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National Strategic Framework For Development of Health Services 2016 - 2025

Ministry of Health - Sri Lanka

Message from Hon. Minister of Health, Nutrition and Indigenous Medicine

Good health is central to human happiness and well-being, and also makes an important contribution to economic progress of an individual, or a country as a whole. Sri Lanka can be proud of the success it has achieved so far in its Health Sector, through careful planning and efficient execution of programmes.

However, when I took office early last year I was dismayed to note that the then ongoing Health Sector Master Plan was to lapse in December 2015, with no new Plan in the pipe line, which made me to go ahead in developing an updated Health Policy and a Health Strategic Master Plan as a top priority. This was of prime importance to implement the developmental programmes of the government of Good Governance, which laid much emphasis on health sector development and welfare of the people.

A new Plan was necessary also due to the changing landscape of health care financing and delivery in the country due to life style changes and emerging environmental issues and accompanying health sector needs. I have no doubt that with proper planning and investment in both infrastructure and health personnel Sri Lanka has the potential to develop a health system comparable to the standards comparable to those in developed countries .

I am pleased to note that in spite of their heavy official commitments, the Director General of Health Services and the team of Ministry officials assigned for the task has come up with the Health Master Plan for the period 2016 - 2025 with in a relatively short period. I also wish to convey my sincere thanks to all the health professionals who contributed for this compilation .

Furthermore, the valuable comments/ observations / recommendations made by the professional Colleges and Associations, Provincial Ministries of Health and Health sector Trade Unions are much appreciated. I sincerely look forward to the full commitment and dedication of all the officials of the Ministry of Health as well as health officials in the Provincial Health Services to achieve the expected Health Outcomes in the Master Plan 2016-2025, with the view to improving Health care delivery to our people.

Dr Rajitha Senaratne
Minister of Health, Nutrition & Indigenous Medicine

Message from the Secretary of the Ministry of Health , Nutrition & Indigenous Medicine

Ministry of Health , Nutrition & Indigenous Medicine is responsible , to safeguard the status of Health of all citizens of Sri Lanka . Therefore a considerable amount from the national budget is allocated by the Government of Sri Lanka , to the Ministry of Health , Nutrition & Indigenous Medicine , to achieve the said objective . Thus it is our duty to utilize those public funds effectively , efficiently and economically to provide better standards of health care throughout the country

As such , it is essential to have a comprehensive Health plan with monitoring tools to make the best use of this massive budget ; and , I am much pleased to note that , the professional of the sector have made a collective and collaborative effort to produce a comprehensive Health Master Plan for ten years (2016 - 2025)

I hope the deficiencies of the previous health master plan will be corrected by the newly prepared Health Master Plan (2016 - 2025) As the proposals have been prepared by the relevant Programme Directors and the Consultants attached to those subjects , the ownership of the plan is correctly vested on the programmes itself . I feel that this is a crucial decision taken by the Ministry to establish sustainability and continuation of the Health Master Plan throughout the next ten year period .

As the indicators and the verifiable means have been identified for all proposals in the Health Master Plan 2016 - 2025 , it is essential to monitor the outcomes . A continued mechanism of Monitoring & Evaluation has to be linked to this Health Master Plan 2016 - 2025 , to achieve the expected health outcomes and justify the utilization of massive amount of public funds . Duplication to be avoided and allocative efficiency should be practiced at each step of translating strategies to activities

Finally I have to endorse that , it is the first and foremost duty of all officials in the Health sector to be adherent to this plan throughout the specified ten year period (2016 - 2025) and achieve the time targets specified in it , to offer best health services to the Sri Lankan nation.

Anura Jayawickrama

Secretary

Ministry of Health , Nutrition & Indigenous Medicine

Message from the Director General of Health Services

Firstly I would like to place on record , my sincere thanks to my team of professionals , the members of National Steering Committee on Health Master Plan (all Deputy Director Generals), the Programme Directors and Consultants attached to relevant subjects , for their tireless work , (despite having to cope with tremendous work load in daily duties) which made the dream of a comprehensive ten year (2016 - 2025) Health Master Plan , a success and a reality .

As the Department of National Planning recommended , the team of professionals involved in the preparation of Health Master Plan , essentially comprised of local experts only , and the National Steering Committee on Health Master Plan , at the first meeting , decided to utilize only the Programme Directors and the Consultants attached at present to the Health Services as the experts responsible for the preparation of relevant proposals . This decision has given a great stimulus to the key officers in all Programms and I find that they have produced excellent proposals for the next ten year Health Master Plan (2016 - 2025). I also acknowledge very specially the collaborative efforts and expert contribution made by all Professional Colleges and Associations , at my request , to make this plan to cover all specialties of Medical Sciences . Although the Preventive sector is well represented in the organogram of the Ministry of Health , the Curative and Rehabilitative sectors need developments . The proposals of Clinical Professions were able to cover the said gap in Health Master Plan , accordingly I have decided to have separate plans for each major task , (as separate plan documents for Preventive Health Services , Curative care and Rehabilitation) This Health Master Plan (2016 - 2025) has been submitted for Public Opinion , Provincial Ministries of Health Services and Trade Unions as well . I am much thankful to all of them for sending valuable suggestions to improve services on various aspects . At last , but not the least , the excellent coordinating of the activity and drafting of this ten year (2016 - 2025) Health Strategic Master Plan was undertaken by the focal point appointed by me for this activity . Dr D. A. B. Dangalla (Director - Policy Analysis & Development and , Acting Senior Assistant Secretary (Medical Services) functioned as the focal point , with his staff , devoted many months to accomplish the given task . I highly appreciate the degree of dedication of Dr Dangalla and his staff , towards the completion of this activity .

It is my advice to all of my officials (as we own the plan as we wrote the proposals) to adhere to the plan throughout the said ten year period and implement all strategies designed by you all , with a rigid mechanism of monitoring and evaluation of time bound targets . to make our health services comparable to Developed Countries .

Dr P. G. Mahipala
Director General of Health Services

Background

As the present Health Policy was prepared in 1996 and , now ; after 20 years it has to be replaced with an updated policy . There are many reasons justifying the preparation of a new health policy ; such as the following - Health issues which were not addressed with the present health policy , have to be tackled with new and different strategies . Newly emerged health issues have to be addressed with a new health policy . After the internal civil war , Sri Lanka can look forward to stability and increased investment in health . The country has the potential to develop a health system on par with the best in the world . But a change is needed ; to reduce inequity , to improve quality , to develop a health system which can respond to the needs and expectations of the new generation

The present health master plan was prepared in 2004 with JICA assistance and it is scheduled to be terminated at the end of 2015 Thus a new health master plan has to be prepared for the next decade starting from 2016 , and the need for a new health master plan is timely as explained below .

Some of the key subjects , which have become priority health issues in the present context , had not been included in previous JICA Health Master Plan (2005 - 2015) Eg . Renal Diseases , Estate Health , Nutrition , etc . Although the Preventive sector had been covered extensively by JICA HMP , the Curative service component had not been sufficiently addressed to the expectations of clinicians . With the demands of patients for better services , (Stroke centres , Cath Labs , Cataract Surgery , Waiting for Bypass Surgery) an extensive analysis of issues , is essential to design strategies . Certain indicators of Health have become stagnant and new approaches are required for further improvements in those sectors

Accordingly , a new health policy , a new strategic framework to develop health services ; and incorporating the new policy and strategic framework , a new Health Master Plan ; are needed for the country .

Simultaneously it is essential to design the goals and the expected Health Outcomes of this Health Master Plan .

Thus it was decided by the Ministry of Health , that the expected outcome would be a people centred health system which is sensitive to the needs and expectations of the patients / people .

The best tool to ascertain the patient factors , is the concept of universal coverage ; a conceptual model which can be summarized as (a) Equity of distribution of services to all patients living in all areas of the country (b) Accessibility to health facilities by each and every patient (c) quality of service provided to each patient , and (d) Financial Protection of all patients

The processing of Health Master Plan was initiated with the establishment of National Steering Committee on Health Policy & Master Plan . The National Steering Committee on Health Policy & Master Plan comprised of DGHS (As Chairman) and the Deputy Director Generals of the Ministry of Health . Dr D.A.B.Dangalla (Director - Policy Analysis & Development and acting Senior Assistant Secretary - Medical Services) was appointed as the secretary to NSC and to function as the focal point for the preparation of Health Master Plan 2016 - 2025 .

