therapists are also assigned to other institutions, but the equipment and space required for physical therapy in particular are not secured, and only training patients in the exercise therapy required after discharge. Two rehabilitation centers are also not specialized for the elderly, and many patients with trauma or cerebrovascular disease do not receive appropriate rehabilitation services for functional recovery or return to daily life after treatment or acute withdrawal. Early rehabilitation after stroke has been shown to result in early ambulation, associated functional impairment, and significant improvement in activities of daily living. This suggests that insufficient rehabilitation functions in medical institutions may delay ambulation and interfere with return to daily life. Therefore, urgent attention focusing capacity building in allied medical sciences is highly recommended.

- Difficulty in Accessing of Healthcare Services for Older People

When an elderly person visits a medical facility, his or her family or other close relatives need to accompany him or her. If the family members have daily work, it is difficult for the elderly person to visit health facilities. Besides, physical disability often makes elder people further difficult to visit health facilities.
It is desirable to be able to receive medical services at home for patients who are difficult to go to the hospital, such as elderly people who need palliative care and activities of daily living, but do not require advanced treatment. In order to provide these services, as mentioned above, PHNO was newly established to aim at providing NCD prevention, palliative care, and home care for the elderly through home care. However, at the time of a PHNO hearing (March 2020), the equipment necessary for home medical care, especially palliative care, such as motorcycles and catheters, which were initially planned to be provided, was not yet available. As shown, even though the central government is triying to improve access to medical services for the elderly, budget allocation and guidance to provide actual services are not sufficient. The Sri Lanka Essential Health Package in 2019 also included the provision of home medical care by primary care facilities as one of the service items of care for the elderly, so the provision of this service is urgent.

- Curative Care Not Concentrated for the Elderly

In Sri Lanka, everyone can access to public medical services for free. In the public services, there are only two teaching hospitals with speficified geriatric wards and clinics for elderly patients. They are Colombo South Teaching Hospital and Peradeniya General Hospital. These facilities have an outpatient, clinic, and inpatient ward for the elderly (Peradeniya General Hospital only) and an outreach clinic (Colombo South Hospital only) to deal with issues specific to the elderly. Some medical facilities in Kandy Province, which

had been the target of the JICA Grassroots Technical Cooperation Project, have installed seats for the elderly, inpatient wards for the elderly, and handrails in the aisles and restrooms, but these efforts are limited. Creating elderly friendly environments in the hospitals, especially accessiblity and elderly friendly toilets will be a major issue to consider with the increase of ageing society.

CHAPTER 8 Comprehensive Analysis and Future Directions

According to the survery framework shown in Chapter 2, the study team has surveyed some important points such as current situation of factors related to the aging sector, multi-sectoral engagements for measures for the aging society, systems for the aging society, budget planning and allocation for measures for the aging society, ministerial roles and needs of the aging sector. Based on the discussions so far, this chapter presents a draft roadmap for solving the issues and summarizes the direction of Japan's cooperation based on priorities.

8.1 Measures to Solve the Issues

Based on the issues related to the elderly sector in Chapter 7, each issue was sorted out and the solutions for each issue were comprehensively examined and summarized in Table 8.1.1. This table shows issues and solutons for them identified when NSE was under MoWCASS. Therefore, it needs to be updated based on the new organizational system where NSE is located under th MoH.

Table 8.1.1 Issues and Solutions for the Elderly Care Sector Identified in this Survey

Issues		Solutions	
Issues	**Details**	**Solutions**	**Specific activities**
Cross-sector issues and responses			
Cooperation between ministries and agencies, within ministries and between the national government and local governments	- The task is to divide the functions of ministries and agencies vertically and optimize them individually, and the division of duties among ministries and agencies is unclear. - Comprehensive roadmap needs to be developed to address the ageing priorities. - At the ministerial level, it is needed to strengthen discussion on the status of efforts, coordination, or cooperation among relevant organizations and within each Ministry. - Effective standardized coordination is needed among in the field level. - It is needed to strengthen coordination with all relevant department in each Ministry. - It is needed to strengthen coordination between the central and provincial governments for effective and efficient implementation of measures.	1. Establishment of a system to implement comprehensive aging measures	- Strengthen function of the inter-agency platforms (organizing and holding regular meetings) - Create an comprehensive road map for measures against the aging of society including - Reconsider an integrated legal and policy system for dealing with the aging of society. - Strengthen communication and coordination among the MoWCASS, MoH, and agencies within each ministry about progress of the program and information through the platforms above-mentioned. - Clarify the division of duties among bureaus and sections within each ministry and agency to obtain a common understanding. - Clarify and inform method of cooperation thoroughly among those related to elderly care (Education of existing staff, monitoring, supervision, etc.). - Strengthen, cooperation and progress through discussions on the ministrys' platforms. - Strengthen collaboration between the central government and provincial governments and their suborganizations. - Develop and implement the strategic plan and result based framework for short term, medium term and long term. - Develop provincial action plan on elderly care based on polices and strategies. Costing of the developed
No availability of sustainable and adequate budget allocation for elderly care	- No budget for measures for the elderly has been confirmed - The need for services for the elderly is not comprehensively confirmed.		

Issues		Solutions	
Issues	**Details**	**Solutions**	**Specific activities**
			action plans and measures to be taken to include activities to the annual budget plans. - Compile and secure budgets for each ministry and agency and cross-agency budgets. - Efforts to secure budget: coordination with the MoH and the MoWCASS and negotiations with the Ministry of Finance.
No availability of data on measures to cope with the aging of society	- Updated information is needed to understand unmet demand, service requirement and gaps in services - The need for services for the elderly is not comprehensively confirmed. - Services (in quantitiy and quality) necessary for the elderly are not grasped. - The requirements for service supervision have not been identified. - The information collected is fragmentary and doesn't provide a complete picture.	2. Strengthening information management related to aging measures	- Establish a registration system for the elderly and specify the target population for aging measures. - Understand their needs. - Identify required services. - Identify delivery measures of such measures - Identify the items required for service supervision. - Establish a framework for information gathering. - The ministry will use the information to grasp the implementation of measures to cope with the aging of society and improve the measures. - Establishment mechanism and operation of the mechanism to secure steady funding source
Mechanisms to promote the use of private services and ensure quality	- Private services are registered by ministry and there are several registration systems. It seems that similar industries related with elderly care are registered with different ministries and agencies. - The criteria for registration is not sufficient. (MoH) - Not all facilities are registered. - Registration status is confirmed but actual services are not overseen. (Ministry of Social Welfare). - There is no sufficient mechanism for the government to use services provided by private facilities. - Some private services do not meet certain quality standards. (The system to supervise the quality of service has not been fully established)	3. Promoting regulation and utilization of private services	[Strengthening public, private partnership on elderly care.] Example of the necessary actions: - Develop standards, rules, and regulations for private services (including penalties) across ministries and agencies. - Clarify how private services are registered. (use of cross-agency information on which ministries and agencies control the private services) - Disseminate the standards and rules. - Register private services based on the standards. - Develop and implement monitoring functions for the registered private services.
Lack of elderly-friendly environment	- Barrier-free facilities for the elderly and disabled are yet to be fully implemented. - Elderly-unfriendly condition such as mountaneous areas might cause health issues among the elderly..	4. Creating an elderly friendly environment	- Provide administrative services such as home renovation for the elderly. - Public facilities should be renovated to make them barrier-free. - Raising awareness and support to enhance barrier-free in public sector. - Identify and renovate areas that are dangerous for the elderly to move around or live. - Monitoring should be conducted after the improvement of the living environment.

Strengthen cooperation between ministries and agencies, within ministries and between the national and local governments	- It is better to strengthen coordination between health care and social welfare services.
	- The present situation of aging measures varies from region to region.
	- Estate-owned clinics do not adhere to national laws and regulations, are difficult to enforce, and cannot guarantee the quality or quality of medical services.
	- There are endemic diseases and genetic problems. lifestyle problems such as high rates of
		5. Introduction of integrated community care system (Integration of health, medical care and social welfare)	- Build community-based integrated care models that integrate health, medical care, and social welfare according to local characteristics and needs.
			- In the development of the above model, the activities in estate areas will be considered in consideration of the following issues.
			  - To make a clinic owned by an estate a public clinic.
			  - Negotiate with the estate owners to review the quality and content of the service.

Issues		Solutions	
Issues	**Details**	**Solutions**	**Specific activities**
	chewing tobacco, drinking, and smoking, also affect NCD and oral diseases.		- Train health care workers at estate clinics. - Provide health education and medical examination services at the estate.
Issues and responses under the jurisdiction of the MoWCASS			
NSE functionality	- It is needed to make a strategic short, mid- to long-term plan for the NSE. - It is better to improve capacity of planning, implementation, monitoring and evaluation of an annual plan by PDCA. - A caregiver Development Project was planned but was not implemented due to a lack of NSE capabilities.	6. NSE Enhancement	- Formulate medium- and long-term plans based on the integrated roadmap - Develop a budget implementation plan with budget for each program based on priorities. - Strengthen project management capabilities for planning, implementation and evaluation and enhance implementation of the action plan.
Preparation for Aging Social security system	- Due to a lack of awareness of the need to prepare for old age and lack of economic capacity, economic preparations such as savings are insufficient. - Free medical services at public hospitals have increased the burden on the providers of medical services, increased the burden of national budget, and decreased public interest in disease prevention. - Appropriate social security systems such as pensions are insufficient. (Insufficient guarantees for private-sector workers) - Some people are not included in either type of pension systems. - In the same context as public assistance, assistance from the Samurdhi sector is being provided, but it is difficult to say that it covers the whole in terms of quality and quantity.	7. Improvement of awareness of active ageing and the social security system	- Introduce a system to collect small medical bills - Take measures such as encouraging savings. (separately considered) - The government should review the basic pension system of private companies and create a system to ensure that all people receive pension benefits without shortages. - Construct a system in which elderly people do not need to receive livelihood social security by enhancing the pension system - Consider the need to review the assistance provided by the Samurdhi Division.
Support (services) according to the situation of the elderly	- It is needed to strengthen support systems for the elderly based on their needs. - Support menu options are limited. - The services that can be provided by nursing homes are limited. - There is a lack of human resources and mechanisms, such as care managers or social workers, to provide appropriate support based on the situation of the elderly and the wishes of the elderly and their families.	8. Develop service provision system according to the situation of the elderly	- Understand the needs of the elderly. - Identify necessary services for the elderly and consider the service provision system and methods. - Consider the situation of the elderly, and the need for human resources to provide appropriate support, such as care managers or social workers, taking into account the wishes of the elderly and their families. If necessary, clarify the education system, division of duties, and number of people required. - Analyze neseccity of roles of care manager or social worker and plan if needed.
Caregivers and quality of service	- There is no standardized definition of caregivers, qualification requirements or training institutions. - Caregivers have no special education and the service can be offered without qualification. - It is needed to strengthen cooperation among ministries and agencies to foster caregivers. - The number and quality of caregivers are insufficient. - There are few applicants for caregivers. - Caregivers are poorly treated (Low pay, long working hours, short vacations, and in some cases	9. Improving the quantity and quality of caregivers	- Grasp the actual conditions of a caregiver. - Identify necessary caregivers (quality and number) based on needs and service providers. - Set the caregiver definition. - Promote cooperation among ministries and agencies for nurturing caregivers. - Create and implement a system for accreditation of caregiver training institutions and approval of training curriculums. - Establish qualification requirements of caregivers and clearly stipulate division of duties.

Issues		Solutions	
Issues	**Details**	**Solutions**	**Specific activities**
	low pay compared to poor working conditions such as overnight work) - Service providers have a poor understanding of service quality.		- The government should take measures to improve the treatment of caregivers, such as providing a budget. - Conduct training and supervision for service providers in order to raise their awareness.
Variations in care due to differences in standards and actual conditions in elderly facilities Facilities and services for the elderly requiring long-term care	- The Sri Lankan Organization for Standardization defines operating standards for facilities for the elderly, such as installation environments, facilities in elder homes, and nursing care services, but these standards are not enforceable, and the quality of services at each facility varies. - Insufficient facilities for the elderly. - There are limited number of facilities for the elderly or services for the elderly requiring long-term care that anyone can use.	10. Expansion of facilities and services for the elderly (considering facilities required by long-term care)	- Confirm the actual conditions of existing nursing homes and services for the elderly. - Reconfirm the operating standards for facilities for the elderly. - The ministry strengthen regulation and management of facilities for the elderly to comply with management standards. - Supervise services according to operating standards. - Determine necessary number of nursing homes based on the needs of the elderly and consider establishing such homes. (Consider securing necessary human resources and budget) - In addition to the above, facilities for the elderly and services for the elderly requiring long-term care that can be used by everyone shall be established (Public, Low Price).
Family burden	- This is the physical and mental burden of the family involved in caring for the elderly, and the suppression of social participation through caring. - Family care often lacks the knowledge and skills to care for the elderly. - The absence of recuperative care may worsen the condition of the elderly, or the elderly may not be able to recover even though they are in a state where recovery is possible. - Family members do not have sufficient options for external services in terms of geographical, economic, and services tailored to their needs. - As a social characteristic, the family is supposed to take care of the family. - Edlerly abuse is confirmed.	11. Introduction of family support	- A consultation desk should be established to provide support and guidance to the families of the elderly. - Strengthen recuperative care. - Expand external services to avoid relying on family care. - Clarification of access to external services - Social traits: Family cares are for the family: Advocacy - Family Abuse: Strengthen measures against abuse being implemented by NSEs, establish senior citizens' committees and community monitoring systems, and reduce the burden on families through the use of external services.
Issues and responses of the MoH			
YED functionality	- It is needed to strengthen capacity of management capacity (planning, implementation, monitoring and evaluation of the plan) and coordination with other organization or departments,	12. YED Enhancement	- Proactive engagement in realization of the action plan, and cooperate and coordinate with related ministries and directorates, related organizations within the ministries and directorates, and local governments to improve medical care for the elderly.
Vertical organization (prevention and treatment)	- It is necessary to reconsider health sector reform based on transition of disease structures from infectious diseases to chronic diseases. - Financial burden is increased due to increase of chronic diseases and pcychiatric diseases..	13. Streamlining the Vertical Service Structure (prevention and treatment)	- Review the system for dividing the prevention and treatment sectors and consider the necessary staffing and placement. (Examples: The PMCU and HLC in the treatment sector conduct institutional checkups by the PMCU and HLC and outreachi checkups by the MOH, NCD checkups and health education and dental checkups as one of health check components.)

Issues		Solutions	
Issues	**Details**	**Solutions**	**Specific activities**
Health education Nutrition Medical examination	- Health education for the elderly is not sufficient. - The patient may not have been diagnosed or treated at an early stage, leading to a serious disease. - Health education and checkups are not packaged. - Utilization of PHNO is not sufficient. - Continuing high-risk lifestyle (Estates in particular) - Having unbalanced diets - Insufficient nutrition services for elderly services. - Many staff members in charge of meals at facilities for the elderly have insufficient knowledge about the nutritional components, calories, or dietary considerations necessary for the elderly. - The utilization rate of the NCD medical examination service is low. - It is very difficult for working adults to take time off from work and visit medical facilities to receive medical examination services. - Maternal and child health services has been mainly provided by the prevention sector and medical examination has not been actively provided. - The subjects of the medical examination are not grasped. - It did not specify who should be covered.	14. Promotion of primary and secondary prevention	- Package health education and checkups. - Health education and medical examination are promoted using PHNO. - Training nutrition specialists (including nutrition for the elderly) - Provide nutrition education to families. - Cultivate staff in charge of meals at facilities for the elderly and formulate and share guidelines (menu guide). - Confirm the health examination subjects in each region. - Identify the people in charge of the area that will cover the health examination in each area. (The treatment and prevention sectors work together to determine which health care facilities are responsible for health examinations in which areas.) - Provide holiday checkups and workplace checkups. (Consider working on holidays, make it mandatory for companies) - Implement initiatives to promote the use of screening services, such as recommendations for medical examinations.
Regional differences in services	- There are provinces where specialized medical care is not available. Specialists visit state hospitals or transport them to Colombo or Kandy. At present, there are problems such as deterioration during transportation and burden of hospital visits after discharge. - In case ambulance is not available, patients need to secure means of transportation and go to a medical facility by oneself. - They have to bear the transportation expenses for local patients to go to the specialized hospital in the city.	15. Correction of regional disparities in medical services	- Establish a system to provide specialized medical care in each province. (Facilities, personnel, equipment, and patient referral systems) - Consider expanding emergency services and utilization of private services. - Strengthen cooperation between specialized hospitals and regional hospitals, and develop guidelines for diagnosis, treatment, and patient referral. - Consider providing support for high-cost medical expenses and introducing a reduction system for transportation expenses.
Number of health care practitioners can provide medical services for the elderly	- Only limited health facilities have established elderly clinics. - Numbers of specialized doctors and nurses for geriatric care are limited. - The number of training programs for elderly people is limited, and there are no staff members with specialized knowledge of elderly care.	16. Strengthening the provision of specialized medical care for the elderly	- Identify the number and quality of medical and nursing care workers required for geriatric care, and formulate plans for human resource development and deployment. - Train specialists in geriatric medicine, rehabilitation and palliative care. - Strengthen training for existing health care practitioners in geriatric care. - Incorporate the content required for geriatric care and care into the health professional development curriculum..
Specialized clinical services for diseases common in the elderly are limited	- The elderly are not aware of the health problems associated with aging. - The patient is unaware of the disease. - Preventive, diagnostic and treatment services necessary for the elderly are not fully provided. - Ophthalmologists are limited and cannot adequately deal with the elderly.	17. Expanding medical services for diseases common among the elderly	- Provide health education for the elderly. - Introduce ophtalmology and dental examinations into health check for the elderly. - Train healthcare professionals for the elderly. - Mediate and coordinate specialized services for the elderly.