At the first meeting of National Steering Committee (NSC - December 2014) it was decided to appoint all programme Directors and the Consultants to prepare the proposal for the relevant programme and respective deputy director generals to function as co-chair to the working groups . Terms of Reference (TOR) for the preparation of programme profiles , were approved by the NSC . Formats for preparation of strategic framework and programme profiles were also identified at said meeting of NSC

The format for the strategic framework was designed from the Reference document titled - Shri Lanka National Health Policy - 1992 (Prof Erl Fonseka , et.al) The said document has analyzed all sub sectors of health in a uniform matrix which contained a brief situational analysis of the sub sectors , followed by several policy measures . Therefore in the preparation of this Health Master plan , the situational analysis section was attached each of the programme profiles . But in the preparation of strategic framework (2016 - 2025) the health problems were listed with strategies designed to over come the issues (Instead of listing policy measures as in 1992 , the present Strategic framework (2016 - 2025) has extended beyond , to the level of designing strategies) A new feature has also been added to link the strategies to achieve the Sustainable Development Goals (Where we should be in 2030)

The format for the preparation of programme profiles (attached) has been adopted from the JICA Health Master Plan (2005 - 2015) As it was a complex document , not referred as expected by many officials during later years . To avoid

similar situation occurring once again , the format was deliberately simplified to contain the essentials but made more practical and user friendly manner ; and new sections are also added to justify the proposal eg . Situation and Problem Analysis in detail with the proposal for each programme .

A new tool has also been introduced (attached) for the Gap Analysis according to the concept of Universal Health Coverage - UHC . (to direct all proposals towards UHC) This new tool was approved by the NSC at the second meeting held in February 2015 .

At the third meeting of NSC (May 2015) it was decided to obtain external technical assistance , as there are no local experts for the following subjects (Disease Burden Studies , Elderly Care , Home based Care , Health Technology Assessment , Human Resources for Health - HRH , Health Economics and Regulating Private Health Sector) The suitable foreign experts shall have both academic qualifications (Post Graduate qualifications) and experience in employment of the relevant subject in other countries . This proposal has been approved by the Department of National Planning and forwarded to the Department of External Resources to seek foreign Technical expertise of aforementioned subjects .

At the fourth meeting of NSC (October 2015) the following areas were noted . Although the Preventive Health Services had been covered extensively by many proposals , the Curative Care sector proposals were inadequate . The said deficiency of not representing the curative care sector adequately at the Ministry level , has been a longstanding issue .(please refer to section on Reforms / Curative Division in pages 77 - 97 , in Vol IV of Health Master Plan / Health Administration & HRH) Therefore , as the Chairperson of the NSC , the Director General of Health Services invited all the Professional Colleges and Associations , to submit their proposals on Curative & Rehabilitative Services , according to the format designed to prepare programme profiles and to use the UHC gap analysis tool to identify the problems .

The responses from the Professional Associations & Colleges were encouraging ; Received the proposals form the following ;

College of Anesthesiologists of Sri Lanka

Sri Lanka College of Obstetricians & Gynecologists

Sri Lanka College of Microbiologists

Palliative Care Association of Sri Lanka

Neurosurgeons Association of Sri Lanka

College of Ophthalmologists of Sri Lanka

Sri Lanka Association of Oral & Maxillo-facial Surgeons

Sri Lanka Heart Association

College of Medical Administrators of Sri Lanka

Sri Lanka College of Pulmonologists

College of Community Physicians of Sri Lanka

Sri Lanka Association of Urological Surgeons

College of General Practitioners of Sri Lanka

Sri Lanka College of Haematologists

College of Otorhinolaryngologists and Head & Neck Surgeons of Sri Lanka

Sri Lanka College of Venereologists

Association of Plastic Surgeons of Sri Lanka

Sri Lanka College of Endocrinologists

As such the Director General of Health Services instructed the focal point to draft separate volumes of Health Master Plan for each major task area , (I) Preventive Health Services (II) Curative Care (III) Rehabilitative Care (IV) Health Administration & HRH .Many stakeholder meetings were held to prepare proposals , the manuscripts of proposals of each programme were prepared by the respective Programme Director and the Consultants attached to the relevant programme , under the guidance of the respective Deputy Director Generals . For the Preventive Sector , an additional group of Consultant Community Physicians were invited (including Professors in Community Medicine and Provincial Consultant Community Physicians) The final draft of all five documents of Health strategic Master Plan (1 / Strategic Framework for Health Development , 2 / Vol I - HSMP Preventive Health Services , 3 / Vol II - HSMP Curative Care , 4 / Vol - III Rehabilitation Care , 5 / Vol - IV Health Administration & HRH) was prepared by the Director - Policy Analysis & Development (the focal point for preparation of Health Master Plan) with the assistance of the staff of PA & D unit

As an additional procedure to cover the minor specialties , the staff of Policy Analysis & development unit , consulted the senior medical specialists of certain specialties to obtain proposals of those minor specialties . eg Medical Genetics , Stokes & Trauma care , Care of Abused Children , Plastic Surgery , Autism , etc

Several Field Studies have been conducted by the staff of the Policy Analysis & Development unit with regard to situational analysis of certain subject areas (a) Health Services of Plantation Estates , (b) CKDu affected communities in Districts of Anuradhapura and Polonnaruwa , Divisions of Thanamalwila , Sooriyawewa , Buttala , Angunakolapelessa , Sewanagala , Embilipitiya , and Thissamaharamaya (c) Primary Level Curative Services – Divisional Hospitals and Primary Medical Care units - the need for re-structuring (d) under utilization of Healthy Life style clinics - application of management

concepts to improve screening (e) study to identify the issues related to management and availability of medicinal drugs at district level .

Further the data available at the Medical Statistics unit and also the data bases of the individual programmes had been analyzed prior to the formulation of proposals . However most of the analyzed data are presented in the Annual Health Bulletin (AHB) and also in the annual progress reports of each programme , As such data analysis is not presented in this document (to avoid duplication) In the previous Health Master Plan , maps & charts had been presented as a separate document ; but it is not required to attach a similar document to this new Health Master Plan because those items are already available with AHB and annual progress reports of individual programmes .

The previous Health Master Plan had a separate volume to describe the situational Analysis , but its linkage to programme profiles published in another document was not evident . To avoid this type of deficiencies , the new Health Master plan has incorporated the situational analysis in to the main text of programme profile (with indication of references to relevant research publications)

The final draft was submitted to the Department of National Planning , Ministry of National Policies & Economic Affairs , to Provincial Ministries of Health in all nine Provincial Councils (Northern , North Western , North Central , Eastern , Central , Uva . Western , Southern & Sabaragamuwa Provincial Councils) and also to the Trade Unions of the Health Services . Further the Health Strategic Master Plan (2016 - 2025) has been published in the website of the Ministry of Health and advertized in print media of all three languages inviting Public Opinion ; and the relevant comments , suggestions , and recommendations received through the said process have been incorporated to the plan .

The excellent leadership and the technical guidance given by Dr P.G. Mahipala - the Director General of Health Services , was the key factor in completion of this massive task . For the previous Health Master Plan , it is said that JICA had to spent Rs 225 Million , and a foreign company by the name of Pacific International was assigned the preparation of previous Health Master Plan with the contribution of a group of local experts . But the new plan , the National Health Strategic Master Plan 2016 - 2025 was prepared with a cost less than Rupees one million (Funded by the Government of Sri Lanka) The main reason for the production of the new plan at a much lower cost is the dedication of Sri Lankan Experts . The

number of Consultants involved in the preparation of this plan was well above hundred and they offered their services voluntarily and without any additional cost to the government . The Policy Analysis & Development unit would like to place its great appreciation to all of those consultants who offered assistance to prepare the HSMP 2016 - 2025 . It has been said that - Doctors are the voice of the poor , the sick and the dead . This statement has been once again proven by the said team of consultants ; by preparing a master plan for the next ten years to grant better health outcomes to the Sri Lanka nation .

= focal point

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Officials attended the Consultative workshops to prepare the Strategic Framework & Health Master Plan 2016 - 2025

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Director General of Health Services

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Dr Jayasundara Bandara - DDG / Dental Services

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Dr Anil Jasinghe - Director / National Hospital of Sri Lanka

Dr Hemantha Beneragam - Director / Maternal & Child Health

Dr Amal Harsha de Silva - Director / Health Education & Publicity

Dr D.A.B. Dangalla - Director / Policy Analysis & Development , and

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Dr L.B.H. Denuwara - Director / Nutrition

Dr S.R.U.Wimalarathna - Director / Planning

Dr (Ms) Champika Wickramasinghe - Director / Health Information & Actg / Deputy Director General (Non Communicable Disease)

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Dr Anil Dissanayaka - Director / National Blood Transfusion Services

Dr H.D.B.Herath - Director / Anti Malaria Campaign

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Strategic Framework for Development of Health Services

2016 - 2025

Introduction

Sri Lankan Health Sector is in need of a New Health Policy and a new strategic master plan ; the reasons are discussed below .

Why a new Health Policy is required now …..

- The present Health Policy was prepared in 1996 and , now ; after 20 years it has to be replaced with an updated policy
- Health issues which were not able to address with the present health policy , have to be tackled with new and different strategies
- Newly emerged and emerging health issues have to be addressed with a new health policy
- After the internal civil war , Sri Lanka can look forward for stability and increased investment in health , as many new avenues are opening with establishment of peace .
- The country has the potential to develop a health system on a par with the best in the world
- But a change is needed ; to minimize inequity , to improve quality and safety , to develop a health system which can respond to the needs and expectations of the new generation , and to match the demographic changes

Why a new Health Strategic Master Plan is needed now …..