Issues		Solutions	
Issues	**Details**	**Solutions**	**Specific activities**
	- Some dentists and dental technicians may not be skilled enough.		Improve the technical level of a professional medical worker.
Rehabilitation	- Limited health facilities can provide physical rehabilitation services (only 2 facilities in the whole country.) - Although most secondary and tertiary care facilities are staffed with physical, occupational, and speech therapists, they are not equipped to provide adequate rehabilitation services. - There is no coordination from treatment services to rehabilitation services. - It is suggested that the absence of appropriate rehabilitation services may delay leaving the bed and interfere with returning to daily life.	18. strengthening of rehabilitation function	- In facilities where physical, occupational, and speech therapists are stationed, a system shall be established to provide rehabilitation services for the elderly in accordance with the services of the facilities. - To perform in-service education for each therapist and to perform rehabilitation service. - To construct a cooperation system between a clinical department and a rehabilitation service. - To provide rehabilitation services for functional recovery necessary for discharge from hospital, and to teach rehabilitation that can be done at home after discharge. - Support rehabilitation in the community.
Access to healthcare services for older people	- If a family member is a dual-income earner or a day laborer, it is difficult to ask for attendance at a hospital. - Especially in rural areas, access to medical facilities is difficult due to distance. - Outreach service for the elderly and home care service by PHNO are limited.	19.Improving access to ,medical services for the elderly	- Provide services such as visit care. - Tickets will be distributed for tours to medical facilities and buses for visits to medical facilities. - Strengthen outreach and home care services. - Strengthen private companies to promote telemedicine or mobile medical services in rural areas.
Hospital system	- There are no clinics, wards, or waiting areas for the elderly. - Slopes, handrails, elevators, etc.for the elderly, are not built in all health facilities yet. - Installation of necessary equipment for the elderly (Pedestrians, wheelchairs, etc.) is needed.	19. Improvement of medical facilities for elderly patients	- Elderly clinics, wards and waiting areas will be established. - Each medical facility will be equipped with ramps, handrails and elevators. - Repair areas that are dangerous to the elderly. - Equipment necessary for the movement of the elderly is installed. - Medical facilities to be designed in the future will be barrier-free.
Declining birthrate	- There are no strategies or plans to cope with the declining birthrate.	20. Introduction of measures against the declining birthrate	- Identify the reasons for the declining birth rate. - Formulate strategies and plans to address the declining birthrate based on the reasons. - Implement a plan to address the declining birthrate.

Source: JICA Survey Team

8.2 Comprehensive Analysis for Prioritization of Measures

For each solution above, compatibility with Sri Lankan policies, importance and urgency and feasibility were comprehensively examined. The compatibility with Sri Lankan policies is assessed from the perspective of neccesity recognized by the Sri Lankan side and exisitence of concrete measures and plans. The importance and urgency was considered from the perspective of the magnitude and urgency of the impact on the aging sector in Sri Lanka. The feasibility was considered from the perspective of the ease of introducing measures based on the current situation in Sri Lanka. Through these 3 perspectives, assessment with 4 scale scoring (0, 1, 2, 3) was carried out on each solution. The concept of the acceptance criteria is shown in Table 8.2.1..

Table 8.2.1 Acceptance Criteria

	Compatibility with Sri Lankan policies	Importance and urgency	Feasibility (ease of implementation)
0	Neither a policy exists nor its necessity is recognized.	No importance is recognized in terms of measures for the aging of the society.	Unrealistic for the time being.
1	No concrete policies exist though its necessity is recognized.	Services can be provided without this measure and no immediate action needed.	It takes time to implement as large scale budget / resources are required. Needs other ministerial approvals.
2	Consistent with Sri Lankan policies	Quite important in terms of measures for aging of the society but this measure can be taken based on other engagement(s).	Some efforts may be time-consuming and costly, but a gradual approach is possible.
3	Compatible with multiple concrete policies and goals and evaluation indexes are defined.	Without this measure, no progress can be made on measures for the aging of the society.	Feasible with the existing resources.

Source: JICA Survey Team

Based on the analysis above, each solution was categorized by field. Then based on the total score of the three perspectives 1) compatibility with Sri Lankan policies, 2) importance and urgency and 3) feasibility, each solution was classified. Solutions with total scores of 8 or 9 as a, 6 or 7 as b, 5 or less as c (Table 8.2.2.).

Table 8.2.2 Result of Solution Assessment

C	Compatibility with Sri Lankan policies
I/U	Importance / urgency
F	Feasibility
T	Total
P	Priority (A: 8-9 / B: 6-7 / C: 5 or less scores)

Solution number: Solution	C	I / U	F	T	P
Cross Sectoral					
1 : Establishment of a system to implement comprehensive aging measures	2	3	3	**8**	a
2: Information management	3	3	2	**8**	a
3: Private sector utilizations and regulations	1	1	2	**4**	c
4: Living environment development (system development)	2	2	2	**6**	b
5: Community-based integrated care	3	2	3	**8**	a
Social Welfare					
6: NSE functionality enhancement	2	3	3	**8**	a
7: Improvement of social security system	2	2	1	**5**	c
8: Development of elderly service system	1	2	2	**5**	c
9: Caregiver training	1	2	2	**5**	c
10: Enhancement of services for the elderly	1	2	2	**5**	c
11: Family support	1	2	2	**5**	c
Healthcare					
12: YED functionality enhancement	3	3	3	**9**	a
13: Expansion of health check, prevention	3	3	3	**9**	a
14: Correction of regional disparities in medical services	2	3	1	**6**	b*1
15: Medical care for the elderly	3	2	2	**7**	a
16: Expansion of diagnosis and treatment department services	3	2	2	**7**	a
17: Rehabilitation enhancement	3	3	3	**9**	a
18: Access improvement to medical services	2	2	2	**6**	b
19: Barrier-free (medical facilities)	3	1	2	**6**	b
20: Measures for declining birth-rate	-	3	2	**5**	c*2

*1: Du e to the high score in Importance and Urgency (score 3), higher priority may be given to this item.

*2: Due to the low score in Feasibility (score 1), lower priority may be given to this item.

Source: JICA Survey Team

8.3 Available Elderly Care related Support Menu by Japan

Based on Japan' experience and technologies, areas where Japan can contribute to Sri Lanka aging related issues are shown in Table 8.3.1.

TC: Technical Cooperation
PA: Policy Advisor
TJ: Training in Japan
PT: Private Technical Transfer
PC: Private Sector Cooperation

Table 8.3.1 Japan's Experience and Areas of Possible Support by Japan

#	Solution	Japan's experience	Area of cooperation	Scheme
A	Healthcare / elderly care system development	- Establishment of universal insurance system (1961) - Establishment of Long-term Care Insurance System (2000) and provision of elderly care services through the public insurance - Private elderly care insurance and pension services	- Capacity building in cross sectoral framework development / management - Medical / Long-term Care Insurance systems - Service standard / supervision - Utilization of private medical / elderly care services covered by public insurance system - Introduction of private insurance / pension - Fiscal forecast on medical / elderly care expenses, study and advisory on financial mechanism	TC PA PC
B	Foundation development for basic information gathering on the elderly and elderly care	- Household survey: National Livelihood Survey etc. - Facility / employee survey: Elderly Service Facility / Business Survey, Elderly Employee Condition Survey etc. - Elderly care survey: Elderly Care Status Survey, etc. - Watch over system, Grasping elderly people's condition through wearable system etc.	- System development and implementation support for regular nation-wide survey - Understanding health condition and behaviour of the elderly	TC PC PC
C	Fair provision of care services to the elderly	- Provision of standardized elderly care services through certification of long-term care need - Appointment of care manager (elderly care support special staff) and provision services based on "Elderly Care Service Planning" (Care Plan) - Elderly care planning through AI etc.	- Standardization of services by the level of care needed - Elderly care planning by care manager - Elderly care planning partly supported by AI	TC PC
D	CBIC system / Coordination among different professions for elderly care services	- Hosting community care conference with local authorities and multiple professions - Elderly care service model development project where medical and welfare services are integrated in Thailand (JICA's Technical Cooperation project)	- CBIC system model development and nation-wide expansion CBIC = Community-based Integrated Care	TC
E	Provision of elderly care services based on needs	- Development of facilities and services which can accommodate various care needs such as home care, facility care etc.	- Facility development based on needs, equity procurement (planning and implementation), service provision system development	FC PC TJ

F	Elderly care professional development	- Nationalization of certified care worker qualification, organized development of home helper (home elderly care supporter) - Provision of standardized elderly care services through those establishment of qualifications - Development of (overseas) elderly care personnel through the Technical Trainee System etc.	- System development, Professional development planning, Training support	TJ TC PC
G	Enhanced prevention of long-term care	- Implementation of long-term care prevention / livelihood support to the elderly who are yet to be in long-term care needs by local authorities	- Provision of various services such as livelihood support in the case of home visit / facility visit care, physical exercise training, preventive services against long-term care, elderly salon etc.	TC PC
H	Healthy life promotion and disease prevention	- Enactment of Health Promotion Act and improvement in 9 areas (nutrition, dietary life, physical activities and exercise, recreation and mental health, tobacco, alcohol, oral health, diabetes, cardiovascular diseases, cancer) through "Healthy Japan 21," implementation of health check, Health Promotion Plans by local health authorities - Health guidance on high risk people identified in annual NCD related screening of BMI, blood pressure, blood glucose, for people age above 40 and under 74 (special health check, special health guidance)）	- System enhancement on NCD health check, guidance and education - Health check in dentistry, ophthalmology and auditory, oral frailty improvement - Nutrition education / diet guidance by age group - Low fat / calorie, reduced salt, high functionality food production / processing - Medical professional training	TC TJ*1 PC PT
I	Home medical services	- Provision of home medical services for the elderly (diagnosis, medication, respiratory / instillation / nutrition / aching pain management / decubitus care) - Charge rate settings in medical insurance (public insurance system) for home medical diagnosis, guidance and home treatment management etc.	- Development of a service system - Standardization and institutionalization of the services	TC
J	Enhancement of specialty medical care	- Sharing roles with different level of medical facilities in providing medical services (from home doctor to advanced medical care) - Team medical care / coordination among facilities by doctors with multiple specialties - Geriatrics	- Coordination development among various diagnosis and treatment departments (neurosurgery, cardiovascular, respiratory, orthopaedics, psychosomatic medicine etc.) - Online diagnosis, telemedicine - Medical technique improvement (specialty doctors)	TJ TC FC PC

			- Equipment required for specialty diagnosis	
K	Enhancing rehabilitation services	- Nationalization of physical / occupational / speech therapist qualifications and their long-term utilization - Provision of rehabilitation services based on prognosis (acute / recovery / remission phases) under public medical care / elderly care systems	- Capacity building (physical / occupational / speech therapist) - Functional development / HR allocation (medical care / elderly care facilities) - Rehabilitation service (including online) through coordination with public / private fitness facilities, elders' committee etc. - Development of support personnel such as volunteers	TJ PC FC

8.4 Direction of Possible Japan's Cooperation for the Aging of the Society

In the preceeding sections, the issues and solutions in Sri Lankan aging sector (8.1), priorities of such solutions (8.2) and Japan' experience in measuers for aging of society and possible support options (8.3) are analyzed.

Based on the assessment, for the solutions above, their implementation processes, required inputs ad possible Japan's supoort are shown in Figure 8.4.1 as a draft roadmap. This roadmap is made based on the folowing thoughts.

(1) For those solutions prioritized in 8-2, expected actions required in the future are analyzed, considering progresses so far made.

(2) As for the expected actions required in the future, "Establishment of Implementation Mechanism," "Planning" and "Pilot Projects" are high priority/shorterm engagements. Nationwide expansion of the pilot projects is a midterm engagement.

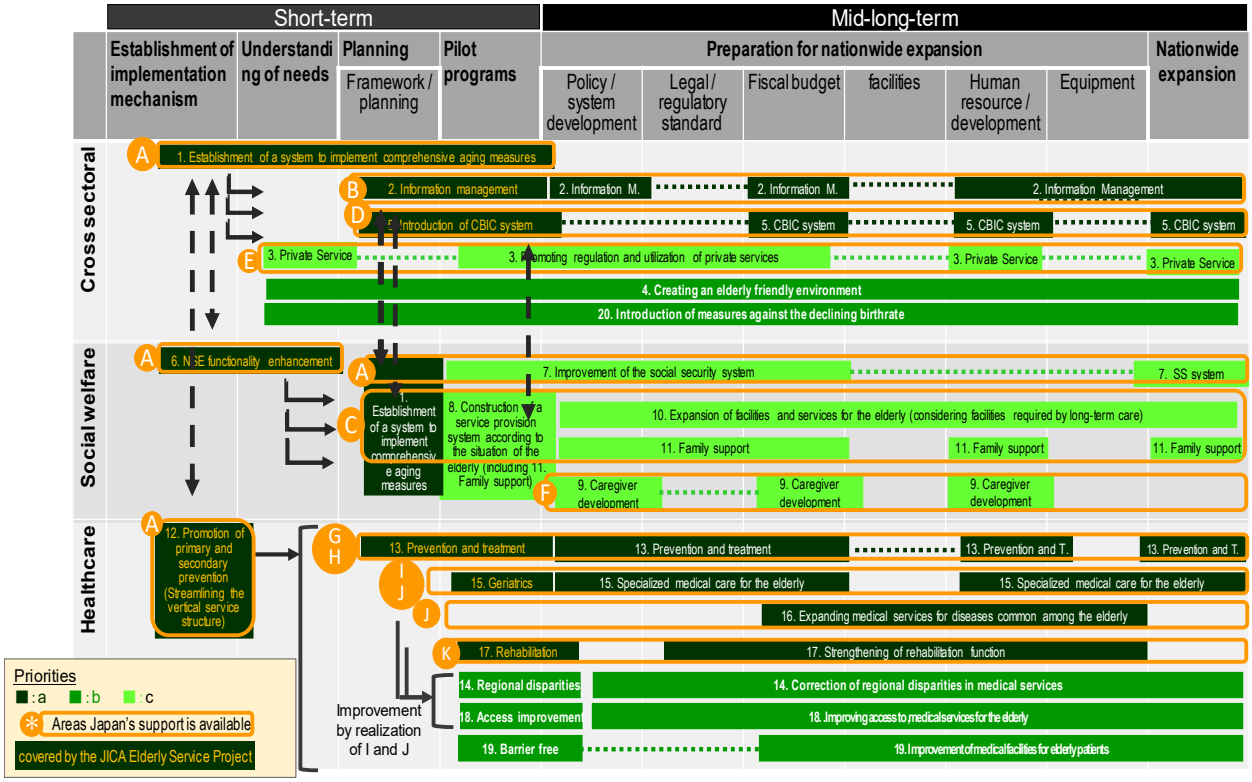
(3) As engagements required for the nationwide expansion, policy development, system development, legal / regulatory standard development, securing resources (fiscal budget, facilities, equipment and human resources), engagements for the nationwide expansion were identified and visualized in the roadmap.

(4) Among those engagements, items Japan's support are available are also plotted in the figure.

As a result, 1) "national level, cross sectoral mechanism development" is given the highest priority. Plus, 2) "social welfare field" is also given the highest priorities in understanding details of the reality and needs and establishment of service system framework and strategy and planning because details of them are not well understood. As for healthcare, improvement of service system and actual engagements for system enhancement and capacity building are required because actual situation and needs are already known and service system and framework are in place. A priority is given to identification of needs and development of framework for service provision, in order to raise the level of measures for aging. It is desirable to do this in parallel with the establishment of cross sectoral implementation mechanism.

As for support for the healthcare sector, a framework is already in place but required human resources, equipment, fiscal support and managerial capacity are insufficient. Therefore, support in these areas are

needed.



Note: The JICA Elderly Service Project shown in the figure: "The Project for Capacity Enhancement of Elderly Service Management in the Community"

Source: JICA Survey Team

Figure 8.4.1 Details of Necessary Engagements for Realization of the Solutions and Possible Japan's Support

Based on these, priorities assessed by the Survey Team in Japan's support for Sri Lankan aging sector are shown Table 8.4.1. The priorities are based on 5 phases considered in developing Figure 8.4.1: 1) establishment of implementation system, 2) understanding of needs and planning, 3) implementation of pilot programs, 4) preparation for nation-wide expansion, 5) nationwide expansion. Considering current situations and progresses, necessary actions are identified, then classified by the above priorities. Phase 1) to 3) items are deemed as short-term, high priority items, phase 4) is mid-long-term items and phase 5) is classified as long-term items. Among the items, those which are hard to plan unless another solution is implemented, are given 1-rank-lower priority to that of the preceding solution.

"The Project for Capacity Enhancement of Elderly Service Management in the Community" (the JICA Elderly Service Project) is planned to commence in 2021. The JICA Elderly Service Project mainly supports areas where [Solution D] Expansion of Elderly Services covers. However, the project activities may include areas related to the other solutions[129]. Therefore, possibility of Japan's support is studied considering

[129] At this moment, cross sectoral cooperation including ministerial level, elderly service, family support, prevention, provision of medical services and rehabilitation are assumed.

possible development of the JICA Elderly Service Project.

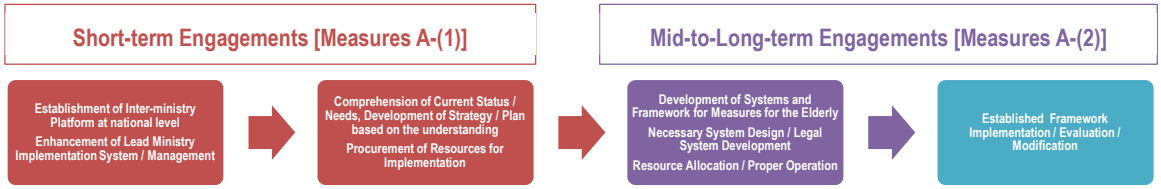
Table 8.4.1 Prioritized Areas of Possible Support by Japan for Measures for Aging in Sri Lanka

Time frame	Total Priority	Symbol	Area	Solution	Note
Short term	1	A	Cross sectoral	Development of implementation system for measures for aging: cross sectoral system	Partially covered by the JICA Elderly Service Project
		A	Social welfare	NSE functionality enhancement	
		A	Healthcare	Framework development for cross sectoral measures	
	2	B	Cross sectoral	Information management enhancement (pilot program)	Partially covered by the JICA Elderly Service Project
		D		CBIC system (pilot program)	
		G H	Healthcare	Health / prevention expansion (pilot program)	
		A C	Social welfare	Framework development for measures for aging / understanding service needs (including ones for private sector) for the elderly	
	3	I J	Healthcare	Geriatric medicine (pilot program)	Partially covered by the JICA Elderly Service Project
		K	Healthcare	Expansion of rehabilitation services	
Mid term	4	I J	Healthcare	Geriatrics (preparation for nationwide expansion, human resource development)	Based on the pilot program
		I J	Healthcare	Expansion of diagnosis and treatment department services (preparation for nationwide expansion, human resource development, facility/equipment enhancement)	
		K	Healthcare	Expansion of rehabilitation services (preparation for nationwide expansion, human resource development, facility/equipment enhancement)	Based on the pilot program
		C	Social welfare	Improvement of social security systems (policy/legal/standard development, securing fiscal foundation)	
		A	Social welfare	Establishment of elderly care service system (framework, implementation plan, policy/legal/standard development)	
Mid to long term	5	B	Cross sectoral	Information management enhancement (preparation for nationwide expansion)	Based on the pilot program
		D	Healthcare	CBIC system (preparation for nationwide expansion)	
		G H	Healthcare	Health / prevention expansion (preparation for nationwide expansion)	
		C	Social welfare	Improvement of social security systems (introduction/implementation)	
		A	Social welfare	Establishment of elderly service provision system (establishment of regulatory function)	
	6	E	Social welfare	Expansion of elderly services (facilities, equipment, human resources)	Based on A
		E	Social welfare	Utilization of private elderly service	
		F	Social welfare	Development of human resources for elderly care	
Long term				Nationwide expansion and implementation of each solution	

Based on the above priorities, details of each solution considering chronological order, as well as possibilities of Japan's support are presented as follows.

[Solution A, B] Expansion of Measures for the Aging (Implementation Process [Short-term] Platform Development, Information Gathering, Needs Assessment and Planning, [Mid-long-term] System Design, Legal System Development, Resource Allocation, Appropriate Operations)

As an implementation system of measures for aging, a cross sectoral platform is developed to coordinate multiple ministries, then understanding real situation and needs, required measures are identified and implemented. As for the information management, it is desirable to parallelly run with the needs understanding and measure planning – monitoring, evaluation, it is included in this phase.



Engagement Details

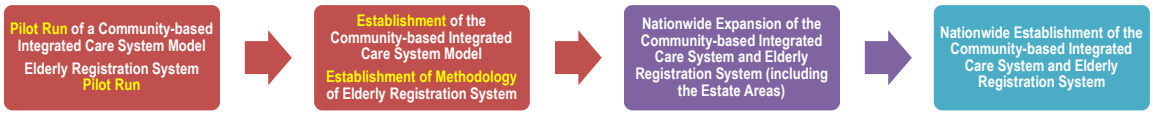
Item	Engagements	Possibilities of Japan's support
Implementation system enhancement for the measures for the aging of the society Strengthening NSE functionality and coordination with other ministries	Develop and iplement a cross-organizational platform among each ministry and agency related to the elderly. A platform will be established within the ministries and a framework will be established for implementing measures for the elderly within and between ministries and agencies (national level). [Development from the outcome and support of the JICA Elderly Service Project] Development of understanding on the importance of measures for aging through workshops held in The JICA Elderly Service Project and/or its succeeding new technical cooperation project.	1. The JICA Elderly Service Project (partly) (due to start in 2021) 2. Dispatch of Policy Advisor
Development of master plan based on needs and capacity building in implementation	1) Strengthen the registration and supervision of facilities that provide elderly care services (medical care, welfare, etc.). Establish a reporting system for facility operations and services, monitor facility operations and the quality of services based on the data and information obtained, and establish and implement a system to provide guidance for identifying and resolving problems. 2) Develop elderly registration system to understand the holistic picture and elderly people requiring support, ensuring delivery of the services. Candidates for the registration system operation methodology is (1) elderly ID registration (NSE / DSS etc.) implemented by the MoWCASS, (2) expansion of the family registration for mother-child relation implemented by the MoH, (3) any other form of registration such as certificate of residence. Considering these options, pursue more feasible and viable option for operation is decided. 3) Based on the above framework, actual situation and needs of the aging sector will be investigated to understand the latest situation, issues, and needs. The survey consists of a) a survey on the latest situation and needs of the elderly and their families, and b) a survey to grasp actual situation of medical, nursing, welfare facilities and services related to the elderly in public and private sectors. 4) Reflecting 3), a framework to provide necessary services shall be considered, and a master plan shall be formulated. 5) together with 3) and 4), all elderly people (and to-be elderly people) will be registered through the registration system and situation of the elderly will be continuously understood. Basic information related to these measures for the	1. The JICA Elderly Service Project (partly) 2. New Technical Cooperation project: Capacity Building in Measures for the Aging of the Society Project -Implementation of data-based planning, implementation and monitoring -High accuracy elderly information accumulation and provision of fair services 3. Private sector partnership (proposal-based) E.g.: Health condition monitoring, analysis service utilizing IoT etc.

Item	Engagements	Possibilities of Japan's support
	elderly will be compiled into a database, which will be managed and updated in an easy-to-be-used manner. 6) Based on inter-/intra-ministry platform, implement policy sharing, discussing action plans, supervising and evaluating activities, and formulating plans for the next fiscal year (using the PDCA cycle) [Development from the outcome and support of the JICA Elderly Service Project] Capacity development for core members in the implementing bodies such as MoH, provincial and district staff for healthcare and social welfare, in policy implementation in the information managagement mentioned above and data-based planning, implementation and monitoring and evaltuion, through policy advisor and new technical cooperation projects.	
Legal system development, establishment of standards	7) The roles, functions, service contents*, regulations and standards, and supervisory functions (scores and penalties) of public and private institutions are formulated. In addition, a supervisory system shall be established. First, the government will establish a system for public facilities, considering utilization of private facilities in light of the shortage of public facilities. * The service contents include judgment and review of the appropriateness of systems such as social welfare, pensions, nursing care, health examinations, health education, systems for providing medical services, counselling services for the elderly and their families, services utilization, abuse prevention and acceptance, and securing savings in old age 8) The NSE and YED will play a central role in the above processes, with the aim of strengthening the capabilities of both parties.	1. New Technical Cooperation project: Legal System for Aging Services / System Development Project -Establishment of legislations and standards for provision of aging services (both medical and welfare) for both public and private enterprises -Legal / standard compliance education and guidance for service providers -System / leader development for monitoring and supervision on compliance with regulations and standards
Securing budget and necessary funding source	Budget forecast required to realize the above services and securing funding source, fiscal management [Development from the outcome and support of the JICA Elderly Service Project] Capacity building in developing budget and evindence collection for securing necessary budget through the JICA Elderly Service Project	Dispatch of Policy Advisor (combined with the above support)

[Solution C] Expansion of Elderly Services [1] Establishment of Service Framework / Mechanism (Implementation Process [Mid-long-term] Implementation Based on Solution A/B)

Solution C is detail-designed and its activities are implemented based on service provision mechanism identified in the above mentioned Solution A and B. According to the identified service needs, development of required service facilities, human resource development, legal systems for these facilities, development and implementation of monitoring and supervisory mechanism, ensuring quality of human resources (qualification systems), freshman/in-service staff training, certification systems are implemented and established.

[Solution D] Expansion of Elderly Services [1] CBIC System [Short-term] [Mid-long-term]



Engagement Details

Item	Engagements	Possibilities of Japan's support
Deployment of a Community-based integrated care (CBIC) system model	A pilot CBIC system model will be constructed in order to link health services (preventive activities, health education, medical examination, etc.), medical services (diagnosis, treatment, rehabilitation, and reintegration), welfare services (providing care, nursing care, and housing), participation in social activities, transportation, and improvement of the living environment and community environment.	The JICA Elderly Service Project
Establishment of elderly registration system	Combined with the development of the model above, elderly registration system proposed in Solution B is introduced by region and study a possibility to comprehend reality of the elderly in each region. [Development from the outcome and support of the JICA Elderly Service Project] In the JICA Elderly Service Project, a feasibility study will be conducted for the registration system in the pilot area. Therefore, outcome of the feasibility study will be taken into account in considering the establishment of elderlly registration system.	(possibility is examined in the JICA Elderly Service Project)
Nationwide expansion of CBIC system	The CBIC system build in the pilot area is expanded nationwide.	Technical Cooperation project (a subsequent project of the above one)
Building a model for the Estate Area	As part of the nationwide expansion of this model, the model will be reviewed and introduced in a form suitable for the Estate Area, and a community inclusive care model will be established. The ministry will also consider linking the project with a move by the Urban Estate Division of the MoH to make estate clinics public. The Estate Area is characterized with poorer indicators in health / life environment / poverty level in comparison with other areas and there are a lot of space for improvement. Plus, unique local community is formed. Therefore, by introducing CBIC system framework which values local community and goes along with local intentions, the level of health / medical / welfare services is targeted to be raised in the Estate Area.	Technical Cooperation project (a subsequent project of the above one)

[Solution G/H] Expansion of Health Check Service and Health Education for the Elderly and Pre-Elderly (Implementation Process [Short-term] Pilot Programs, [Mid-long-term] Human Resource Development, [Long-term] Nationwide Expansion)

Health check service is conducted mainly by NCD Unit. A framework is already established to provide health check services to chronic disease. Therefore, elderly-oriented services such as dentistry and ophthalmology checks, dementia check as well as health education are added to the existing framework. In parallel, due to current low health check coverage, service provision mechanism is reviewed and coordination enhancement among the concerned parties is envisaged. For this activity, based on Sri Lankan side request, a pilot program can be planned in the JICA Elderly Service Project and its outcome will be taken into account in the case if the pilot program is actually implemented.

Engagement Details

Item	Engagements	Possibilities of Japan's support
Enhanced regular health check service	From the prevention viewpoint, current NCD related medical examination services are expanded, and regular eyesight, hearing, and dental examinations will be conducted in addition to NCD	1. (Possibility of implementing a pilot program is examined in the JICA Elderly Service Project)

Item	Engagements	Possibilities of Japan's support
	measures from the late middle age of life to maintain health. In doing so, the government will review part of the system and consider creating a service provision system to ensure that all persons subject to medical examinations receive comprehensive medical examinations, while identifying the persons subject to medical examinations and utilizing the existing health system.	2. Private sector partnership (proposal-based) E.g.: Health check service, introduction of medical health information management application to reduce clerical work / concentration of medical resources on medical services, etc.
Coordination enhancement among health check, diagnosis and treatment	The division of roles shall be reviewed and a system shall be established to ensure follow-up with regard to cooperation with necessary medical services such as pharmacotherapy and cataract surgery.	1. (Possibility of implementing a pilot program is examined in the JICA Elderly Service Project) 2. Private sector partnership (proposal-based) E.g. Health data analysis service, etc.
Enhancing health and nutrition education	Health and nutrition education is packaged so that necessary messages can be delivered. If possible, schools should be encouraged to provide health education that combines nutrition.	1. Possibility of implementing a pilot program is examined in the JICA Elderly Service Project 2. Private sector partnership (proposal-based) E.g. Introduction of completely processed food for the elderly for diet / nutrition management, restricted food management, cost reduction and simple health/nutrition check services, etc.
Development of educators for improvement of health	Education on community medical staff and volunteers about health / nutrition and lifestyle improvement education	1. (Implementation possibility is examined in the JICA Elderly Service Project) 2. Private sector partnership (proposal-based) E.g. Health / nutrition check, diagnosis / improvement advice service, etc.

[Solution I] Expansion of Health Care Services for the Elderly and Pre-Elderly (Implementation Process [Short-term] Pilot Projects, [Short-mid-long-term] Human Resource Development, Nationwide Expansion Preparation, [Long-term] Nationwide Expansion)

For expansion of health care services for the elderly, (1) enhancement of elderly medical care and its service system and (2) strengthen prevention / diagnosis / treatment system on diseases common to the elderly are envisaged. In this solution, focus is placed on (1) and (2) is mentioned later as Solution J.

In this solution, development of geriatrics specialized doctors, provision of geriatrics services at major facilities, and enhancement of home-visit nursing service are pursued. For visiting nurse service, home care by PHNO has started in 2019. However, the service is yet to be fully implemented. Thus, a feasible implementation method needs to be identified in a pilot project for future nationwide expansion. Its details are as follows.

Item	Engagements	Possibilities of Japan's support
Development of geriatrics specialists	Regarding medical technicians, required certification qualifications and education curriculums are clearly defined but geriatrics facilities have been limited so far. Human resource development based on required number of personnel considering introduction of geriatrics diagnosis department, rehabilitation services, home-visit nursing services.	1. Training in Japan 2. Cooperation with university hospital etc. (the above mentioned Policy Advisor support)

Item	Engagements	Possibilities of Japan's support
Elderly care training for freshman / in-service medical staff	-Plan and implement service training and follow up training to in-service medical / elderly care staff so that they can learn knowhow and techniques required in better elderly care and medical services. -Embed elderly care in the education program for medical / elderly care freshman	1. Technical Cooperation: Development project of medical and care professionals for the elderly 2. Training in Japan
Establishment of geriatrics diagnosis department	Establishment of geriatrics diagnosis department in tertiary medical facilities or MoH appointed facilities.	
Home-visit nursing service implementation structure enhancement	Currently, the MoH is developing PHNOs to promote home care, but the effort has just started and is not functioning well. Therefore, for the implementation of home-visit care services by PHNOs, support will be provided for the expansion of home-visit care and elderly care services, including the development of PHNOs, procurement of materials and equipment necessary for home-visit care, supervision of implementation status, monitoring, and coordination with nursing care. [Development from the outcome and support of the JICA Elderly Service Project] In the JICA Elderly Service Project, a feasibility study may be conducted for improvement of medical service in the pilot area. Therefore, outcome of the feasibility study will be taken into account in considering the home-visit nursing service implementation streucture enhancement.	1. Technical Cooperation: Development project of medical and care professionals for the elderly (Implementation possibility is examined in the JICA Elderly Service Project) 2. Private sector partnership (proposal-based) E.g. Introduction of facility-visit / home-visit rehabilitation care support software for reduction of clerical work such as scheduling / care record keeping tasks

[Solution J] Enhancement of diagnosis and treatment department services (Implementation Process: [Short-mid-long-term] Resources, Implementation Planning, Human Resource Development)

Regarding diagnosis and treatment department services common among the elderly, at least a system is envisaged where the elderly can take diagnosis and treatment services at all states for diseases common among elderly people. The actual special medical field includes, neurosurgical, respiratory, ophthalmic, orthopaedic, dentistry, oral and psychiatry. It is necessary to implement this solution based on a comprehensive mid-long term plan because this engagement requires a lot of time taking factors such as facilities, equipment and human resource development. Respiratory diagnostic department is included in the "Health and Medical Service Improvement Project" (signed in July 2018). Details of the solution is as follows.