- The present health master plan was prepared in 2004 with JICA assistance and it is scheduled to be terminated at the end of 2015 Thus a new health master plan has to be prepared for the next decade starting from 2016
- Some of the key subjects , which have become priority health issues in the present context , had not been planned in JICA HMP

Eg .Renal Diseases/ Thalasemia/ Estate Health / Health Technology Assessment

Strengthening EmOC services / Health of Disabled / Adolescents' Health / Nutrition

Occupational Health / School Health / Health of people in Urban areas

- Although the Preventive sector had been covered extensively by JICA HMP , the Curative service component had not been attended to the expectations of clinicians
- With the demands of patients for better services , (Stroke centres , Cath Labs , Cataract Surgery , Waiting for Bypass Surgery , Transplant Surgery , Stem cell & Bone marrow , etc) an extensive analysis of issues , is essential to design strategies

Therefore

- A new Health Policy is required
- According to the new health policy ; A new Health Strategic Master Plan is also required
- Therefore , a strategic framework for the new health policy and new health master plan , has to be prepared

Before the preparation of National Strategic Framework for HP & HMP , it is essential to identify the gaps & issues of the existing health system

The basis of Gap analysis

- As the final goal should be , to develop a health system , which is **PEOPLE - CENTRED** , it is essential to identify the needs and expectations of the patients
- A best tool to ascertain the patient factors , is the concept of universal health coverage

- **Universal Health Coverage**
  - **Equity** of distribution of services to all patients
  - **Accessibility** for each patient
  - **Quality** of services provided to each patient
  - **Financial** Protection of the patients

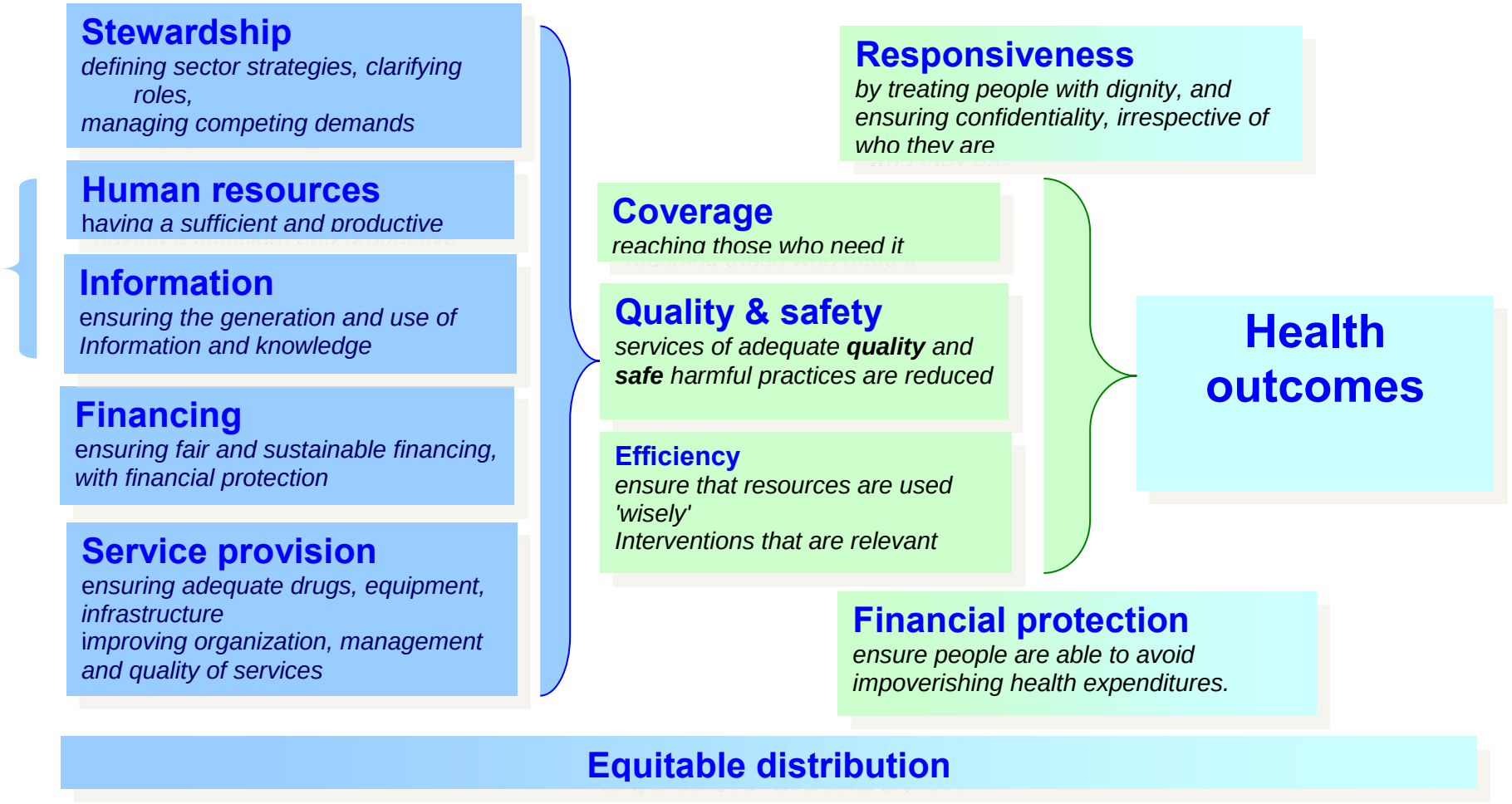
Thus a workshop was conducted to analyze the gaps and identify issues in the Sri Lankan Health sector , and thereafter to develop a National strategic framework to address the identified issues (The next Health Policy 2016 - 2025 , and the Health Master Plan for the said period will be based on this National Strategic Framework)

The present Health system of Sri Lanka comprises of three main divisions (a) Health Administration (b) Preventive Services (c) Curative Services . Considering the demand for services , it has been decided to add a few additional divisions to improve efficiency of the Sri Lankan Health system of 2016 - 2025 . (eg - Rehabilitation Servicers as a separate and new division) Thus in this new national strategic framework the following divisions are separately discussed

- **Health Administration & HRH**
- **Curative Services**
- **Preventive Services**
- **Rehabilitation Services**
- **Health Financing**

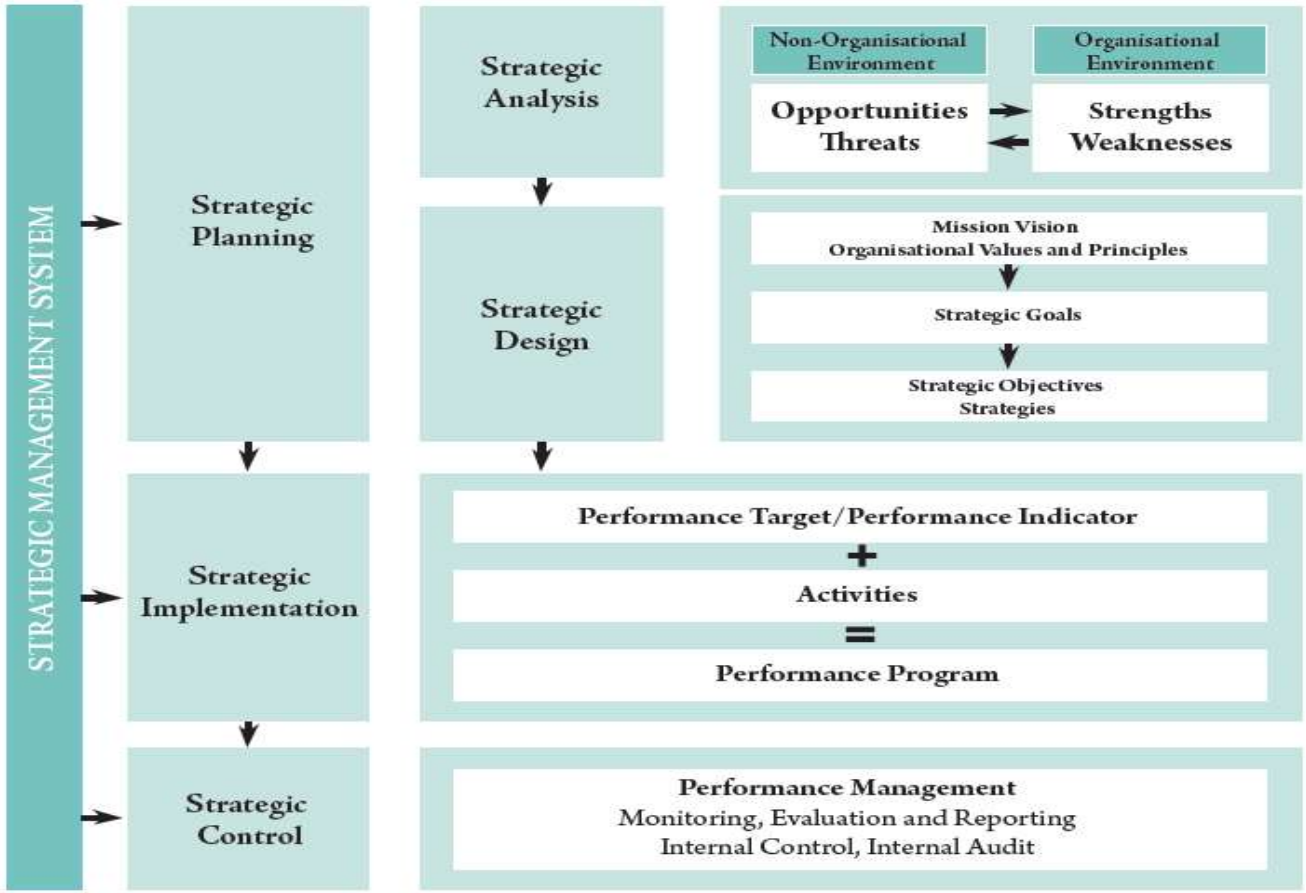
Each of the aforementioned Five Divisions of Health System will be discussed in the pages to follow , under several Thematic areas . The major planning issues which had been identified under each thematic area , are presented with the relevant strategic framework designed to address the said issues . (The relevant programe managers to develop major activities and detailed action plans - which should be presented in the profile of the relevant programme in the next Health Strategic Master Plan)

The aforementioned Five Divisions can be explained in relation to the following model introduced by the World Health Organization



Division of Health Administration includes the functions of Stewardship . Divisions of Curative Care , Preventive Services and Rehabilitative Care , can be grouped under Service Provision . Separate Divisions for Human Resources and Financing have already being identified . Information is a unit which will serve the needs of all Divisions ; Health Administration (Stewardship) , HRH , Financing and Service Provision (Curative , Preventive and Rehabilitation)

Strategic Management System



All the study groups were engaged in Strategic Planning as in above flow chart considering the Strengths , Weaknesses , Opportunities & threats (SWOT) and also the mission vision and values of the MoH

1. Public Health Sector

Thematic Area 1 .1 -**Changing Disease Burden**

No.	Identified Issues	Proposed Strategies/ Activities	Indicators of Sustainable Development Goals - SDG
1.1.1	**Non Communicable Diseases** - 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 (healthy village , healthy market , healthy work place , healthy canteen etc) and strengthen the legal framework Implement Accident & Emergency Care Policy with special emphasis on Pre Hospital care and Post trauma care/rehabilitation Establishment of National CKDu Authority	*SDG indicators* *-Probability of dying between exact ages 30 and 70 from any of cardiovascular disease , cancer , diabetes , chronic respiratory disease , (or suicide)* *-Percentage with hypertension diagnosed and receiving treatment* *-Prevalence of insufficient physical activity* *-Age-standardized (to world population age distribution) prevalence of Diabetes (preferably based on HbA1c) , hypertension , cardiovascular disease , and chronic respiratory disease*

		and implementation of Strategic plan for CKDu prevention and control Incorporate Vision 2020 programe as a Govt unit under DDG (NCD) Establishment of sub units 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 Establish a sustainable back referral system Major behavior changes towards healthy life styles Implementation of Post Trauma component of National Road Safety Policy	*-Road traffic deaths per 100,000 population* *College of Consultant Community Physicians of Sri Lanka - has suggested another indicator = Hypercholesterolemia*
1.1.2.	**Fast pace of life** – injuries, fast food , stress	Establish Health Promotion programs at all levels on selected issues And specific counseling for needy persons	*SDG indicators* *-Prevalence of insufficient physical activity* *-Fraction of calories from added saturated fats and sugar*

			-Age standardized mean population intake of salt (Sodium Chloride)per day in grams in persons aged 18+ yrs *-Prevalence of persons (aged 18+ yrs) consuming less than five total servings (400 grams)of fruits and vegetables per day* *-Percentage of change in per capita (red) meat consumption relative to a 2015 baseline*
1.1.3.	**Nutrition** challenges - double burden - over and under nutrition	Establishment of Nutrition Bureau (incorporating D/Nutrition, D/Nutrition Coordination , Nutrition units of MRI and FHB) which will be headed by DDG / Nutrition , And Implementation of comprehensive and coordinated nutritional plan at all levels (with special emphasis on family level) Reduce obesity among adults to 10% by 2025 Reduce obesity among elderly to 10% by 2025 Reduce under nutrition among adults to 10% by 2025 Reduce under nutrition among elderly to 10% by 2025 Reduce anemia among adults to 10% by 2025 Reduce anemia among elderly to 10% by 2025	*SDG indicators* *-Percentage of population overweight , and obese , including children under 5 yrs* *-Prevalence of under weight children under five years of age (%)* *-Proportion of population below minimum level of dietary energy consumption (%)*

1.1.4.	**Elderly / Ageing Population** - Issues related to ageing of population -Non availability of elderly and disable friendly environment -Lack of awareness on active healthy ageing -Lack of intra and inter sectoral collaboration on elderly care -No specialized service centres or no specialists in elderly care -Lack of proper attitudes among young generation with regards to elders	Establish programmes for Healthy Ageing (creating Public awareness and correcting attitudes of younger generation) Promotion of elderly and disable friendly environment Availability and equitable distribution of Gediatric Specialists	
1.1.5.	**Mental Health** -Depression will be the leading morbidity in 2030 according to Disease burden projection -Increased magnitude of mental diseases (eg Suicide , Dementia) -Inadequate Public awareness on Mental health issues	Gradual expansion of services (system and protocols , cadre and infrastructure Development) Promotion of Mental health in different settings Client friendly services Empowerment of Care givers	*SDG indicator* *-Proportion of persons with a severe mental disorder (psychosis , dipolar affective disorder or moderate-severe depression) who are using services*

	-Mal distribution of Human resources island wide (eg. University Psychiatrists are underutilized) -Deficiency of Councellers , Clinical Psychologists , Psychiatrist Social Workers -Non availability of infrastructure at Provincial level	Prevent social isolation of patients with Minor mental condition, Arrange a proper long term follow up plan depending of the diagnosis	
1.1.6.	**Gender issues** (rights , violence) not addressed	Establish a programe to manage Gender issues in health Effective diagnosis and proper referral system if indicated.	
1.1.7.	Increasing trend for natural **disasters** due to climate changes Increase of man-made disasters	Monitor and ensure Disaster Preparedness at all levels Collaborate with other sectors who do the risk assessment and communicate the public through MOH, PHI, PHM in a effective manner	
1.1.8.	**Socio behavioral challenges** - lack of effective life skill development	Education reform to support life skills for health improvement	
1.1.9	**Suicide**	Background analysis of evidence based data	

	Increase trends in suicides Development of suicidal culture	to identify prevalence of suicides in each area (Registration of Deliberate Self Harm) Identify leading causes of suicide according to statistics Increase awareness on lethal effects and actions of toxic chemicals Behavior Change Communication and counseling of risk groups Identify social issues in the area Start rehabilitationof people with history of previous suicidal attempts . Education about life issues related to suicide , stress handling and communication related to problem solving techniques with high risk groups Establishment of problem solving counseling centres under the guidance of Consultant Psychiatrist and Sociologist Encourage media to discourage suicide Encourage religious priests to arrange programmes to grant harmony to people with social or family problems Obtain the assistance of Divisional Secretary	

		, GramaNiladhari and village leaders to arrange a welfare society to get them involved in social activities	
	Easy access to chemicals and mechanical instruments	Restrict the availability of lethal chemicals to the general public Establish a sales policy for lethal chemicals Train a social worker or family member to observe the behavior of the person at risk Stop storage of excess chemicals in home environment by educating general public	
	Non availability of proper resuscitation facilities at community level	Train social workers or interested parties about first aid techniques and equipment handling Establish proper ETU system in local hospitals . Establish emergency transport access in each area	
	Inefficient treatment facilities in hospitals	Establish Poison Information centres functioning 24 hours in each District Arrange treatment facilities to common	

		chemicals with strict treatment protocols Provide ante dotes to common chemicals . Endo tracheal tubes Oxygen cylinders and instruments to all units dealing with patients of attempted suicide For patients need specialists care , an efficient transport system should be available from local hospital Following clinical management , all patientsshould be referred to the Psychiatric unit	
	No system for rehabilitation	Establish a proper system to register and monitor the treated victims Multi disciplinary rehabilitation approach with Community Physician , Community Psychiatrist , Sociologist , Counselor , Priest and welfare team Proper follow up and monitoring system	
	No data on actual causes and effects	Facilitate Research Promote multi sectoral approach in research	
1.1.10	**Drug abuse** - deficiency of services for quitting and rehabilitation	Develop special multisectoral programme for rehabilitation of persons with drug abuse (	

		with the involvement of Sociologists and Criminologists	
1.1.11	**Alcohol** - Indirect promotion Availability of illicit types of alcohol Danger of school children getting involved Deficiency of rehabilitation services Non availability of quitting facilities	Establish rehabilitation services at district level with facilities for quitting All health promotion programmes should have a special sub programe on alcohol control	*SDG Indicator* *-Harmful use of alcohol*
1.1.12	**Tobacco control**	Enhance and sustain the tobacco control programe Establishment of rehabilitation centers with experts in government sector	*SDG indicator* *-current use of any tobacco product (age – standardized rate) indicator - SDG*
1.1.13.	**Environment** issues affecting health	Expand the Environmental Health unit of MoH (DDG / E & OH and FS) with facilities for research and monitoring the environmental health hazards and legal framework for preserve green environment	*SDG indicators* *-Mean urban air pollution of particulate matter* *-Mortality from indoor air pollution* *-Indicator on chemical pollution (Carbon dioxide emissions per capita ; Consumption of Ozone depleting CFCs , etc) MDG indicators* *-Proportion of population with sustainable access to improved water source (urban*