Item	Engagements	Possibilities of Japan's support
Capacity enhancement on cerebrovascular diseases	Sri Lanka is currently aiming to establish stroke units in each province, and the government will provide support for the establishment of such units based on the current situation. In addition, the government will support the expansion of sanatorium-type medical facilities by converting existing regional hospitals. The ministry plans to allocate one facility in each prefecture.	1. Financial Cooperation (establishment of stroke unit) 2. Cooperation with university hospitals (student exchange, information exchange etc.)
Capacity enhancement on brain diseases	Establishment of dementia clinic and provision of services to the elderly. Continued training on neurosurgery specialized doctor for appropriate diagnosis and treatment. Cooperation with community to develop a system to accept dementia patients in the community	1. Feasibility check through CBIC system model development 2. Private sector partnership (proposal-based) E.g.: Introduction of applications for poriomania / safety confirmation of solitary elderly people / dementia prevention and so on.
Capacity building in elderly-prone diseases	For development of required specialty doctors and equipment procurement based on disease structure of the elderly needs, develop	1. Financial Cooperation (equipment procurement)

Item	Engagements	Possibilities of Japan's support
such as respiratory / cardiovascular diseases	and implement human resource development plan and equipment allocation plan based on the current resource and needs.	2. Cooperation with university hospitals (student exchange, information exchange etc.)
Ophthalmology services	-There are many elderly people who cannot notice their ophthalmologic anomaly. Therefore, as a part of health education, ophthalmologic screening is advised in the time of anomaly health check. -Include ophthalmologic screening in regular health check from early times and develop ophthalmology service system as tertiary level treatment so that immediate treatment is possible once anomaly is found. -In addition, the MoWCASS and the NPO (HelpAge) provide eyeglasses and surgical services for cataract patients and will coordinate with the service organizations under the jurisdiction of the MoH and cooperate without overlapping.	(feasibility check in the health education system development) (feasibility check in the health check enhancement) 1. Financial Cooperation (equipment procurement) 2. Cooperation with university hospitals (student exchange, information exchange etc.) (coordinated in Solution A)
Dentistry services	-Continual education from younger age on brushing on teeth and oral care -Implementation of regular dental / oral health check -developing a system where immediate treatment is provided in the time of anomaly -procurement of required equipment according to medical facility level -Implementation of continued training on in-service dentists to maintain / improve technique	(feasibility check in the health education system development) (feasibility check in the health check enhancement) 1.Financial Cooperation (equipment procurement) 2. Cooperation with university hospitals (student exchange, information exchange etc.) (coordinated in Solution A))
Both ophthalmology and dentistry services	[Development from the outcome and support of the JICA Elderly Service Project] In the JICA Elderly Service Project, if health check enhancement is implemented in the pilot area, these diagnosis and treatment departments are included. Therefore, outcome of the health check enhancement will be taken into account.	
Others	For those cases with NCDs with stable conditions, the possibility of introducing telemedicine is also examined.	

[Solution K] Enhancement of Rehabilitation Services for the Elderly ([Short-term] Pilot Programs, [Mid-long-term] Functionality Expansion)

Currently, only two facilities are providing rehabilitation services. Therefore, functions of rehabilitation services for the elderly should be expanded. For example, (1) establishment of acute phase rehabilitation function in tertiary medical facilities. (2) Addition of rehabilitation function to some core hospitals as a part of conversion of such hospitals into mid-phase cure medial facility, which is currently studied by the Sri Lankan government and (3) provision of continued rehabilitation services (CBR) after discharge from hospital.

Engagement Details

Item	Engagements	Possibilities of Japan's Support
Rehabilitation function enhancement	- Plan and implement system development where tertiary medical facilities and core hospitals can provide rehabilitation services in the acute phase and rehabilitation services and the sanatorium-type medical facilities described above can provide rehabilitation services in convalescent phase. Specifically, establishment of department, ensuring space, development of equipment and facilities, specialty human resources	1. Technical Cooperation: Rehabilitation system enhancement project - human resource planning - human resource development -rehabilitation system

Item	Engagements	Possibilities of Japan's Support
	(physical, occupational, and speech therapists) are planned and implemented. - At the same time, develop mechanism to guide the elderly for rehabilitation so that they can continuously engage rehabilitation after discharge from hospitals. [Development from the outcome and support of the JICA Elderly Service Project] In the JICA Elderly Service Project, there is some pssibility to work for community rehabilitation services in the pilot area. Thus, following activitis might be investigated based on the results.	development at each facility 2. Financial Cooperation: Procurement of equipment required in rehabilitation, facility development

[Solution F] Development of Specialists for the Elderly (Details are Designed Based on Service Provision System Identified in Solution A [Mid-long-term])

Regarding the development of specialists related to the elderly care services, medical service system has been established to provide medical services to some degree. Therefore, the existing framework is utilised and required number of personnel is calculated for development plan. As for elderly care, based on the service provison mechanism identified in [Measrues A], required number of personnel and skills are identified, then a humn resource development plan is made. In addition, smooth recruitment is persued by identifying conditions and requirements for elderly care human resources in [Measrues A] combied wth improvement in treatment and image. Because it takes time to develop a human resource framework and human resource development, it is desirable to start developing this solution when some ideas are developed for Solution A.

Engagement Details

Item	Engagements	Possibilities of Japan's Support
Development of human resource development plan	Based on the survey of the current situation and the identification of needs, expert technicians necessary for medical and welfare services for the elderly will be identified, the necessary expertise, qualification requirements, educational institutions, the number of people necessary to provide services, etc. will be identified, plans for human resource development and assignment will be prepared, budgets for human resource development and employment will be secured, and human resource development will be implemented in accordance with the plans.	Dispatch of Policy Advisor
Caregiver and welfare specialist development	-Since there are no clear regulations or employment standards for caregivers, they should be established. Required number of caregivers to be trained in the future is calculated, based on understanding the existing caregivers, their technical level and needs. At the same time, the definition of career type, qualifications, training institutions, curriculums, etc. will be examined with reference to Japanese nursing care etc., and each educational institution will be able to provide education that meets the requirements of the curriculum necessary for training caregivers. -As an existing educational organization, National Institute for Social Development (NISD) can be a candidate for caregiver training institution. NISD has a research function and is training social worker. Therefore, it is thought that the institute can also train caregivers with required techniques in elderly care, counseling and social participation functions. To raise feasibility, coordination with NSE is also considered.	1. Technical Cooperation: Development project of medical and care professionals for the elderly 2. Acceptance of Sri Lankan caregiver trainees through the Technical Trainee System 3. Private sector partnership (proposal-based) E.g.: Caregiver career path development by expansion of elderly care business in Sri Lanka, Caregiver development business in Sri Lanka (care skill, Japanese)

Item	Engagements	Possibilities of Japan's Support
	-Combined with the above measures, with the aim of improving the treatment of caregivers, elderly facilities are encouraged to comply with standards are encouraged and necessary support is provided. PR activities will be conducted to improve the image of caregivers. -By developing a career path that enables learning basic elderly care giving in Sri Lanka, overseas (Japan) training and acquisition of skills, better employment opportunities after returning to Sri Lanka) in elderly care industry, develop a program and implementation structure aimed at elderly care human resource development, quality improvement of Sri Lankan elderly care services and improvement of caregiver treatment For the overseas training experience, Japan's Technical Trainee System (including Specific Skill) is utilized. For the utilization of the system, the following measures are implemented. -Before application / acceptance: detailed explanation of the purpose of the system and eliminate work opportunity-seeking (migrant worker) as much as possible to the trainee candidates. Before coming to Japan - opportunities for Japanese language training in Sri Lanka, acquisition of basic elderly care knowledge are provided in cooperation with existing institutions and private sector cooperation to promote technical learning in Japan as well as reduce burden on Japanese elderly care businesses and raise their interest in Sri Lanka. -During training in Japan - regular contact and career advice after returning to Sri Lanka -After the training - for elderly care related career development in Sri Lanka, private sector cooperation, elderly care service business start-up support (matching with entrepreneurs etc.) are planned. Private sector cooperation (those operating elderly care business in Sri Lanka) is also sought. -In order to promote Japanese elderly care businesses to join this support, hold explanatory meetings.	

Reference: These are additional topics suggested by the YED in the MoH.

- Upgrade state sector health institutions to elder-friendly mainly marinating accessibility and elderly friendly toilet facilities.
- Increase availability of assistive devices for the disabled elders
- Improve eye care facilities at primary health care setting including cataract surgeries.
- Improve establishment of day care centres for elderly with recreational facilities and facilities to enhance mental wellbeing of the elders
- Establish elder-friendly parks including facilities to promote physical activities at community setting.
- Improve paramedical services for disabled elderly at primary health care setting.

Attachment-1 Examples of Institutions for the elderly or the Disabled

a) Facilities for the Elderly

Table 1 Private Sector (Businesses) Example

Name of the facility	Summary
Cinnamon Care	In addition to facilities for the elderly, care for dementia is also provided. Practicing the latest care through application. Providing high-quality care by caregivers who have acquired NVQ levels 2 and 3 in the UK. Provides nursing care and nursing care for retired people, and respond comprehensively to both long-term and short-term needs. Social recreational activities are also conducted.
Village 60 plus	Established in 2009. Providing care services for the elderly aged 60 and older. The company also sells products related to nursing care for the elderly. Rooms are with hot water and air conditioner. Three meals with different menus every day. 24 hour medical care, nursing services, laundry, changing sheets, internet facilities, housework, bath, meals, and comprehensive care such as transportation.
Jude Elder Care Home	A facility established by doctors that continues to be registered and renewed by the Social Welfare Ministry. Occupancy costs are more than 35,000 rupees for shared rooms and more than 65,000 rupees for private rooms. Costs include breakfast and afternoon tea and snacks, simple medical care and checkups by a doctor, counseling, simple nursing care, communal toilet, laundry, bed and cupboard.
Western Healthcare (pvt) LTD	It has a history of more than 25 years, and 4 elderly facilities have more than 150 residents. It offers medical care, nursing, meals, recreation, laundry, and even small nurse pars, restaurants, recreation centers, swimming pools and concierge services.

Based on the website of each facility

Source: JICA Survey Team

Table 2 Government Facilities (1) (Free or Low Cost)

Name of the facility	Eujin Nona Memorial Elder Home
Summary	Facilities for the Elderly under NSE jurisdiction started in 2016
Structure	Total 7 persons Manager: 1 person (ERPO in the region). Caregivers: 2 (One male and one female). Workers (Cleaning, etc.): 2. Cooks: 1 person, night guards: 1 person. Only the manager is a government employee and the others are temporary staff. Caregivers live-in, no shift.
Tenants	Men: 11 Female: 17 One woman with dementia and a few older people use a walker, but none require close assistance or use diapers (There was one before, but he died.). Two or three people need dietary support, but if it is brought it to mouth, they can eat normally. Basically, they move in until they die, and if their health condition makes it difficult, they are taken to the hospital.
Support from the neighbours	Most of the meals are covered by donations from residents. It is also scheduled so that donations do not overlap.
Management	NSE is only required to report the actual use of emergency funds. Although there are no clear monitoring rules, the headquarters is visited three or four times a year by district and county level ERPOs about once a month. There is a system where they can talk over the phone if they are in trouble.
Facilities	It is generally clean and almost odorless. There are 3 persons x 12 rooms, one of which is a warehouse. There is a small courtyard where they can take a walk. The handrail is about 3 cm in diameter (The width of the railing does not matter). There is a slight difference in level in the toilet, but it seems to be no problem from the viewpoint of the residents' health.
Medical cooperation	Visiting a doctor is not a rule. There used to be a doctor who would visit me on a regular basis, but now there is noone, so the management takes them from the facility to the hospital on a regular basis. At that time, they bring the diagnosis history of the individual managed in the facilities to improve the continuity of the medical examination.
Issues	Securing caregivers. In addition to the low salaries, young people prefer to work in the office and are not interested in career-giving.

Source: JICA Survey Team

Table 3 Government Facilities (2) (Free or Low Cost)

Name of the facility	Kandy Friend in Need Society
Summary	This is the first facility for the elderly in Central state, opened in 1837. From the outset, the government and the private sector have been operating the fund by saving funds donated by the people in good faith. 2% of the funds were contributed by the government, and the rest were paid by the interest of the fund. The central government contributed Rs. 2 million for the renovation of the building.
Structure	This facility has a facility management committee (home management committee) with 20 members. This committee manages funds, manages facilities for the elderly, and hires and pays staff. The main members are doctors and experts. It is managed by 12 staff members including the head of the facility, and their salaries are paid by the fund. The staff consisted of one director, two kitchen staff and the rest of the care staff. We have an old van as a means of transportation. Employment of staff is not systematic. It is not possible to hire staff who have received the necessary training, so when volunteers arrive, they are trained to become staff. Staff members acquire skills and knowledge through work at facilities for the elderly. Some skilled staff are seeking higher salaries.
Tenant	The conditions for admission to this facility for the elderly are divided into 2 categories: those who are 60 years of age or older and live in the facility with their own expenses, and those who live in the facility free of charge. At present, the former has 21 inmates and the latter has 84 inmates, a total of 105 inmates. The latter group consists mainly of elderly people who live in poverty and have no relatives, such as children or relatives. The former stayed in a private room and the monthly payment was 18,000 rupees (without bath) and 20,000 rupees (with bath). Free residents stay in a large room called the common hall. 1 common hall has 25 beds, 4 halls have 100 beds in total, and paid residents have 12 rooms with bath and 10 rooms without bath, 122 beds in total.
Regional support	All meals at the facilities for the elderly are covered by donations from local residents.
Management	For the poor, the Ministry of Social Welfare pays 40 rupees per person per day to the facilities for the elderly. The NSE pays 70 rupees per month to elderly people over the age of 1,900. To help the elderly earn their own income, they make mats and baskets by performing handicrafts. These products have regular sales opportunities.
Facilities	For private rooms, there is 1 staff per 6 rooms, and there is also a room for sick elderly people (sick room), and when residents enter there, there is 1 staff. The staff work day and night for four days, with one day off. Some of the staff are on duty.
Medical cooperation	Residents should visit Peladeniya Teaching Hospital or Kandy General Hospital once every 3 months for screening and follow-up. Vans are used to move residents, but each time only 10 people can be transported, which costs money such as gasoline and is not economical.
Issues	In Kandy Province, there are 12 registered facilities for the elderly, of which 5 are private and 7 are public. In addition, the prefectural government is conducting a survey and analysis of the operation of private and unregistered facilities for the elderly in order to grasp the current situation. In particular, the facilities for the elderly in rural areas are under strict management because they do not have enough beds and staff and do not provide enough care for the elderly. However, these facilities provide meals on time and provide medical services on a regular basis with the support of public medical institutions, while receiving support from the government, they employ the necessary staff and provide the necessary care. In terms of salaries, support staff at other facilities are paid 5,000 rupees a month, while 15,000 to 20,000 rupees are paid a month at this facility.

Source: JICA Survey Team

Table 4 Private sector: Charity Facilities (1) (Free or Low Cost)

Name of the facility	Moratuwa Social Service Society Home for Elders
Summary	A facility with a history started in 1919 (Seven survivors of the pandemic began.). The construction cost of the facility was donated.
Structure	A total of 27 people * Training through OJT, 30 years of service for long term employees Director: 1 (representative of the community). Administration: 7 members. Caregivers: 9 (7 females and 2 males). Doctor: (1 person), Nurse: 3 (Female). Others (Kitchen, cleaning, drivers, etc.): 7. Many of them are live-in employees and can work 24 hours a day.
Tenants	Men: 45, Women: 120 (full occupancy) There were 155 persons free of charge, 10 persons charged, mainly self-supporting persons (bedridden 25 persons, dementia 10 persons, walkers 10 persons, wheelchairs 25 persons, difficulty in excretion 25 persons, difficulty in eating 10 persons, difficulty in shower and changing clothes 10 persons). In consideration of the residents' health condition and religious reasons, it is necessary to check liquid foods and foods they do not provide (management by name and plate). During meals and teatime, the residents change into white clothes and sit in the reserved seats to promote their independence.
Regional support	The cost of food, equipment, equipment and other items necessary for the operation of the facility is covered by private donations. There is also a board to keep the donations together.
Management	Registered in NSE and Western State. State ERPOs are required to report occupancy and financial information (State ERPO reports to NSE). The income source of the facility is 1. Government financial support (Approximately 750 rupees per free resident * There is a detailed calculation formula.), 2. Paid rent, 3. Rent income (350,000 rupees/month) in the vicinity of the facility. Receive tax breaks for social welfare services (With certificate of registration). Donors also receive tax deductions.
Facilities	It is generally clean and almost odorless. There is a shop where residents can buy daily necessities at a low price. It has a primary care (Diagnosis, prescription of drugs) room, a large community room and a dining room. A free room (1F) is a large room for about 10 people, and a charged room (2F) is a private room (Rs. 25,000/month + meal + tea included) * The price of a neighboring house is Rs. 60,000/month, so it is inexpensive.
Medical cooperation	Doctors visit for half a day on Mondays, Wednesdays, Fridays. There are three nurses, one resident at Home. Each resident has a medical notebook that contains medical history, surgical history, medicine, and other information. The notebooks are also brought to public hospitals, and the residents are checked on their health condition on the day before a doctor's visit (It is common in public hospitals, but advanced in facilities for the elderly.) where information is coordinated, and the residents are selected to receive medical treatment preferentially.
Task	It is difficult to deal with people with diverse backgrounds such as family, economy, health and society. There are many people waiting to move in (Waiting Waiting Waiting List (receipt of application form) and Waiting List (Application received and after interview) have many names. The ideal facility lacks funds (Example: 27 Total Salary Rs.500,000/month) and equipment (Example: Mattress). Due to the law, the number of paid rooms must be within 10% of the total, so the management is unstable.

Source: JICA Survey Team

Table 5 Private sector: Charity Facilities (2) (Free or Low Cost)

Name of the facility	**Adyathmika Methsevana Peaceful Home**
Summary	The expenditure of facilities (It is undesirable to stay here for a long time.) based on the concept of a temporary place of comfort was Rs. 26,000/month, and the facility income alone was in the red.
Structure	2 persons in total (management of father and son) General superintendent: 1 (father). The manager of this facility: 1 person (son). The 2 are not caregivers, but rather close to the apartment owner (someone who consults with you when you have a housing problem).
Tenant	Men: 2, Women: 5 (Number of positions: 15) Age: 54 to 70 The short stay is three months, and the long stay is six years. a facility for persons who are independent (Everyone can take care of themselves, including one who uses a walker.) and have no supporters (have no relatives) (In the past, people with mild dementia were accepted, and some died here.). When you move in and rent every month is free. Regarding the elderly allowance Rs. 750/month, if you leave within six months, you will be refunded the amount. If they continue to live there for more than six months, they will not return the land and will use it to manage the facility (because they want to leave early,). When a resident dies, the family is contacted, but many families are not interested. In such cases, funerals are held at institutions. However, the police, hospitals and family members often confirm defects (Determination that appropriate care is not provided). Various written records are kept to avoid the risk
Regional support	Dana (offering) covers a part of the facility operation costs such as meals and materials.
Management	Registered in Western Province. Currently applying for NSE registration with support from ERPO. The facility makes money from the owner's wallet (50,000 rupees per month for bank account, reward for training instructor,) and dana (offering). I get a deposit of 50,000 rupees when I move in. The money is used when residents spend money on medicine and other expenses, and is basically returned. Revenue was 50,000 rupees per month (part of the resident's pension, benefits from the NSE, bank interest, donations, etc.). Expenditure: 45,000 rupees/month for meals (35000 rupees/month), utilities (10,000 rupees/month) (When there is a shortage of income and expenditure, compensation is provided by the training lecturer for individual management, grassroots activity advisor Rs. 30,000/monthly tuition fee, etc.).
Facilities	They do not like to be called facilities for the elderly, but rather (house of peace) (Similar to group facilities in Japan). It is generally clean and almost odorless. It is divided into male and female rooms. There is a spacious space with a large garden. The shower and toilet are in separate rooms. There is a kitchen and residents can cook for themselves.
Medical cooperation	Residents go to nearby hospitals if necessary.
Task	Governments often implement social welfare policies and initiatives in political performance (the mood of the moment without planning). In that sense, there is a lot of waste. Since there are limits to what the government can do, more private sector participation is imporartant. The land had been donated and had a good relationship with the donor, but after the donor died and his relatives are on a court case (As a result, facilities cannot be renovated.).

Source: JICA Survey Team

b) Facilities for the Disabled

Table 6 Private Sector: Business (Free or Low Cost)

Name of the facility	Senehasa Elder Home-Homagama
Summary	Started business with husband and wife in 2000 * The initial cost is about 10 million rupees (Community members donated about 6 million rupees and loaned about 4 million rupees.).
Structure	Total of 6 persons aged 25 ~ 52 * OJT education Caregivers: 5 (3 females and 2 males). There is a person in charge of cooking, but regardless of the person in charge, they deal with situations on the spot. Ideally, there would be 8 people, and some caregivers would take maternity leave, and they are recruiting, but they cannot gather at Rs. 25,000/month (Current cares givers are paid 45,000 to 50,000 rupees per month). He is not undergoing rehabilitation.
Tenants	22 men, 28 women (Number of positions: 60), mainly 25 ~ 83 and 60 ~ 70 years old (25 ~ 29 years old - 2 persons, 30 ~ 49 years old - 10 persons, 50 ~ 59 years old - 7 persons, 60 ~ 83 years old 31 persons) 20 persons were free of charge, 30 persons were charged (15,000 rupees/month to 25,000 rupees/month), mainly people who were self-supporting (bedridden people, 2 persons with dementia, 5 persons with walkers, 6 persons with wheelchairs, 15 persons with difficulty in defecation, 15 persons with difficulty in eating, showering and dressing). The symptoms varied (Mental disability, depression, dementia, lower body disability, etc.), and over the years 2 individuals developed gait and visual impairments. The fees for the 30 paying subscribers will be determined on a case-by-case basis, from Rs. 15,000/month to Rs. 25,000/month, taking into account the pension status of the subscribers and the economic status of their families.
Regional support	Food is provided by donations from development officers. In February 2020, out of 90 meals, 40 were donated (The donation of 40 meals is small judging from the results.).
Management	Registered in NSE and Western State. It is required to report the number of residents and financial information to the state government (be reported by the state government to the central government). Revenue is 80,000 rupees/month + donation (Donations range from 0 rupees/month to 30,000 rupees/month.). Pension for residents (25,000 rupees + 15,000 rupees), NSE allowance (2,000 rupees x 20), other donations, etc. Expenditures are 190,000 rupees per month. Medicines (50,000 rupees), employee salaries (80,000 rupees), meals (40,000 rupees), utilities, etc. (20,000 rupees) In some cases, central and state governments have asked for tenancy (Directions). Receive tax breaks for social welfare services (With certificate of registration). Donors also receive tax deductions.
Facilities	It is generally clean and almost odorless. A large room (6 to 8 people), each room has 1 TV, radio, toilet and shower room. They also serve liquid food according to the person. It is difficult to live in a wheelchair because of the difference in level when entering the room and the small space of the toilet and shower room.
Medical cooperation	The doctor and nurse visited the facility on the second Wednesday of each month (They belong to a public hospital (Homagama Base Hospital) and respond to requests from the facility. It is not a partnership with public hospitals based on government policies and arrangements.). Caring givers do decubitus ulcers themselves while watching doctors and nurses perform treatments such as amputation and disinfection.
Issues	The manager wanted to build a clean and more satisfying facility if he had a budget, but he could not because his business was judged to be poor and the bank's loan limit was low. Although it is the government's job, the government does not provide adequate support to facilities and residents. Caregivers should also receive pension benefits as civil servants. The 20 free residents must apply for and receive financial support from the government. However, the owner did not apply because he had to pay more than 2,000 rupees for transportation from the facility to the reception desk. He would like to see a system in which proxy applications, SSO and ERPO provide money to the facilities.

Source: JICA Survey Team

c) Day Care

Table 7 Private Sector: Business (Free or Low Cost)

Name of the facility	Kandy Day Care Center
Summary	This day center has 80 members, but due to a religious holiday today, many of them visit the temple. The purpose of this center is the independence of old people. Specifically, they aim to maintain good health and mental condition, and to do activities to earn income, so that they do not rely too much on their children and do not have to enter nursing homes.
Activities	More than 1000 elderly people live in the area, but some do not participate. About 200 elderly people live in the Yatinuwala district where the center is located. Many elderly people are experienced and able to work, but the retirement system does not allow them to find work. Many elderly people do not have enough money to live on, so they aim to learn how to earn their own income by improving their skills and mentality. The center offers job training in yoga, dance, singing and handicrafts. They may also call in health workers from clinics and hospitals to open clinics. Senior style promotion officers from district offices (Divisional Secretary) (Elder Style Promotion Officer) may also participate.
Tenants	Many elderly people who use this center are not economically affluent and many have no family to rely on. They are meeting and chatting with each other and discussing ways to solve each problem. Because children often work during the day, it is difficult to take care of the elderly, but through participation in the activities of this day center, they participate in social activities. If I can live happily, I think I can live long. When elderly people are injured, they visit their homes to encourage them or gather to cook.
Regional support	The activities are carried out with the advice of the monks of the temple under the jurisdiction.
Management	The government paid the village for the activities and continued with 5% commission. In the past 3 years, it has operated activities with a commission of about 1.1 million rupees.
Achievements	Older people who could not walk in the past became able to walk without support by attending the day center and exercising. We get together, we sing, we dance, we talk, we do things we can't do at home, we motivate ourselves, we train our minds, we can turn into positive thinking. Last year, it won first place in a contest organized by the state's Social Services Department on senior citizen activism, and was awarded a chair, table, chest board, cooking tool, and space for activities.
Issues	There is no prospect for funding at this time, but they hope to receive training, build toilets and set up libraries.

Source: JICA Survey Team

Attachment-2 Overview of PGIM Education Courses Relevant to Elderly Healthcare

Course - Diploma

Geriatric Medicine				
Duration	1 year			
Program	Taught component: 195 hours		Clinical component: 720 hours	
	Module	hours	Module	hours
	1. Geriatric Medicine / Surgery	75	1. General medicine	135
	2. Evidence Based Practices (EBP)	15	2. Surgery	45
	3. Preventive Medicine and Health	30	3. Psychiatry	45
	Promotion	15	4. Oncology	45
	4. Ethical and Legal Issues	15	5. Gynaecology and Genitourinary	45
	5. Cancer Care and Palliation	15	6. Neurology	45
	6. Clinical Nutrition Management	15	Cardiology	45
	7. Rehabilitation		Dermatology	22.5
			Chest Medicine	22.5
			Endocrine & Diabetes	22.5
			Gastrointestinal	22.5
			7. Ophthalmology	22.5
			ENT	22.5
			8. Rheumatology	45
			Rehabilitation	45
			9. Dental hospital	22.5
			Community visit / MOH	45
			10. Family medicine	22.5
Institutes	National Hospital of Sri Lanka and others			
Outcome	1. identify specific health related problems and needs in the elderly in view of planning and implementing interventions at the domiciliary settings, PHC level and institutions providing care for the elderly 2. provide humane care and treatment based on sound judgment in the primary care setting 3. make appropriate referrals when indicated 4. provide leadership in the community level program implementation and research activities pertaining to the elderly 5. liaise with health care institutions and CBOs 6. develop effective communication skills in the management of elderly patients and their caretakers 7. demonstrate good knowledge on research methodology			

Palliative Medicine				
Duration	1 year			
Program	Taught component: 227 hours		Clinical component 675 hours	
	Module	hours	module	hours
	1. Introduction	15	1. General medicine	90
	2. Management of pain	23	2. Respiratory medicine	45
	3. Management of common	30	3. Neurology	45
	symptoms	23	4. Cardiology	45
	4. Psychological aspects of	23	5. Oncology	225
	palliative care		6. Oncosurgery	45
	5. Communication skills and	15	7. Nephrology	45
	counselling	8	8. Community and Family	45
	6. End of life care and hospice	15	medicine	45
	care	15	9. Rheumatology / Rehabilitation	45
	7. Palliative care emergencies	15	10. Paediatrics	
	8. Palliative care for non-	15		
	malignant disorders			
	9. Palliative care in geriatric	15		

Palliative Medicine				
	patients 10. Ethical issues and legal aspects 11. Rehabilitation, cancer survivorship[130] and community support 12. Paediatric palliative care 13. Nutrition in palliative care	15		
Institutes	National Hospital of Sri Lanka, National Cancer Institute Maharagama, Teaching Hospitals, Provincial or District General Hospitals where there are trainers who meet PGIM eligibility criteria			
Outcome	- Manage symptoms and other clinical problems secondary to life-limiting progressive disease and other common concurrent medical problems. - Address and manage psychological, emotional and social issues of patients and their families within the palliative care context. - Be able to identify psychiatric conditions and make appropriate psychiatrists referral. - Identify specific disease processes and common emergencies which may arise in the context of palliative care. - Prescribe medications within the palliative care setting. - Provide care for dying people. - Recognize that spirituality may be a key dimension of the experience of dying patients and ensure spiritual issues are addressed. - Establish therapeutic and supportive relationships with patients and families. - Work effectively with others and collaborate effectively amongst health professionals. - Participate in advocacy for the welfare of individual patients with a life-limiting illness and their families, and facilitate discussion/ encourage promotion of palliative - care issues within the general community.			

Course - MD / Subspecialty

Rehabilitation Medicine				
duration	3 years			
Program	Domestic: 2 years, Overseas: 1 year			
	module	month	module	month
	Stage 1 - Rehabilitation Unit - Neurology Unit - Paediatric Neurology & Rehabilitation Stage 2 - Rehabilitation Unit - Neurology Unit - Paediatric Rehabilitation	 2 2 2 6 3 5.5	Stage 3 - Neuro-trauma unit - Orthopaedics - Rheumatology - Plastic surgery and burns unit - Post Cardiac disease rehabilitation - Rehabilitation of patients with respiratory diseases Stage 4 Overseas training in Rehabilitation Medicine	 0.5 0.5 1 0.5 0.5 0.5 12
Institute	Stage 1-3: Rehabilitation hospitals Stage 4: overseas training centre			
Outcome	- the trainee will have the knowledge and skills to promote the health and wellbeing of people with disability and will be aware of and understand the social and cultural factors which influence disability and their impact on the rehabilitation process. - the trainee will be able to formulate a management plan that respects and includes the patient needs. - the trainee will be able to assess and record the common psychological disorders, psychosocial and behavioural consequences commonly seen in disabling disorders, and also the corresponding contextual factors that influence activity and participation.			

Rehabilitation Medicine	
	- the trainee will be able to coordinate the care of individuals with disabling conditions in a wide range of settings from the acute hospital environment to the individual's home in the community. - the trainee will have the knowledge and skills necessary to work with rehabilitation teams in different settings, and within and across health, social and CBOs. - the trainee will have developed leadership skills such that they can deliver, manage and develop a rehabilitation service. These leadership skills are seen as key, without which trainees will not be able to take up a consultant role. - the trainee will have an understanding of the ethical and medico-legal framework within which decisions are made and respect for how others' ethical, moral or religious frameworks affect their decision making.

Rheumatology & Rehabilitation Medicine				
duration	3 years			
Program	Domestic: 2 years, Overseas: 1 year			
	module	month	module	month
	Stage 1 - Rheumatology & Rehabilitation Medicine Stage 2 - Paediatric Rheumatology & Rehabilitation Medicine - Rehabilitation Medicine - Orthopaedics - Radiology - Immunology Laboratory - Histopathology Laboratory - Consolidation period	12 3 3 1 0.5 0.25 0.25 5+	Stage 3 - Overseas training	12
Institute	Stage 1: Teaching Hospitals Stage 2: Lady Ridgeway Hospital for Children, Rheumatology and Rehabilitation Hospital Ragama, Teaching Hospitals, Medical Research Institute Stage 3: Rheumatology unit recommended by the Specialty Board in Rheumatology and approved by the GIS			
Outcome	- Knows the aetiology, pathophysiology, diagnostics and therapeutics for a broad range of rheumatology &Rehabilitation Medicine related health problems that are relevant to Sri Lanka, and at a regional and global level. - Has the necessary procedural skills and competencies of data gathering (i.e. skills of history-taking, physical examination and practical procedures), synthesizing and analysing of information (i.e. decision-making), and therapeutic procedures. - Makes comprehensive assessments of problems considering the patient as a whole and is able to diagnose and manage acute and chronic, complex and multisystem rheumatological disorders in adult and paediatric patients. - Provides competent and coordinated, high quality care with the assistance of multidisciplinary teams in the hospital and in the community, which includes Rehabilitation Medicine, palliation, and end-of-life care. - Effectively seeks and critically evaluates information and provide cost-effective care based on scientific evidence. - Maintain professional standards through continuing development and learning Critical appraisal and analysis of clinical research methodology and results. - Bases clinical practice on our values and ethics. - Communicates effectively with patients, relatives, members of the health care team and community in a culturally sensitive manner. - Demonstrates empathy and show compassion towards patients. - Knows and practices medicine with due attention to patient safety and the safety of the healthcare team. - Management of time and other resources to the benefit of the patients and colleagues - Takes an advocacy role, especially in issues relating to health. - Knows the functioning and structure of the health system, functions effectively within the administrative structure, and is able to lead and mange healthcare teams specially in relation to Rehabilitation Medicine team. - Document health records and communicate using the written medium - Demonstrate motivation and skills in self-learning and reflection. - Uses Information Technology in clinical practice. - Teach, mentor and train health professionals including undergraduates, postgraduates and other consultant, educate public and advocate for health promotion. - Formulate, plan, conduct and report ethically conducted original research or clinical observations that makes a			

Rheumatology & Rehabilitation Medicine	
	significant contribution to the development of the discipline and satisfies peer review and merits publication. - Function in different settings locally in Sri Lanka or in other parts of the globe.