			& rural) MDG indicator *-Proportion of urban and rural population with access to improved sanitation (MDG indicator)*
1.1.14.	**Occupational issues affecting health** No proper system to support the prevention of occupational injuries and diseases through Primary Health Care . Inadequacies in provision of integrated occupational health services Lack of empowerment of workers for promotion of healthy life styles Inadequacies with regards to human resources in the area of occupational health at the MoH No pre medical check ups and regular screening for identified health risk factors for workers Research on Occupational Health and safety is not put in to the practice	Promote and monitor the healthy workplace policy with legal framework to ensure healthy workplace Strengthen Primary care services to deliver a core package on occupational health and safety for all workers Strengthen provision of occupational health services by strengthening policy , regulatory and service delivery measures at central , provincial , district and regional levels Strengthen provision of occupational health and safety services at secondary and tertiary health care levels Develop and implement mechanism to empower workers for health promotion through workplace settings approach Enhance human resource development of heMoH to facilitate the provision of occupational health services Implement a cost effective screening programme with pre medical check ups and	

	No Occupational injury and diseases surveillance system for the health sector Occupational health and safety are not addressed adequately in other policies of the Government	regular periodic screening for identified health risk factors for all workers Promote research and utilization of its findings on occupational health and safety and ensure sustainable financing mechanism that support cost effective occupational health interventions at both preventive and curative sectors Strengthen national health information system for occupational injuries , diseases and risk factor surveillance Strengthen monitoring and evaluation of the national occupational health and safety programme of MoH Raise priority and integrate occupational health and safety across all Govt Ministries and Private sector organizations	
1.1.15	**Food safety** - challenges due to an open market economy	Expand the Food Administration unit of the MoH (DDG / E & OH and FS) with facilities and staff for research and monitoring the food safety island wide 24 hrs and implement legal provisions in situ without delay Food safety policies Revision of food act to establish authority on food safety Chemical food safety	

		Risk assessment Improvement of food laboratory	
1.1.16.	Challenges persisting in **Estate (Plantation) Health**	Already prepared Estate Health Policy should be adopted / Implemented for vulnerable population living in difficult to reach estate locations	
1.1.17.	Problems in **Urban health** Unsatisfactory sanitation issues eg. In public places, railways, public toilets	Establish a separate division in MoH to manage Urban Health issues Provision of facilities for research and monitor urban health issues routinely Comprehensive plan to uplift urban sanitation in liaison with Municipal Councils	
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 -Cancer diagnostic facilities are not available at district level	Increase in public awareness on primary prevention of cancers Establish facilities for detection of cancers through Primary Health care Establish diagnostic facilities for cancer at each district	
1.1.19.	**Quarantine** (ensure the maximum security against the international spread of diseases, with the minimum interference with world	To strengthen POE to prevent a possible entry of diseases concern with international spread in complying with IHR 2005	

	traffic and trade)	To establish and develop health and notification and information system at point of entry which links with the National surveillance system. To strengthen the legal framework including the issues related to public health emergency of international concern (PHEIC) to the Quarantine Act To train public health staff on boarder health security and IHR To conduct operational research related to IHR	
1.1.20.	**Unaddressed Migrants health**	Enhance border health security , full implementation of IHR 2005 Establishment of Migration Health unit in liaison with D/Quarantine and Chief Epidemiologist and monitor both the foreigners who are employed in Sri Lanka and also the Sri Lankans employed in other countries (and their families in SL)	
1.1.21.	Emerging and Re-emerging diseases	Strengthening of disease surveillance and outbreak investigation Strengthening of communicable disease surveillance including at POE Enhance inter sectoral collaboration	*SDG indicators* *-Incidence rate of Diarrheal Diseases in children under 5 yrs* *-Neglected Tropical Disease (NTD) cure rate* *-Incidence and deaths associated with*

		Capacity building inter relation to prevention diagnosis and treatment of emerging and re-emerging diseases Promote and conduct operational research related to emerging and re emerging diseases	*Hepatitis*
1.1.22.	**Leptospirosis**	Prevent and control of leptospirosis And other zoonotic diseases of public health importance Strengthening of zoonotic disease surveillance Outbreak investigation Enhance inter-sectoral collaboration Promote and conduct operational research related to zoonotic diseases	
1.1.23.	**Dengue**	Strengthening of dengue surveillance Strengthening of dengue case management Dengue Prevention	
1.1.24.	**Leishmaniasis**	Control and prevention of cutaneous leishmaniasis	
1.1.25.	**Filariasis** (Eliminate LF by interrupt of transmission by 2020 and alleviate suffering and disability)	Strengthen the parasitological surveillance and control activities Strengthen the entomological surveillance and control activities	

		Strengthen the laboratory facilities in the AFC Prevent complications and disabilities of affected individuals by morbidity management	
1.1.26.	**Malaria**	Strengthening of surveillance for early detection of malaria Maintaining skills for diagnosis and treatment and ensure radical cure Strengthening outbreak preparedness, prevention and response Strengthen entomological surveillance & effective response through IVM Ensuring quality assurance monitoring and evaluation: Strengthening IEC Improving programme management and performance Engaging in operational and implementation research	*SDG indicator* *-Incidence and death rates associated with Malaria (SDG / MDG)*
1.1.27.	**Leprosy** (Burden of Leprosy in Sri Lanka Reduced, but …….	Curtail Active Transmission of Disease Minimize Delayed Presentation and defaulting (Disability Reduction)	

		Ensure Quality clinical Services delivered at all treatment centres Ensure satisfactory Rehabilitation services available to all leprosy patients with disabilities Ensure availability of Trained human resources for leprosy control	
1.1.28.	**Tuberculosis** -the No of TB cases is lower than the estimated TB cases (some cases are missed at the Primary care level) -upward trend in case fatality due to TB (late detection of cases and inadequate attention to co – morbidities)	More awareness and alert by primary care physicians Early case detection Provision of more facilities to investigate and manage co – morbidities at district chest clinic Inward treatment facilities at district level Regular Review of TB Deaths Strengthen the present programe of Defaulter tracing by District chest clinic PHI by re – establishing the previous programe of defaulter tracing by range PHI	- *Percentage of TB cases detected and cured under DOTS (indicator - SDG / MDG* - *Incidence , prevalence and death rates associated with all forms of TB (SDG / MDG)*

	Treatment Defaulters (TB patients who are alcohol and drugs addicts are the majority of Treatment Defaulters) Control of Urban TB TB and Migration TB among Prisoners and Estate populations TB control in risk groups eg Diabetes MDR TB TB patients obtaining treatment from Private sector	NPTCCD and PHSD to establish a system for monitoring and defaulter tracing	
1.1.29.	**HIV - AIDS** -Women represent an increasing share of HIV infected (specially the Migrant workers) -Adolescents comprise nearly one fifth of the population and a vulnerable group	Develop new strategies to capture the at risk groups	*SDG indicators* - *HIV incidence , treatment rate , and mortality (Indicator - SDG)* - *Condom use at high risk sex (Indicator - SDG)*

	-Condon use should be further increased -HIV testing as an entry point for people to make an assessment of themselves in relation to their risk behaviors		- *HIV prevalence among 15 – 24 yr old pregnant women (MDG indicator)*
1.1.30.	**Rabies** -Dog Rabies still remains at low endemic level and there is a risk of re emerging -lack of transport for animal vaccination in districts -deficiencies in cadre of animal vaccinators in the districts -Enormous expenditure on post exposure treatment for patients (Rs 350 million annually)	Control the population of animal reservoir with special emphasis on dogs sterilization Provision of transport and cadre to district dog vaccination units to improve coverage of vaccination and establish herd immunity in animal reservoir Ensure protection to those exposed and update knowledge of curative staff on post exposure treatment (PET)	
1.1.31.	**Vaccine Preventable Diseases**	Immunization policy should be implemented Monitor the private sector with necessary legal tools Timely changes should be attended by the National consultative committee on Immunization	*SDG indicators* *-Percentage of children receiving full immunization as recommended by national immunization schedule*