Old Age Psychiatry				
Duration	3 years			
Program	Domestic: 2 years, Overseas: 1 year			
	module	month	module	month
	Stage 1 - Knowledge - Skills - Research Project - Liaison with other disciplines - Liaison with agencies providing care for the elderly (HelpAge Sri Lanka, Sri Lanka Alzheimer's Association, Postgraduate Institute of Medicine – University of Colombo, Residential care facility for the elderly, Day care facility for the elderly, Patient's home, Dementia centre at Mallika Niwasa, Colombo, Pain management clinic at National Cancer Institute, Maharagama, Hospice, ICU caring for an elderly patient) - Participation in continuous medical education (CME) activities - Dissemination of knowledge	12	Stage 2 - Knowledge gathered during first twelve months of training - Skills - Research: at the end of the second twelve months, the trainee is expected to submit the completed dissertation to the Board of study in Psychiatry. - Liaison with other agencies (government and non-governmental institutions/ organizations that provide care etc.) - Participation in continuous medical education (CME) activities - Teaching – Post graduate teaching on the subspecialty training for registrars in psychiatry and allied disciplines are encouraged - Dissemination of knowledge - Management and policy planning Stage 3 Overseas training The trainee should consolidate in areas such as psychotherapy in old age, specialized services for dementia, delivering community care for elderly patients living in community, elders' homes and nursing homes, shared care with other stakeholders, and ethical and legal issues in old age psychiatry.	12 12
Institute	Stage 1-2: It is recommended that trainees work in two different institutions (National Institute of Mental Health, National Hospital of Sri Lanka, Colombo South Teaching Hospital, Colombo North Teaching Hospital, Teaching Hospital Kandy, Teaching Hospital Peradeniya, Teaching Hospital Karapitiya and any other unit accredited by the Board of Study in Psychiatry at the time of the allocation meeting). Stage 3: Overseas unit recognized by the BOS in Psychiatry			
Outcome	On completion of training, a specialist in old age psychiatry is expected to possess adequate knowledge and skills to manage elderly patients, contribute to service development and research, and to work with relevant stakeholders to provide a specialist mental health service to older people. He/she should be able to contribute to advancement of old age psychiatry, voice opinion with policy makers and contribute to raise public awareness. - Patient care: The trainee is expected to learn from patients in multiple settings -outpatient, inpatient, day hospital, liaison and community. - Medical knowledge, skills and attitudes: The trainee is expected to keep abreast with current knowledge in old age psychiatry, constantly attempt to learn new skills and sharpen existing skills and have a healthy attitude to practice.			

Old Age Psychiatry	
	- Interpersonal and communication skills: The trainee is expected to develop good skills In working with patients and families and the multidisciplinary team. - Professionalism and confidentiality: The trainee should at all times be mindful of ethical principles and responsibilities in the areas of doctor-patient relationship, consent for treatment, and dealing with families and professional boundaries. Responsibility towards work, commitment, honesty is required. Comprehensive record keeping and good time management are other useful professional skills to develop. - Evidence-based approach to practice: The trainee should apply evidence-based approach to practice as far as possible.

Course - MD / Specialty

Geriatric Medicine				
Duration	5 years			
Program	Domestic: 3.5 years, Overseas: 1.5 years			
	module	month	module	month
	Stage 1 (Registrar training (pre-MD training)) - General Medicine - Clinical appointments - Cardiology - Neurology - Psychiatry - Rehabilitation - Dermatology - Endocrinology - Gastroenterology - Nephrology - Respiratory medicine - Geriatric Medicine	12 2 2 1 2 1 2 1 1 1 6	Stage 2 (the MD examination) Stage 3 (Senior Registrar training (post-MD training)) - Domestic - Overseas Stage 4 (Pre-Board Certification Assessment)	— 12 18 —
Institute	Accredited by Specialty Board and BOS			
Outcome	**Provision of care for older people in different settings, including hospitals, residential care facilities and the community** - To assess, diagnose, treat, and manage acute and chronic illnesses in older people - To apply principles of internal medicine to the health problems of frail older people with complex co-morbidities - To discern whether and when to request diagnostic tests and how to interpret results - To be familiar with the principles of palliative and end of life care - To recognize the special needs of older people from culturally and linguistically diverse backgrounds - To offer comprehensive geriatric assessment to elderly patients through the multidisciplinary health and social care team - To manage the frail elderly (using the domains of physical, mental and social frailty) and plan out further management strategy for follow up - To organize rehabilitation and follow up of patients after acute and chronic medical conditions - To organize and give leadership to outreach clinics in the community to screen and assess health issues of the community-based elderly in liaison with MOH and primary care providers - To provide necessary advice and expertise to day-care centres, elderly homes, nursing homes and houses where the frail elders need care as and when necessary **Conducting research in Geriatric Medicine** - To initiate formation of research teams and carry out research projects that would help to provide better care for the elderly in the local setting - To be conversant with the information technology including research methodology and data analysis in order to carry out useful clinical research related elderly care **Training of medical officers, healthcare workers and caregivers in different aspects of Geriatrics** - To contribute to the education of medical officers, students and other health care workers and to further develop the field of Geriatric Medicine - To plan and implement programs for capacity building of personnel involved in care of the elderly which includes			

Geriatric Medicine	
	trainees in Geriatric Medicine to doctors, paramedical personnel and caregivers - To guide community health care providers on Geriatric Medicine issues **Fostering teamwork** - Work within teams that provide assessment, rehabilitation, and care of older patients - To effectively lead the multidisciplinary team providing care, to organize smooth uninterrupted services according to the stipulated management plan - To liaise and communicate effectively with other clinicians for referrals both ways (to receive referrals as well as to refer for subspecialty care) - To establish and maintain cordial and respectful relationships with other professional colleagues - To network effectively with the general practitioners who provide continuing services to a population of people whom they have been following u and organize clinical meetings where they are updated on provision of better services - To liaise with relevant authorities at all levels for the development and provision of resources to promote increased awareness about elderly health issues of general population in the interest of improving elder health in the community **Practicing and promoting positive attitudes towards caring for older people** - To provide care that encompasses concern, companionship, comfort and compassion - To reinforce good attitudes towards the elderly in keeping with the traditions of our rich culture in respecting the elders - To be sensitive to the spiritual and cultural needs of the elderly - To promote respect towards the elders, enhance their capabilities and recognize their contribution for a better society **Developing managerial and advocacy skills** - Promote strategies for healthy ageing and organize their implementation - Understand and acknowledge the importance of social, cultural and economic factors that contribute to illness and vulnerability - To advocate to policy makers regarding all issues concerning the elderly including caregiver impact - To advocate and establish liaison with other agencies related to social services, housing voluntary agencies and the private sector involved in the provision of services for elders **Promoting active and healthy ageing** - To organize health promotion and disease prevention activities for the elderly in liaison with primary care providers and community leaders - To promote the dissemination of knowledge on healthy ageing **Adhering to correct principles of ethical and legal issues in geriatric medicine** - To understand the basic principles and practice ethics in the care of the elderly - To have a sound knowledge of the legal issues regarding elders' rights, care of the elderly and end of life situations.

Reference: Community-based Integrated Care System (for discussion)

Lessons learned from Community-based integrated elderly care services in Japan

JICA Data Collection Survey on aging sector in Sri Lanka
(Fujita Planning Co., Ltd)

Community-based integrated care system for elders

Analysis of academic literatures

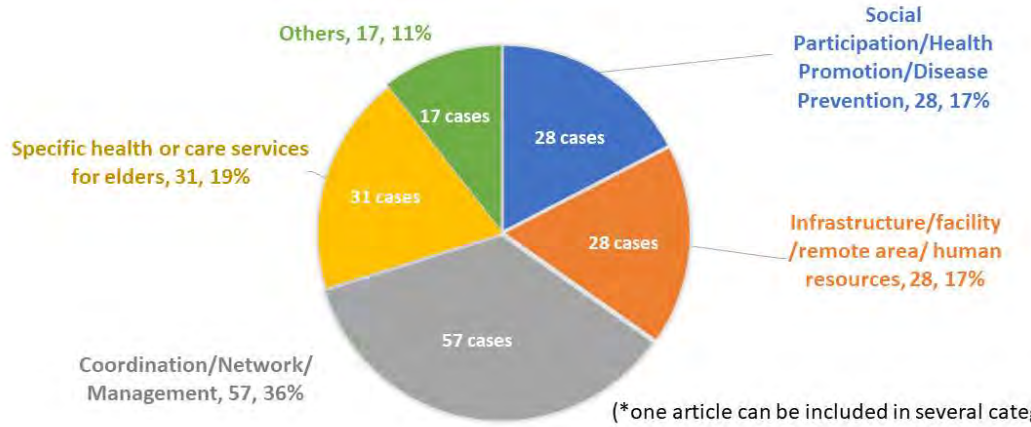
Purposes of survey

- Purpose of this survey is to identify major topics to be discussed, important factors for successful system development and maintenance, good practices and lessons-learned from Japanese academic articles investigating community-based integrated care system in Japan.

Articles to be compiled

- Data source: Ichu-shi (operated by Japan Medical Abstract Society)
- Key word: Community-based Integrated care system
- Number of articles to be retrieved from website: 96 articles
- Number of articles to be used for analysis: 95 articles

Major contents and key factors written in the articles of community-integrated care system for elders



(*one article can be included in several categories)

Details of Social participation/Health Promotion/Care Prevention

	N
Social participation	19
Social participation of persons with dementia	13
Health Promotion/Care prevention	7

Social participation (including persons with dementia)
- To use public library as communication space for elderly and dementia persons.
- Community café for elderly persons (with dementia) – involvement of other generation and supporters
- Provide learning opportunity for elderly persons including dementia patients
- Urban residents tend to have less opportunity to participate in/find supports – need to have some mechanism to connect them.

Key points of implementation (for Sri Lanka):
- Provide opportunity of social participation for elders and persons in community.
- Flexibility is needed based on elders' needs and feasibility of maintenance/operation.
- Consider how to include dementia persons in social participation.
- Urban area: need framework to link supporters and elderly people, especially persons to be isolated from society.

Details of Social participation/Health Promotion/Care Prevention

	N
Social participation	19
Social participation of persons with dementia	13
Health Promotion/Care prevention	7

Health promotion/care prevention
- Care for prevention by oral rehabilitation
- Sport activities are effective for reducing isolation and care prevention.
- Regional intervention to give opportunity of sport activities will contribute on healthy life among elderly persons.
- Community café for elderly persons (with dementia)
- Effectiveness of stretching as self-medication for improving metabolism and relaxation.

Key points of implementation (for Sri Lanka):
- Going out, exercise/sports contribute on prevention of dementia
- Importance of oral rehabilitation for care prevention
- Important to make opportunity of sports activities and exercise.
- Importance of public promotion to encourage elders to join social activities.

Details of Coordination/Network/Management

	N
Multi-sectoral coordination/interprofessional work	22
Management/coordination by Government	15
Coordination between health and care services	13
Resident or resident group participation	12
Participation of University Medical Hospital	7
Care management by nurse or care manager	6
Support to discharge and back to normal life	5
Information sharing/networking	5
Hospital-centered integrated care	5

Key points of implementation (for Sri Lanka):
- Multi-sectoral alignment and coordination are crucial
- Building of a network and information sharing about elderly people

Multi-sectoral coordination/Interprofessional work
- Interprofessional work is crucial for community-based integrated care system and interprofessional education is key for realization of better coordination.
- Need to strengthen interprofessional education among experts of social welfare and social work.
- Need to reduce discrepancy of recognition among health and social welfare and connect them.
- Important to make face-to-face relationship among staff of health, social welfare and other relevant experts.
- Need networking between medical service providers and social care service providers.
- Train public officers to establish framework of community-care system based on opinions from residents and make action plan.
- Need to promote multi-sectoral coordination for elderly services

Details of Coordination/Network/Management

	N
Multi-sectoral coordination	22
Management/coordination by Government	15
Coordination between health and care services	13
Resident participation	12
Participation of University Medical Hospital	7
Care management by nurse or care manager	6
Support to discharge and back to normal life	5
Information sharing/networking	5
Hospital-centered integrated care	5

Key points of implementation (for Sri Lanka):

- Leadership and overall coordination by government is crucial
- Need to make multi-sectoral coordination mechanisms by government

Management/coordination by government

- Strengthen leadership of middle-class management contributes on team-building and effective governance for elderly services
- using PDCA cycles for implementation and problem solving
- Important for regional government to coordinate among all the relevant stakeholders.
- The government need to be a leader to organize periodical meeting for information-sharing and coordination among experts working for elderly care.
- Many elders did not know home-based nursing care system – need publication of services
- Need government to develop information management tools including aspects of both medical and social welfare.
- Need to identify continuous care-management process from hospital to community

Details of Coordination/Network/Management

	N
Multi-sectoral coordination	22
Management/coordination by Government	15
Coordination between health and care services	13
Resident/volunteer participation	12
Participation of University Medical Hospital	7
Care management by nurse or care manager	6
Support to discharge and back to normal life	5
Information sharing/networking	5
Hospital-centered integrated care	5

Resident/volunteer participation

- Volunteers contribute on checking elders living safely and identifying needs for support their lives by periodical visit and discussion.
- Important to communicate between regional volunteers and care managers/nurses.
- Single, male, person with small network with neighbors tend to be difficult to reach social support for daily life.

Key points of implementation (for Sri Lanka):

- Multi-sectoral alignment and coordination are crucial
- Building of a network and information sharing about elderly people

Details of Coordination/Network/Management

	N
Multi-sectoral coordination	22
Management/coordination by Government	15
Coordination between health and care services	13
Resident participation	12
Participation of University Medical Hospital	7
Care management by nurse or care manager	6
Support to discharge and back to normal life	5
Information sharing/networking	5
Hospital-centered integrated care	5

Participation of University Medical Hospital
- University hospital joins community activities – many young people have chance to participate in social activities.
- Collaboration with University contributes on training young generation to work for elderly services
- University medical hospital can contribute on training future geriatricians, public health nurses, OT and PT and service providers for elderly people – apply necessary curriculum of both theory and practice.

Key points of implementation (for Sri Lanka):
- University and university hospital should be included in the community integrated care system to provide social services
- Future professionals should be trained based on needs and conditions.

Details of Coordination/Network/Management

	N
Multi-sectoral coordination	22
Management/coordination by Government	15
Coordination between health and care services	13
Resident participation	12
Participation of University Medical Hospital	7
(Care) management by nurse or care manager	6
Support to discharge and back to normal life	5
Information sharing/networking	5
Hospital-centered integrated care	5

(Care) management by nurse or care manager
- Public health nurses and care managers are expected to make appropriate care plan for each elder person considering all possible medical and care services
- Necessary to strengthen management and coordination capacity of (public health) nurses and care-givers
- Necessary to educate human resources (nurses) for ensuring quality of home-based care

Key points of implementation (for Sri Lanka):
- Public health nurses and care managers should be trained both professional skills and care management.
- Continuous training is needed to revitalize their skills and knowledge.
- Governments should share necessary information and opportunity of discussion with them to provide appropriate services.

Details of Coordination/Network/Management

	N
Multi-sectoral coordination	22
Management/coordination by Government	15
Coordination between health and care services	13
Resident participation	12
Participation of University Medical Hospital	7
(Care) management by nurse or care manager	6
Support to discharge and back to normal life	5
Information sharing/networking	5
Hospital-centered integrated care	5

Support to discharge and back-to normal life
Information sharing/networking

- Management and coordination capacity of (public health) nurses and care-givers
- Important to coordinate between hospitals and communities to support elders to come back to community.
- Effective to conduct care conference with medical staff and social welfare staff.
- Establishing admission-discharge center in university hospital for smooth coordination for patients to come back from hospital to community

Key points of implementation (for Sri Lanka):

- Continuous coordination and support for elders is needed from hospital to community.
- Continuous coordination between medical services and care services is crucial
- Need to set opportunities of discussion and information sharing

Details of Framework/infrastructure/human resources

	N
Regional Development/Framework	12
Human resource/Education/Training	11
Resident/elderly care home	7
Nurse/elderly care station	4

Key points of implementation (for Sri Lanka):

- The system should be its own style based on regional characteristics and resources.
- Consider including all necessary stakeholders and elders, especially high-risk elders to be isolated.

Regional development/framework

- Need to establish community-based health services in the system in order for elderly people to live in their accustomed homes until the end of life.
- Need to strengthen regional care function for prevention of dementia and promotion of appropriate knowledge about dementia for making elders with dementia-friendly community
- Regional integrated support center organized by regional association of doctors – comprehensive center in coordination of all kinds of stakeholders.
- Need to connect elderly persons living alone with neighbors to build support system.
- Need to consider its own style of integrated community care based on regional characteristics and resources.

Details of Framework/infrastructure/human resources

	N
Regional Development/Framework	12
Human resource/Education/Training	11
Resident/elderly care home	7
Nurse/elderly care station	4
Infrastructure/social services in remote area	2

Human resource development
- Need to strengthen capacity of public health nurses not only for clinical aspects but also management decision-making in the integrated care.
- Positive mind-set among care providers contributes on elderly people coming back to their normal lives.

Key points of implementation (for Sri Lanka):
- Necessity of training medical and care professionals for elders such as geriatricians, public health nurses, care managers and care givers for providing home-based care services.
- Both technical skills and knowledge and management skills are needed for care management.
- Positive mind-set is needed to encourage and support elders to select how they want to live.