		Ensure high immunization coverage for all EPI vaccines Ensure vaccine efficacy , safety and quality for all vaccines used in NIP Ensure the achievement of eradication ,elimination and control targets in line with global , regional and national initiatives Strengthening of case based investigations of vaccine preventable diseases Promote and conduct operational research related to vaccine preventable disease Rational introduction of new vaccines	*-Percentage of One year old Children immunized against Measles*
1.1.32.	Maternal care Shift of morbidity pattern in pregnancy towards medical diseases complicating pregnancy	As suggested by College of Obstetricians , all pregnant women should be screened at 30 wks by a team of multi disciplinaryspecialists (Obstetrician , Cardiologist & Physician) -Reduce maternal mortality -Reduce direct obstetric morbidities -Reduce indirect obstetric morbidities -Reduce anaemia in pregnancy -Every mother will gain the optimum weight during pregnancy	*SDG indicators* *Antenatal Care Coverage (SDG / MDG)* *-Post natal care coverage (SDG / MDG)* *-Coverage of Iron folate supplement (SDG / MDG* *-Maternal Mortality ratio (per 100,000 live births) MDG indicator* *-Health facilities meeting service specific-readiness requirements (MDG / SDG)* *-Ratio of Health Professional to*

		-Reduce still births to 3.2/1000 births by 2025 -Reduce the proportion of intrapartum still births (less than 30% of all still births)	*population (MOO , NOO, PHMM , EmOC caregivers)*
1.1.33.	Newborn care	-Reduce cause specific newborn mortality (perinatal causes) -Reduce neonatal morbidities due to preventable causes -Reduce Low Birth weight -Reduce prematurity	*SDG indicators* *-infants under 6 months exclusively breast fed* *-Healthy life expectancy at birth* *-Infant mortality rate (per 1000 live births) MDG indicator* *-Reduce neonatal mortality to 3.4/1000 live births by 2025 (MDG / SDG)*
1.1.34.	Child health care	Reduce child mortality Reduce cause specific child mortality (birth defects, injuries) Reduce cause specific child morbidity due to common childhood illnesses Reduce morbidity due to child injuries (intentional and non intentional) Improve the quality of life of children with special needs Optimize psychosocial development of under five children Reduce stunting to 10.8% by 2025	*SDG indicators* *-Diarrheal Disease in children under 5 yrs* *-One year old children immunized against Measles (SDG & MDG indicator)* *-Under fivemortality rate (per 1000 live births) MDG indicator*

		Reduce wasting to …….. By 2025 Reduce under weight …… by 2025 Maintain overweight < 1% 2025 Reduce anaemia to 10% by 2025 Reduce vitamin A deficiency to 15% by 2025 Optimize oral health of children < 5 years	
1.1.35.	School health and Adolescent health Health issues of adolescents have not been attended SMI to be revisited, counseling ,health promotion	Study the health needs of adolescents and establish a programe to address the issues identified Enhance School Medical Inspections with special emphasis on counseling and health promotion Reduction of malnutrition (Obesity, under nutrition) Reduction of morbidity due to adolescent pregnancy Reduction of mortality due to adolescent pregnancy Reduce anaemia among adolescents Reduce STIs Reduce psychological problems among adolescents Reduce mortality due to injuries (intentional and non intentional) Achieve optimal health among adolescents through healthy life style	SDG indicator *-Adolescent birth rate (MDG indicator)*

1.1.36.	Health of the Youth	Reduction of malnutrition (Obesity, under nutrition) Reduction of morbidity due to unwanted pregnancies Reduction of mortality due to unwanted pregnancies Reduce anaemia among youth Reduce STIs Reduce psychological problems among youth Reduce mortality due to injuries (intentional and non intentional) Achieve optimal health among youth through healthy life styles	*SDG indicator* *-Percentage of young people receiving comprehensive sexual education*
1.1.37.	Pre-conception woman	Reduce malnutrition among women entering pregnancy (undernutrition, overnutrition, anaemia) Reduce morbidity due to chronic diseases (heart diseases, diabetes, thalassemia)	
1.1.38.	Womens' health	Reduce mortality due to common NCDs Reduce morbidity due to common NCDs Reduce mortality due to GBV Reduce morbidity due to GBV Reduce malnutrition (under and over) Reduce mortality due to acute illnesses Reduce morbidity due to acute illnesses	*SDG Indicator* *-Percentage of women with cervical cancer screening*

1.1.39.	Family Planning	Reduce maternal mortality due to unmet need of family planning Reduce maternal morbidity due to unmet need of family planning Reduce unmet need of family planning Reduce contraceptive prevalence Reduce burden of subfertility	*SDG indicators* *-Total Fertility rate* *-Contraceptive prevalence rate (MDG Indicator)*
	Differences in reproductive health seeking behavior leading to increase TFR	Establish community based awareness programe for the communities with no reproductive health seeking behavior	*-Met demand for Family planning (modified MDG indicator)*
	Unmet need reflected in high abortion rates - unsafe abortions	Increase counseling skills of field Midwives Ensure availability of field Midwives in respective fields 24 hrs	

Thematic Area 1 .2 - **Client perspective**

No.	Identified Issues	Proposed Strategies/ Activities	SDG - Indicators
1.2.1	Lack of responsiveness	Ensure domains of health system responsiveness in all health settings (access ,	

		dignity ,communication , choice of method , confidentiality ,basic amenities, choice of provider , courteousness , being treated without discriminating , perceived adequacy of staff / equipment / drugs)	
1.2.2	Inequities in access to preventive health services	Study and implement methodologies to address inequities in access to preventive health services	
1.2.3	The Public has less access to information on Preventive Health	Establish a system of Innovative IEC and time bound methods - hotlines etc.	
1.2.4	Inadequate public demand for preventive health services	Involve social marketing experts , psychologists ,sociologists , and commercial artists and establish a mass social marketing program on preventive health services under DDG / NCD	

Thematic Area 1 . 3 - **Stewardship issues leading to organization changes**

No.	Identified Issues	Proposed Strategies/ Activities	SDG indicators
1.3.1	Enhance Stewardship role for preventive health - policy, facilitation and regulation	Establish outcome indicators for all preventive health policies Regular review of Sectoral Policies and Legal tools	
1.3.2	Update preventive health legislature , to include new areas eg- regulation of media for public health	Establishment of a Committee comprising relevant Directors , Preventive health experts and legal officers to review and draft updated acts	
1.3.3	Poor Inter sectoral coordination among different preventive programmes at national level and also with other thematic	Effective mechanisms such as NHDC and NHC should be re established Improve Advocacy skills to get other sectors on	

	areas, eg rehabilitative, curative, administrative	board	
1.3.4	Poor Inter sectoral coordination among different preventive programmes and at district & provincial levels	The district & provincial representatives of national preventive programs (M.OO. / MCH , NCD , Mental Health and , RE , STD, DTCO ,RMO) should work as a team at district and Provincial levels	
1.3.5	Poor Inter ministerial coordination eg Ministry of Education	Revitalize NHDC and specially NHC	
1.3.6	Provincial level managers find it difficult to report and relate to conflicting central government and provincial health communications	As an agenda item , the subject of conflicting issues , should be discussed at the national and provincial health ministers forum	
1.3.7	Organization barriers - preventive health aspects of programs undermined due to inclusion in curative service and other areas	Building team concept between preventive , curative and rehabilitative service planners Preparation of comprehensive plans incorporating preventive , curative and rehabilitative sectors	
1.3.8	Certain Preventive Programes do not have Policies In some of the preventive health policies the outcome indicators have not been specified (overall results to be achieved)	Establish Sectoral Policies for all Preventive Programmes Develop and monitor outcome indicators for each objective in preventive health policies	
1.3.9.	Non Expansion of preventive organization structure leading to challenges in overall Management	Re Structure the organization of preventive programmes	
1.3.10.	Non availability of Governance	Good Governance systems to be introduced for	

	systems - standards for equipment, guidelines, transparent procedures, accountability,	the preventive programmes	
1.3.11.	Inclusiveness of all sectors including private sector in rational involvement of preventive health service delivery	Re asses the Private Health sector involvement in preventive health and develop a comprehensive plan with Private Health Sector Regulatory Authority to implement all preventive programmes in private health sector (with routine monitoring mechanism)	
1.3.12.	Lack of a Media Watch, Role of HEB to be revisited	The role of HEB is to be modified to monitor media (print & electronic) and publish/broadcast correct information on preventive health issues HEB should establish a system for public awareness better than the existing print and electronic media Increase public involvement and social media channels	
1.3.13.	Lack of a coordinated mechanism on Global health issues - eg follow up WHA resolutions etc	The subject of Global Health Governance (International Relations) which is presently under D/International Health should be supported with a Deputy to assist in the said subject	

Thematic Area 1 . 4 - **Information support**

No.	Identified Issues	Proposed Strategies/ Activities	SDG indicators
1.4.1	Lack of efficiency in information flow	Establish e - health initiatives for preventive health information flow and provision of Tabs and network connectivity to all at concessionary rate	
1.4.2	Lack of focused research and operationalizing of research findings	National Health Research Committee to identify priority areas for research in preventive health Priority should be given (at the approval for research topics) , for the identified areas for research studies in MD & MSc in Community Medicine and MD & M Sc in Medical Administration Translation of research in to policies and practices	
1.4.3	Lack of information flow from private and civil society agencies	Develop a practical mechanism to obtain preventive health information from NGO involved in preventive health (Develop operational directives and SOP)	

Thematic Area 1 . 5 - **Monitoring & Evaluation**

No.	Identified Issues	Proposed Strategies/ Activities	SDG indicators
1.5.1	All Public health programs do not receive the same attention for monitoring and evaluation	Strengthening the monitoring and evaluation mechanism (need to address the accountability)	
1.5.2	Program objectives, targets, indicators are ill defined	Establish Specific Measurable Attainable Realistic and Time bound (SMART) programe objectives , targets and indicators for all preventive health programmes	
1.5.3	Several public health programs are not results driven - Results based plans to be adopted	Results Based Monitoring (RBM) should be incorporated to all preventive health programmes	

Thematic Area 1 .6 -**Quality of preventive health services**

No.	Identified Issues	Proposed Strategies/ Activities	SDG indicators
1.6.1	Lack of proper systems for validation of procedures Eg equipment calibration, vaccination procedures	Establish norms and protocols for procedures in preventive health Bio Medical Services to attend the calibration of equipment used in preventive health services	
1.6.2	Lack of system for accreditation of public health services - public health accreditation system	Establishment of proper accreditation system for public health services.	