Details of Framework/infrastructure/human resources

	N
Regional Development/Framework	12
Human resource/Education/Training	11
Resident/elderly care home	7
Nurse/elderly care station	4
Infrastructure/social services in remote area	2

Resident/elderly care home
- Need to identify utilization of care services and provide several kinds of services to respond to the needs and support elderly people to keep their daily lives.
- Need to establish elderly home with hub function containing home-based medicine, nursing services, care services working in 24hrs.

Key points of implementation (for Sri Lanka):
- Hub function including all kinds of elderly services should be established.
- Many kinds of care services should be provided to satisfy elders' needs based on their conditions.
- Consider both quality of services and efficiency of service provision.

Details of Specific medical services/care services

	N
Dementia	13
Care services	5
Oral frail/dental issues	5
Home-based nursing care	3
end-of-life care	3
Geriatric medicine/Home medical care	3
Rehabilitation	2
Disease care services	2
Psychiatric services	2
Emergency system for elders	1

Dementia
- Dementia assessment is effective for care management in community-level.
- Need to consider psychiatric aspects for treatment, care and social participation for both elders and their families.

Care services
- Need to provide continuous care services in community: without any termination.
- Small-scale multi-functional nursing home is effective to provide needs-oriented services and contributes on building community integrated care system.

Details of Specific medical services/care services

	N
Dementia	13
Care services	5
Oral frail/oral function issues	5
Home-based nursing care	3
end-of-life care	3
Geriatric medicine/Home medical care	3
Rehabilitation	2
Disease care services	2
Psychiatric services	2
Emergency system for elders	1

Oral frail
- Appropriate oral care contributes on reducing duration of hospitalization, incidence of pneumonia and prevention of additional cause of diseases.
- Important to strengthen coordination between medical and dental services and include dental care specialists into multi-sectoral coordination.
- Important to encourage dental care specialists to join regional care meeting to participate in the regional integrated care system.

End-of life care
- Need multi-sectoral cooperation and phycological approach for both elders, families and nurses/care givers.
- Effective to provide training opportunity for experts providing community care services and families of elders.

Details of Specific medical services/care services

	N
Dementia	13
Care services	5
Oral frail/oral function issues	5
Home-based nursing care	3
end-of-life care	3
Geriatric medicine/Home medical care	3
Rehabilitation	2
Disease care services	2
Psychiatric services	2
Emergency system for elders	1

Home-based medical care/geriatric medicine

- Need to train doctors who can provide home-based medicine and care/family doctors.
- Need to establish one-stop elderly services including home-based medicine and care.

Rehabilitation:

- Current training curriculum: mainly acute rehabilitation, not enough for daily rehabilitation/community-based rehabilitation. Need to strengthen education of community-based rehabilitation, too.

Details of Specific medical services/care services

	N
Dementia	13
Care services	5
Oral frail/oral function issues	5
Home-based nursing care	3
end-of-life care	3
Geriatric medicine/Home medical care	3
Rehabilitation	2
Disease care services	2
Psychiatric services	2
Emergency system for elders	1

Psychiatric service:

- Important for psychiatric approaches not only for patients and their families but also all kinds of service providers for smooth coordination of multi-sectoral cooperation.

Disease care services 1: Heart Failure

- Disease control of heart failure: Establishing "health promotion center" as comprehensive disease prevention and control center in community.

Disease care services 2: COPD

- Continuous and integrated support system for patients with COPD in community

Others

	N
Respite care/family support	7
Overview	5
Infection/hygiene control	3
Nutrition	2
Disaster control	1

Infection control

- Developed manuals for hygiene and infection management in elderly care home. Will improve the contents after evaluation of the utilization.
- necessary to provide infection control training for medical professionals and care providers.

Nutrition

- Repeating hospitalization and discharge may be a risk factor of bad nutritional condition – importance of nutritional management during hospitalization
- Necessity of unified nutritional information management among health facilities, elderly homes and home-based care.

Disaster management

- Need to establish disaster management system including hospital into the integrated community-care system

Community-based integrated care system for elders

Good practices at municipalities in Japan

Source and Reference: Collection of cases on community-based integrated care system
https://www.mhlw.go.jp/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/chiiki-houkatsu/dl/jirei.pdf
Ministry of Health, Labour and Welfare

Long-term Care Services

Kakegawa City, Shizuoka Prefecture

Establishment of a system for comprehensive home care through multidisciplinary cooperation

Population: 118,922
% of pop. ≧ 65yrs: 22.6%
Medium and small city

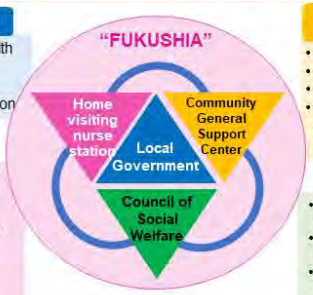
Background Since the citizens desired medical care and nursing care at home, it was necessary to establish a Community-based Integrated Care System that focuses more on the life in the community and not only on the elderly. In order for all the citizens to live to the end of their lives in environments familiar to them, Kakegawa City worked on the development of a community health and medical care support center, "FUKUSHIA", which would serve as a community base and general consultation counter for supporting comprehensive home care including medicine, health, welfare, and nursing care.

Activities

- Kakegawa City established the system which set up local government, Community General Support Center, Council of Social Welfare, Home Visiting Nursing Station in a same facility
- Kakegawa City promotes the community-based integrated care system which combines formal service and informal service using the network

Local Government
- Assignment of Public Health Nurse and administrator
- General support by multidisciplinary cooperation

Support for home medical care
- collaboration with primary care physicians (PCP), clinic and hospitals
- Promoting end-of-life care at home
- Advocacy to citizens and care giver to provide medical knowledge



Support for home long-term care
- Long-term care prevention
- General consultation
- Protection of rights
- Comprehensive and continuous care management

Daily life support
- watching system in the community
- fostering of a council of social welfare
- Projects related self-reliance support of daily life

Output/ Outcome — **Enabled to respond issues more quickly and prevent cases from becoming severe**

The "FUKUSHIA" system has made easier collaboration among the organizations by arranging multiple organizations at a single floor, which also made it possible to approach difficult cases (financial and psychological support, risk of abuse, etc.) from multiple perspectives, such as elderly people living with unemployed children and disabled people who were not certified as recipients of governmental support but need support.

Collaboration between Medical care and Long-term care

Tsuruoka City, Yamagata Prefecture

Promoting Collaboration between Medical care and Long-term care by Medical Association Team's utilization of ICT

Population: 135,403
% of pop. ≧ 65yrs: 29.6%
Medium and small city

Background A number of care manager who coordinate services of long-term care in community voiced their dissatisfaction about collaboration with medical care, saying that they could not get the information from nurses and others of hospitals, hospital related personnel could not understand the actual situation of long-term care in community, and could not take the time to consult with us even if it was necessary. These were the turning point to lead to the promotion of collaboration between medical care and long-term care.

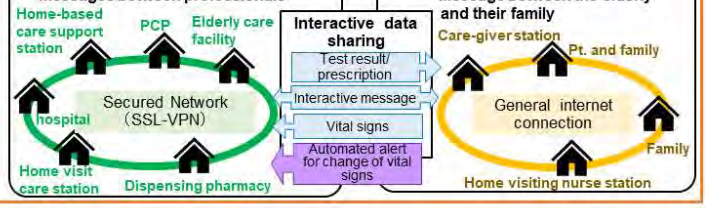
Activities

Establishment of Information Sharing System by Medical Association Team's utilization of ICT

- **Net4U**: Tool of sharing information of patients for both medical and long-term care staff
- **Note4U**: Tool of sharing information and communication for the elderly and their family with professionals

[Net4U]
- **medical information:** diagnosis, findings, prescription, treatment, test results etc.
- **documentation template**
- **electric data and image**
- **messages between professionals**

[Note4U] - **message**: medical information, care diary, message
- **Vital signs:** Wt, BP, BS etc
- **Other information:** dietary intake etc.
- **Photo library**
- **Message between the elderly and their family**



Output/ Outcome — **Strengthened collaboration between Medical and Long-term care, actioned timely**

- Both medical and long-term care providers have gained a mutual understanding of each other's positions and duties, which has facilitated cooperation between them.
- By shortening the time required for information sharing, doctors and nursing care facilities can share information in both directions, enabling them to respond appropriately to patients.

Collaboration between Medical care and Long-term care

Yusuhara Town, Kochi Prefecture
Collaboration of medical, health and long-term care by establishing a hospital with health and welfare support center

Population: 3,750
% of pop. ≧65yrs: 41.8%
Rural village

Background Yusuhara Town has a history of becoming a no-doctor district in 1971 and experienced difficulties in securing doctors. During the era that main issues of health sector were infectious diseases and MCH issues in early of the 20th century, it experienced establishing a sanitation association to improve the sanitary environment of residences. The residents desire to secure doctors, to prevent disease, and to ensure health promotion was consistent with the government's one, Yusuhara Town enhanced the collaboration of the hospital and health and welfare facilities cooperating with the residents.

Activities

- ●Coordination of medical, health, welfare, and nursing care through the establishment of Yusuhara Hospital and the Yusuhara Health and Welfare
- ●Support Center Promotion of regional health and welfare in collaboration with residents
- ●Conduct community care meetings and care plan meetings.
- ●Implementation of comprehensive measures for all stages of life, from the inside of the belly to the elderly.

Output/ Outcome **Health checkup coverage is 73% through supports by health promotion volunteer**

- The integration of the hospital and the administrative building has promoted information sharing and cooperation among related parties, and improved the level of staff satisfaction
- .By integrating the hospital and administrative buildings, information sharing and cooperation among related parties were promoted, and staff satisfaction was improved.
- Information sharing and detailed support were promoted through the implementation of community care / care plan meetings.

Housing

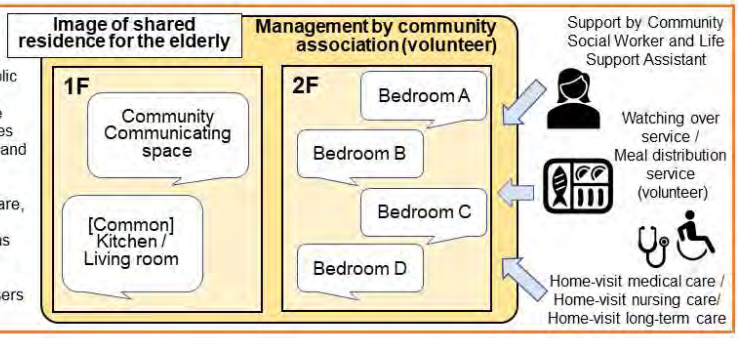
Nanbu Town, Tottori Prefecture
Secure housing for low-income people through Shared residence using existing resources.

Population: 11,568
% of pop. ≧65yrs: 31.1%
Medium and small city

Background There were the issues related housing for the elderly such as; 1) With the aging of the generation whose family member is a few, the number of elderly people who live alone or tend to stay indoors has been increasing, and 2) there were the a few residences such as special care facility and long-term care facility in the town for the elderly who needs home care, and there was a lack of residences for the people with minor illnesses or low income. Against these issues, the residents and local government jointly started the project securing these residences and the place to communicate for the elderly.

Activities

- ●Renovation of existing private houses and public facilities, etc.
- ●Local residents provide daily life support services such as watching over and distributing meals as necessary.
- ●Medical and nursing care, and long-term care services are provided as visit-home services as necessary.
- ●Keep the burden on users as low as possible.



Output/ Outcome **The residence having the advantages of both "home care" and "facility care"**

- By renting and renovating vacant houses, labor and rent costs reduced and set fees that are accessible to low-income people. It makes easier for pensioners to use the facilities. The community communication space gives a sense of security to those who live alone.
- Life supports such as nursing services, meal distribution and watching over services by volunteers are provided as needed.

Housing

Sakaiminatoshi City / Yonago City, Tottori Prefecture
Expansion of the function of special care facility into the community

Population: 36,004
% of pop. ≧65yrs: 27.4%
Medium and small city

Background In the past, long-term care service facilities were not located in areas where many of the elderly had been lived, which made it difficult to take a comprehensive activity for all the community residence including the elderly. In addition, since there was a lack of social resources in the community, the elderly needed the services in the wider community area.

Activities

- ●Establishing a base of care in the place where many of the elderly can easily access
- ●Expanding the functions of special care facility into the community
- ●How to effectively implement the above initiatives
  - • Consider the development of leaders of the younger generation.
  - • Intergenerational communication and collaboration with local social resources
  - • Promote support for not only the elderly, but also the needy

Output/ Outcome

Strengthen communication between local residents and elderly care facilities, created an environment of cooperation in the community.

- The care facility is located to the community residents, such as near school, which make the residents work together with the facility
- Increased communication between generations
- Enable care provider to provide continuous support at the elderly's home, and to support elderly people living in the community.
- All organizations / facilities in the community are involved in understanding the needs of the community

Life support

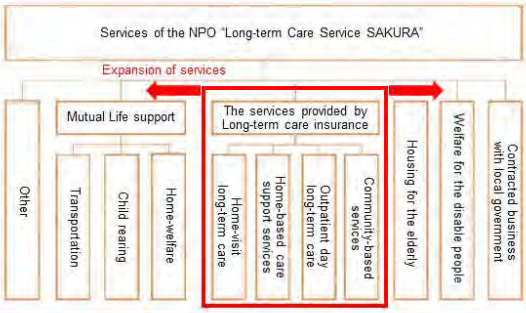
Nagoya City, Aichi Prefecture
Efforts by NPOs to provide livelihood support services with the participation of residents

Population: 2,247,645
% of pop. ≧65yrs: 22.3%
Three metropolitan areas

Background Nagoya City has about 80,000 elderly people who need support and care, and the City developed "Medium-term Strategic Vision" which includes the following measures; 1) support for elderly people who need nursing care to live in their own communities, 2) support for elderly people who have difficulty in living at home, and 3) improvement of long-term care services. Against this background, the NPO "Long-term Care Service SAKURA" was established with the basic principles of "helping, learning, and raising up each other", and has developed into a wide range of services for the elderly.

Activities

- ●The informal services which local resident support are the basic concept of the service.
- ●It is important for people to be willing to help others even when they are 70 years old, and the NPO established a mechanism matching these people with the others' needs. It is important to be aware that the way local residents are involved differs depending on the characteristics of each district.
- ●For sustainability of its projects as the NPO, try to stabilize its management.
- ●By understanding each other's characteristics, both the NPO and local government, and collaborating and cooperating, their activities are enhanced more.



Output/ Outcome

From "support given" to "participation in support" through community participation

- Awareness of going out and social participation of the elderly has been promoted.
- Safety and lifestyle support services are provided to the elderly people in the community.
- Enabled the elderly to maintain their lives in their familiar communities
- Develop a community where the elderly can continue to live with peace of mind.

Life support

Doshi Village, Yamanashi Prefecture

Watching over, supporting shopping, and creating a place to communicate in a mountaintious village

Population: 1,903
% of pop. ≧ 65yrs: 30.1%
Rural village

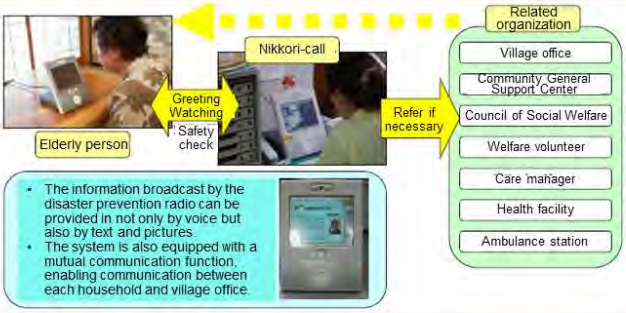
Background The villages are scattered in the long and narrow mountains. The population is aging, and 34% of the households are single, married couples, or parents and children. In addition, 18.2% of the residents live in villas, and most of them are single or elderly couple households. Some people feel burdened by socializing with their neighbors, and the function of mutual aid that the community used to have is declining. In response to a call from the local government, residents identified issues in their village and discussed what they could do to solve them.

Activities

●**NIKKORI (smiling) CALL:**
A system to watch over the elderly in the community was developed.
[Village /Prefecture/ Central government] budgetary support for operator personnel costs

●**Shopping tour:**
Monthly Operation of a microbus for shopping support.
[Village] budgetary support of driver's fee and volunteer insurance, free rental of village bus

●**Community tearoom :**
Creating a place for residents to communicate.



Output/ Outcome **Strengthen the watching system for the elderly and long-term care prevention in the village**

- NIKKORI CALL: Strengthened the system for watching over the elderly and provide appropriate services as necessary
- Shopping tours: Regular outings activities for elderly people makes the effect to prevent long-term care more, and increase the enjoyment and motivation of volunteers.
- Community tearoom: By providing a room of individual home as a place of tearoom, which makes social participation easier, and it leads to the prevention of long-term care for the elderly who do not participate in various activities in the community.