2 .Curative Health Services

Thematic Area 2.1

Patient centered care

No.	Identified issues	Proposed Strategies	SDG indicators
2.1.1.	Underutilization of primary health care	a) Establish at least one rehabilitation/geriatric/palliative care hospital per district to improve the hospital bed utilization	
		b) Establishment of a policy on forward and back referral system	
		c) Strengthen Public relations and availability of services of Primary Level Curative Institutions	
		d) Establish ETU/PCU (Emergency Room) in all primary care institutions	
		e) Appoint MO/NCD to HLC in Primary Level Curative Institutions (DH A,B, & C) with DA (B.Sc – Health Promotion) and provide facilities for field screening clinics as extension of HLC at village	

		level .	
		f) Ensure availability of all relevant resources (HR, drugs, equipment etc)of each primary care institutions	*SDG indicators* *-Percentage of Health facilities meeting service specific readiness requirements* *-Percentage of population with access to affordable essential drugs and commodities on a sustainable basis* *-Percentage of new health care facilities built in compliance with the building codes and standards* *-Ratio of health professionals to population (MOO , NOO , PHM , EmOC caregivers)*
2.1.2.	lack of accessibility for 24 hours OPD / ETU services	Establish 24 hours OPD / ETU services based on service requirements Allocate separate staff to manage acute conditions in geriatric age group to minimize waiting and delay in treatments (Reduce the burden of complications)	
2.1.3.	No proper patient transfer policy	a) Strengthen the patient transfer policy and ensure its implementation b) Ensure whom to take care of the patient during transfer according to the severity of illness c) Take the available transfer units belong to each institutions and minimum distance and average time to reach the hospitals to	

		ensure the minimum time of transport. d) Arrange a transfer team in every hospital and give them a training regarding basic life support, how to do the emergency handing relevant to each major illness.	
2.1.4.	Shared Care / Cluster system not in place – no sharing of resources	a) Identify and establish an institutional cluster system for referral, training, consultation and sharing of resources	
		b) GP linked healthcare and referral system for a designated population	
2.1.5.	Overcrowded OPD and clinic services –	a) Promote Appointment system to OPDs and clinics (extension of clinic time to evenings) b) Efficient HR allocation to OPD and monitoring system to establish more personalized system.	
		c) Ensure appropriate architectural structure for the OPD / Clinic services	
		d) Establish e-based OPD /clinic system	
2.1.6.	Inappropriate issue of pharmaceuticals and ordering laboratory investigations	a) Ensure Rational prescribing of drugs and ordering laboratory investigations	
		b) Establishment of proper dispensing mechanism of pharmaceuticals (No substitution	

		, relevant dosage , instructions in patients' language)	
2.1.7.	No personal Health records	Establishment of electronic health records linked to the national grid (Establish a separate unit for this project)	
2.1.8.	Comprehensive palliative care / highly specialized services not provided	a) Establish One palliative care hospice in each district	
		b) Establishment of specialized centres at district level (Poison, dialysis)	
2.1.9	Need to improve the responsiveness in health care	Establish the facilities and standards for responsive care for all including the adolescents disabled, elderly & special groups in hospitals.	
2.1.10	Unsatisfactory logistics / supportive services (linen and food supply , cleaning / janitorial services , Laundry Services , Security services)	Strengthen the supporting system for the hospitals (Develop standards and enhance PPP)	
2.1.11	Long waiting time for certain surgeries	Increase the operating capacities in Secondary and Tertiary care hospitals Upgrade and increase the ICU bed strength at each level	
		Implementation of incentive based system for idling hours in the OT	
2.1.12	No Registry for congenital malformations	Introduce congenital malformation referral	

	and referrals	system in the Secondary and Tertiary care hospitals Appoint a trained medical personal in Clinical genetics in each tertiary care centre to identify, Diagnose the genetic disorders and dysmorphic infants and children . Maintain a registry for birth defects and genetic disorders .	
		Ensure immediate referral to the identified centers (National Genetics Centre)	
2.1.13	Lack of Medico – Legal services after 4 pm on weekdays and after 12 noon on weekends and public holidays	Development of a system to avoid delays in Medico Legal examination of accuses , after duty hours	
2.1.14	Sometimes relations have to wait more than 24 hrs to get the dead body released from the hospital	Establish procedures to avoid delays in releasing the dead body	

Thematic Area 2 . 2

Policy dialog

No.	Identified issues	Proposed Strategies	SDG indicator
2.2.1.	Lack of policy dialog between different section of health sector	a) Ensure coordination between different sections in health sector	

		b) Promote communication between all sections in health sector	
2.2.2	Frequent use / local purchase of expensive drugs	Development a policy for local purchase of essential life saving drugs and devices	

Thematic Area 2 . 3

Medical Equipment

No.	Identified issues	Proposed Strategies	SDG indicator
2.3.1.	No asset management Plan – No proper inventory for medical equipment	Establish an e-based inventory management system for all medical equipments at all levels	
2.3.2.	Deficiency of Technology Assessment	a) Development of National Medical Equipment Policy b) Establish a technology assessment unit at National level	
2.3.3.	Deficiency of End User / Maintenance training for medical equipment (lack of funds)	Establishment of a medical equipment - end user / maintenance training units at national & regional levels	
2.3.4.	Deficiency in maintenance of medical equipment (No Bio Medical centers – Inadequacy of Bio Medical Engineers)	a) Establish medical equipment maintenance units BH upwards in a phase manner	
		b) Appoint appropriate staff to the established medical equipment maintenance units	
		c) Appoint Bio Medical engineers to DGH and above in phase manner	
2.3.5.	No standard norms for equipment at different levels of care (and **appropriate sophistications)**	a) Formulate standard equipment guidelines for different levels of care	

		b) Formulate appropriate specifications for equipment identified for different levels of care	
		c) Update the standard equipment list and specifications once in two years	
2.3.6.	No proper condemning policy for medical equipment	Develop a policy and guidelines for condemning medical equipment (ie beyond economical repairs, technically / clinically obsolete)	
2.3.7.	Delay and complexity of procurement process	a) Ensure using **standard** specifications and guidelines for the procurement process , every two years .	
		b) Streamline the procurement process in the procurement division of the Ministry	
		c) Decentralization of procurement based on the institutional level	
2.3.8	Decision making regarding equipment , new units Donations etc , disregarding the policy & procedures and the knowledge of Head of Institutions	Ensure purchase of equipment , establishment of new units , Donations etc with the concurrence of the Head of the Institution and according to policy and procedures	
2.3.9.	No calibration laboratories for all Medical	Ensure the calibration function of all	

	equipment	medical equipment at the central and decentralized levels (quality & safety)	
2.3.10	No accountability for utilization of equipment	a) Develop institutional policy on utilization of medical equipment	
		b) Ensure reasonable utilization (with appropriate technology assessment for relevant care level) of medical equipment in the institutions	
2.3.11.	Inappropriateness of unsolicited foreign funded proposals	Evaluate foreign funded proposals by the technical committees appointed by DGHS	
2.3.12.	Unregulated donations from overseas	a) Formulate donation acceptance policy	
		b) Ensure the implementation of such policy	
2.3.13.	Non existence of policy on sharing of equipment (Intra Institution and inter institutions)	a) Formulate policy on sharing of equipment	
		b) Develop infrastructure for sharing of equipment (Diagnostic Centre)	
		c) Ensure inter and intra institutional sharing mechanism of equipment	
2.3.14.	No encouragement for local production of Medical Equipment	a) Review the legal enactment of registration of local product s of Bio Medical Equipment	
		b) Provide incentives for local production of Bio Medical Equipment	
		c) Technology innovation Research Centre to be established in MRI / BES	

2.3.15.	No equipment detail files for the medical equipment	Ensure maintenance of detail files for relevant medical equipment in all the institutions.	
2.3.16	No quality assurance programme for medical equipment (specially for radiographic equipment)	Establishment quality assurance programme for medical equipment (specially for radiographic equipment	