Long-term care prevention

Tone Town, Ibaraki Prefecture

Promotion of resident-centered long-term care prevention projects and dementia countermeasures

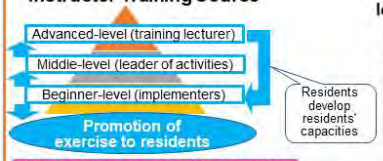
Population: 17,481
% of pop. ≧ 65yrs: 32.4%
Medium and small city

Background Tone Town had participated to the research which includes the exercise for dementia patients, conducted by the local national university since 2001. In connection to the activities by prefectural government and town government, the town started training for the elderly volunteers to develop the exercise instructors, and the instructors established the "Rehabilitation exercise elderly instructors' Association" in 2005. They have held exercise classes at the elderly clubs continuously.

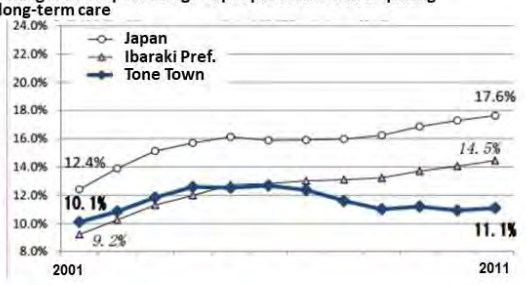
Activities

●Established exercise classes for the elderly at a community center etc as voluntary activity. (Held 2-4 times a month at 13 locations in the town)

● **Rehabilitation Exercise Elderly Instructor Training Course**



Changes in the percentage of people certified as requiring long-term care

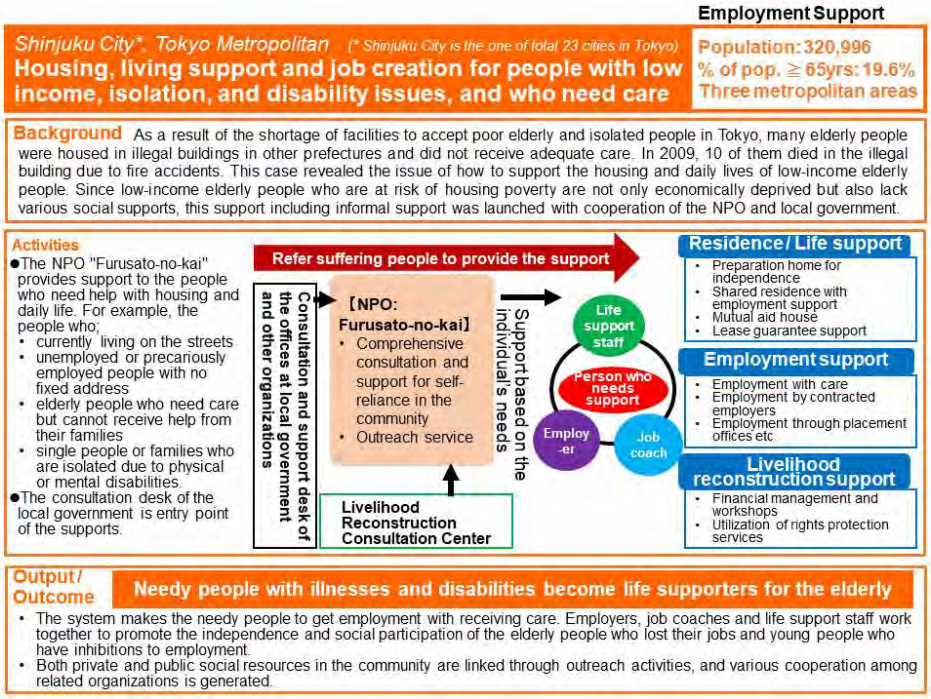


Involvement of professionals

- **Public Health Nurse**
  Utilize the town newsletter to spread awareness
  Encourage those who need participation in the exercises
- **Doctors in public clinic**
  Encouraging outpatients at clinics to participate in gymnastics and supporting the activities of instructors

Output/ Outcome **Long-term care prevention is promoted through the support to the elderly by the elderly**

- It is a great opportunity for the elderly to have fun and to take social participation.
- In Ibaraki Prefecture, municipalities with a larger number of Elder Rehabilitation Exercise Instructors have a lower rate of people requiring minor long-term care.
- The "FURI-FURI-Gripper Exercise", which activates muscles, conducted with the national university has been proven to increase blood circulation and activate the brain.



Use of good practice in Sri Lanka

1. Multi-sectoral coordination / Interprofessional work

Major contents and key factors written in the articles:

- Interprofessional work is crucial for community-based integrated care system and interprofessional education is key for realization of better coordination.
- Need to reduce discrepancy of recognition among health and social welfare and connect them.
- Important to make face-to-face relationship among staff of health, social welfare and other relevant experts.
- Need networking between medical service providers and social care service providers.

Key points of implementation:

- Multi-sectoral alignment and coordination are crucial
- Building of a network and information sharing about elderly people

Good practice in Japanese municipalities : Kakegawa City, Shizuoka Prefecture
Establishment of a system for comprehensive home care through multidisciplinary cooperation

Multi-sectoral life support center "Fukushia" was developed and has worked for smoother interprofessional-coordination


Multi-sectors such as health, social welfare and childcare work at the at the same floor


Multi-sectoral coordination


Outreach support in community


Multi-sectoral approach in providing service


Emphasis on prevention

Photos: https://www.city.kakegawa.shizuoka.jp/gyosei/docs/9832.html

Use of good practice in Sri Lanka
2. Social participants / Care prevention

Major contents and key factors written in the articles:

[Social participation]
- Provide opportunity of social participation for elders and persons in community.
- Provide learning opportunity for elderly persons including dementia patients

[Care prevention]
- Sport activities are effective for reducing isolation and care prevention.
- Regional intervention to give opportunity of sport activities will contribute on healthy life among elderly persons.
- Care for prevention by oral rehabilitation

Key points of implementation:
- Flexibility is needed based on elders' needs and feasibility of maintenance/operation.
- Urban area: need framework to link supporters and elderly people, especially persons to be isolated from society.
- Important to make opportunity of sports activities and exercise.

Good practice in Japanese municipalities: Tone Town, Ibaraki Prefectures
Promotion of resident-centered long-term care prevention projects and dementia countermeasures

The elderly works as volunteers to provides exercise class for care prevention in their communities weekly.



Exercise classes;
1) to make the daily life activities easy,
2) to build up and maintain physical strength
3) To prevent aspiration [oral exercise]

Photos: http://www.town.tone.ibaraki.jp/page/page000901.html

Use of good practice in Sri Lanka
3. Resident/volunteer participation

Major contents and key factors written in the articles:
- Volunteers contribute on checking elders living safely and identifying needs for support their lives by periodical visit and discussion.
- Important to communicate between regional volunteers and care managers/nurses.
- Single, male, person with small network with neighbors tend to be difficult to reach social support for daily life.

Key points of implementation:
- Multi-sectoral alignment and coordination are crucial
- Building of a network and information sharing about elderly people

Good practice in Japanese municipalities: Nagoya City, Aichi Prefecture
Efforts by NPOs to provide livelihood support services with the participation of residents

- Residents registered as volunteers to the coordination body such as NPO and cooperative society etc, and the coordination body dispatch the volunteers according to the elderly's needs.
- Volunteers provide informal service for livelihood support for a fee, such as laundry, house-cleaning, meals serving.


service of transfer (NPO Sakura)

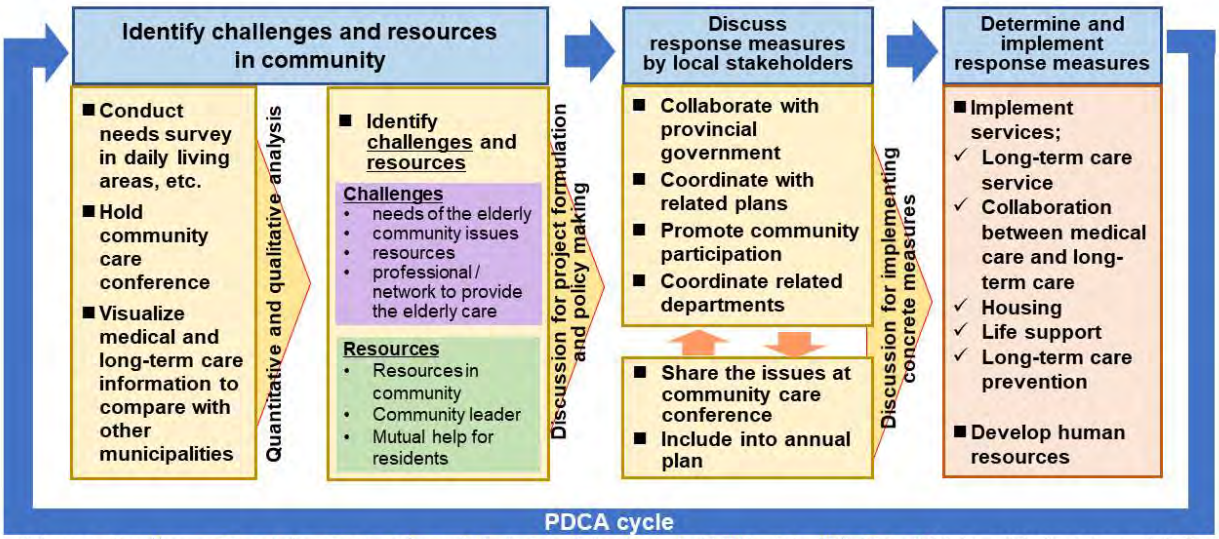
Not only in Aichi, but also in the other prefectures, volunteers provide similar livelihood services.



services of livelihood supports (Cooperative society of Iwate)

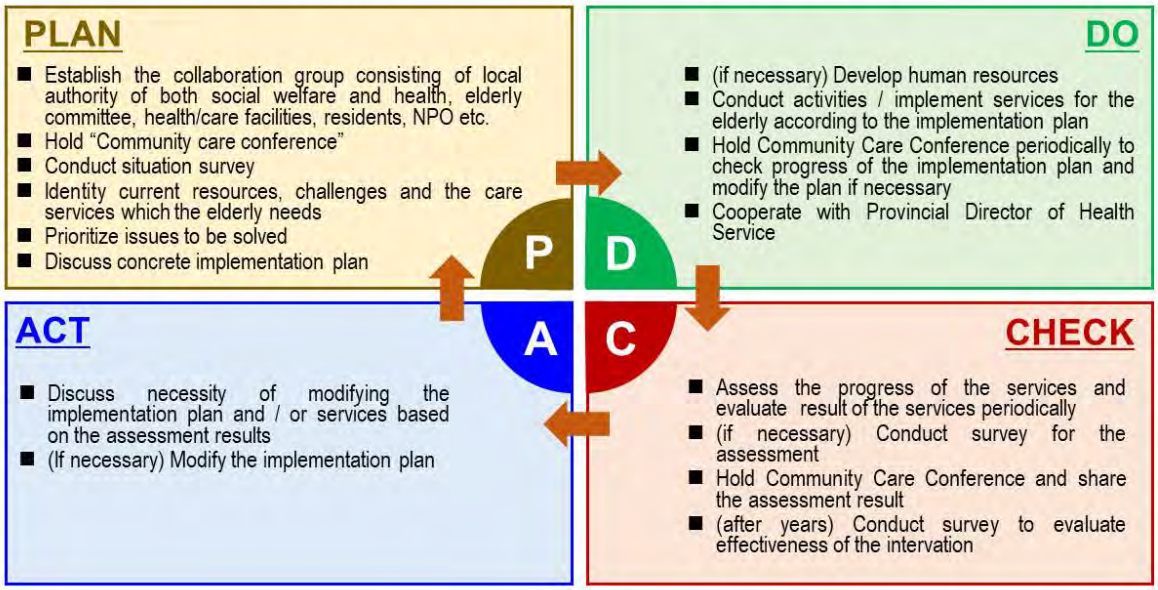
Photos: https://www.kaigo-sakura.com/support/index.html, https://www.iwate.coop/member/tasukeai/shien-wks.html

Process of establishing "Community-based integrated care system for elders" in municipalities in Japan



Reference: https://www.mhlw.go.jp/seisakunitsuite/bunya/hukushi_kaigo/kaigo_koureisha/chiiki-houkatsu/dl/link1-6.pdf (Ministry of Health, Labour and Welfare)

How to implement "Community-based integrated care" in Sri Lanka



Technical Intern Training Program

Technical Intern Training Program is aiming to transfer skills / knowledge accumulated in Japan to developing regions

Legal Framework and its Purpose

Legal Framework

- The Act on Proper Technical Intern Training and Protection of Technical Intern Trainees was promulgated on November 28, 2016 and came into effect on November 1, 2017.

The Purpose

- To transfer skills, technologies, or knowledge accumulated in Japan to developing and other regions and to promote international cooperation by contributing to the development of human resources who can play roles in the economic development of those developing regions.

Outline

The outline of technical intern training program as of the end of Dec, 2020 as follows;

- Establishment of Organization for Technical Intern Training
- System of accreditation for technical intern training plans.
- Notification system for implementing organizations
- Licensing system for supervising organizations
- Protection of technical interns
- Accreditation of Sending Organizations by Sending Countries

1

In addition to trainees and enterprises, sending organizations and supervising organizations are part of the program

Procedures and Qualification

The procedures for accepting trainees

Individual enterprise type	Supervising organization type
Enterprises in Japan accept employees of overseas local subsidiaries, and conduct technical intern training.	NPOs (supervising organizations) accept technical intern trainees for technical intern training at affiliated enterprises

The qualification of trainees

The requirements for a person to enter Japan as a technical intern trainee includes;

- plan after returning home: to engage in works needing skills acquired in Japan
- Japanese language: N4 level when entering Japan, and N3 level in a year

Process

The processes before entering Japan are as follows;

	Sending organizations / Trainees	Enterprises
1		affiliation with supervising organization(s) and application for accepting
2	Recruiting and preliminary review by sending organizations	
3	Interviews and matching (conclusion of job contract)	
4	Lecture implementation including Japanese test by sending organizations	

2

Many trainees are struggling with Japanese language, which leads to limitation of the scope of work

Issues during lecture period

Issues from trainees' view point

- Around 50% of trainees reply that they have difficulties in studying Japanese language
- Most trainees do not have difficulties in daily conversation, but some have problems in Japanese for work.

Issues from enterprises' view point

- 68% of the enterprises reply that they see assistance of trainees in learning Japanese for caregiving as an important support for trainees.
- However, some enterprises have difficulties in providing such assistance because they are not specialist of Japanese language teaching.

Impact due to the issues

Negative impact by Japanese skills

- Japanese language skills limit the scope of work that trainees are able to do and learn.
- A study shows that Indonesian trainees need 3 months longer period than Japanese to learn caregiving skills on average.

Issues from enterprises' view point

- Many enterprises hope for improvement of Japanese language teaching before entering Japan.
- 78% of enterprises reply that the most important factor when recruiting is Japanese skills.

3

Foreign trainees apply for the program to get skills and money and Japanese enterprises value their work

Intension of enterprises

Enterprises' view

- Generally enterprises highly value trainees in quality of caregiving service and have intention to keep accepting new trainees.
- The main reason of accepting trainees is shortages of human resources.

Case study :
an enterprise that accept trainees from Sri Lanka

- The reason of choosing Sri Lanka: the enterprise feels safe in that the sending organization is owned by the government.
- The assessment for the Sri Lankan trainees: the enterprise highly value them, saying they are talented and diligent in their work

Merits and issues for trainees

Why trainees chose caregiver in Japan

- The main reason for choosing elder care in Japan is that they want to learn Japanese caregiving skills. At the sometime, making money is also important objective for them.
- As a whole, they are satisfied with the work experience in Japan.

Case study :
a trainee from Sri Lanka

- It was not easy to get a job opportunity in Japan. After knowing the program and considering job type, I had decided to go for elder care.
- I was surprised by excellent care facilities, which I had never seen before in Sri Lanka.
- As for career path after returning to Sri Lanka, I am hoping to start a business selling Japanese elder care products

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Some measures have to be taken to make full use of Technical Intern Training Program

	Issues	Possible measures
trainees	When the main purpose is earning, they are at risks of low motivation in learning caregiving skills	Explain fully the propose of the program and encourage those who agree to the purpose to apply for the program.
	There are few jobs that trainees are able to make use of skills acquired in Japan after returning to Sri Lanka.	Cooperate with private enterprises in Sri Lanka for job placement / Encourage the entry of Japanese enterprises into the market
	Difficult for trainees to focus on learning caregiving skills due to poor Japanese skills	Cooperate with existing organizations and promote new entry to improve Japanese language training
	There are less access to opportunities due to low interest of Japanese enterprises in Sri Lanka	Hold briefing sessions in Japan to increase the interests / improve Japanese training to enhance the attractiveness of Sri Lankan
enterprises	Japanese enterprises do not know much about Sri Lanka and Sri Lankan	Hold briefing sessions on Sri Lanka and Sri Lankan in Japan / cooperate with supervising organizations that know well about Sri Lanka
	Japanese enterprises hope for trainees with basic skills of Japanese language and caregiving	Improve training of Japanese language and caregiving before entering Japan to enhance the attractiveness of Sri Lankan

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