Thematic Area 2 . 4

Laboratory Services

No.	Identified issues	Proposed Strategies	SDG indicators
2.4.1.	No equity of laboratory services based on levels of care	Carry out investigations according to the level of care delivery	
2.4.2.	Unnecessary investigations and duplication	Ensure adherence to circular instructions for day and night investigations	
2.4.3.	Highly specialized laboratory (MRI) carrying out basic investigations	Develop and adherence to protocols for specialized laboratories	
2.4.4.	No proper accreditation programme for the laboratory	Establish a National system for Accreditation of Health Laboratory / Investigations	
2.4.5.	No contingency plan for investigation and supporting services during crisis	Establish public owned enterprise laboratories network (Such as OsuSala)	
2.4.6.	**Enormous expenditure on laboratory items (3-part & 5 part analyzers ; test kits and laboratory chemicals)**	**Establish a mechanism to produce laboratory chemicals locally (for the analyzers)**	

2.4.7.	**Increased Out-of-pocket expenditure by patients**	**Establish a system to provide high-tech diagnostic services at least per each PGH**	

Thematic Area 2 .5

Specialist Services

No.	Identified issues	Proposed Strategies	SDG indicators
2.5.1.	No policy on finer specialties	a) Develop fine specialties such as Transplant (Kidney, Liver, and Stem cells), Genetic diagnosis in a phased manner based on the requirements	
		b) National policy on finer specialties such as cardio thoracic, plastic surgery, neuro surgery	
		c) Define job description and quantum of work for the finer specialists	
2.5.2.	**The present capacity of Medical Services Administration in the Department of Health Services is inadequate to coordinate the modern and new trends in development of Curative services**	**Establish reforms to the management structure of Curative Services Division (with necessary expansion of directorates to cater the demands)**	
2.5.3.	**Anesthesiology**	*Proposals submitted by College of*	

	Demand of Anesthetic services for ever increasing and expanding surgical services Safety of patients under anesthesia and recovery depend on updated monitoring facilities Inadequate ICU facilities to cater the demand Non availability of Pain clinics and acute pain rounds in hospitals	*Anesthesiologists in Sri Lanka* Re arrange operating theatres and recovery units as per guidelines of the college of Anesthesiologists Increase the total number of ICU beds to the ratio of 5 % of total hospital beds Establish pain clinics in all teaching hospitals and acute pain rounds in all hospitals with specialist units	
2.5.4.	**Gynecology & Obstetrics** Still 150 - 200 mothers die annually during the intra partum period and this backdrop of service failures and not achieving the standard quality care , have to be corrected	*Proposals submitted by Sri lanka College of Obstetricians & Gynecologists* Introduce Clinical Governance and Accountability Partograms (and kick counts) to be maintained at all hospitals Active Management of third stage of labour in all hospitals Reduce prolonged labour and sepsis Reduce post partumheamorrage Ensure multi disciplinary approach for complicated cases	
2.5.5.	**Microbiology** Healthcare associated infections (HAI) are causing high morbidity and mortality in patients High Cost incurred in the management of patients with HAI , by the MoH	*Proposals submitted by Sri Lanka college of Microbiologists* Develop a system to monitor HAI Strengthen infection control & prevention in health care settings	

	The risk of acquiring HAI by health care personnel working in hospitals and other healthcare settings Inappropriate and irrational use of anti microbials (anti biotics) in hospital wards and outpatient settings Poor hand hygiene compliance in healthcare facilities	Reduce the rate of HAI in Sri Lanka Update antimicrobial policy Establish antimicrobial stewardship programs in all hospitals Establish monitoring programe for antimicrobial usage Capacity building in hand hygiene	
2.5.6.	**Palliative Care** A huge number of citizens suffer un necessarily at the end of the life inspite 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) MOO and NOO are to be professionally trained in Palliative care Community & Home based care	
2.5.7.	**Neurosurgery** The number of head injuries have increased and become more severe and complex Although a substantial amount of neurosurgeries are done in the private sector , Neuro Trauma mainly present to the Govt Health sector With the expansion of medical specialists	*Proposal submitted by Neurosurgeons Association of Sri Lanka* As only 13 Neurosurgeons work in 8 Neurosurgical units in Govt Health sectors and the high cost and demand for operating theatre and ICU facilities (including high running cost too) ; a well integrated and standardized system of neurosurgical centres is essentially	

	services in the country and advancement of imaging facilities etc , other neurosurgical problems are diagnosed more than ever before	needed	
2.5.8.	**Ophthalmology** Prevalence of blindness due to Cataract , Glaucoma , Diabetic Retinopathy Childhood Blindness Refractive errors	*Proposals submitted by College of Ophthalmologists of Sri Lanka* Elimination of blindness due to Cataract , Glaucoma and Diabetic Retinopathy in the Elderly Elimination of Childhood Blindness Rehabilitation of people with low vision	
2.5.9.	**Oral & Maxillofacial Surgery** Due to deficiencies in infrastructure , equipment , manpower and consumables in peripheral OMS units , Patients in rural areas have to travel a long distance to reach the main OMS centres to obtain advanced treatment options Eg - patients with oral cancer , jaw deformity , cleft lip & palate	*Proposal submitted by Sri Lanka Association of Oral & Maxillofacial Surgeons* All OMF unit of Tertiary and Secondary care hospitals should be developed as separate Dental Specialist units with needy equipment and cadres , to provide the OMS services to the patient at the nearest Hospital with specialist unit of OMF	
2.5.10.	**Cardiology** Several major cities in the country have excellent cardiac services but basic facilities for the management of cardiac emergencies are wanting in many peripheral institutions Standard cardiac care units have not been placed according to the basis of	*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	

	population density and division of provinces	to nearest Cardiac Cath lab in designing new facilities Norm to have Two Cardiac Cath labs per Province with parallel cadre development	
2.5.11.	**Haematology** Thalassemia Haemophelia HaematologicalMalignencies	*<u>Proposals submitted by Sri Lanka College of Haematologists</u>* *Establishment of Haematology Day Care Centres for Haemophelia&Thalasemia* *Establishment of Bone Marrow transport centres at LRH , (next aiming at TH Kandy &Th Jaffna)* *Genetic labs* *To establish centre of excellene of comprehensive diagnosis including molecular diagnosis for Haemophelia , Thalasememis , Thrombophelia and HaematologicalMalignencies*	

Thematic Area 2 .6

Quality and Safety

No.	Identified issues	Proposed Strategies	
2.6.1	No accreditation	Establish accreditation processes for healthcare institutions Promote financial allocations with accreditation	
2.6.2	Lack of guidelines	a) Develop and institutionalize	

	2.1Lack of SOPs 2.3. No systematic clinical audit	evidence based cost effective clinical protocols and guidelines on clinical practice	
		b) Establish mechanisms for professional guidance, peer review and audit of clinical practices and provision of feedback	
		c) Strengthen the clinical information management system to help in decision making	
2.6.3.	No mechanism to collect adverse events, readmissions	a) Ensure an effective risk management system	
		b) Establish an effective readmission, incident and near-misses reporting system	
		c) Strengthen programmes for safe clinical procedures and processes	
		d) Promote a proactive culture aimed at quality, staff safety and prevention of medical errors	
2.6.4.	Lack of proper mechanism to monitor curative sector including private sector - Accountability	a) Develop and adopt mechanism for performance assessment, systematic review and corrective action in curative healthcare	
		b) Strengthen the regulation mechanism on private health sector	
2.6.5.	No CPD programme for technical category	a) Facilitate continuous professional development of staff to empower	

		them with required knowledge, skills and attitudes	
		b) Link CPD points with annual increment / Research allowance	
2.6.6.	Lack of Health Promoting Hospitals/Health Institutions	Ensure participation and sensitization of staff, patients and community in sustaining a health promoting culture in health facilities	
2.6.7.	Increase in anti-microbial resistance	Develop and implement institutional antibiotic policy (Drugs and therapeutic committee)	
2.6.8.	Irrational use of Drugs	Conduct regular audit on usage of drugs	
2.6.9.	Occupational safety not attended adequately	a) Promote and ensure Occupation safety for all healthcare workers	
		b) Encourage using protective gears by the healthcare workers	

Thematic Area 2 . 7

Healthcare Settings

No.	Identified issues	Proposed Strategies	
2.7.1.	Underutilization of health care facilities eg. OT, CT,	a) Develop supportive structure (ICU, HDU) and human resources	
		b) Strengthen the mechanism for optimum utilization of healthcare	

		facilities	
		c) Promote sharing of resources between public and private hospitals	
2.7.2.	Inappropriate and in-coordinated development leading mal functioning (standards and architecture for infrastructure, norms for HR and technology)	Ensure architectural norms /HR/Technology for each functional unit of the hospital according to the re-categorization of the hospital	
2.7.3.	non conducive environment in hospitals	a) Promote green and clean environment	
		b) Ensure Healing environment in hospitals giving priority to cancer and long term patients	
2.7.4.	improper waste management especially waste disposal	Promote reduce recycle and reuse	
		Ensure proper waste disposal based on categorization of waste	
		Strengthen the liquid waste management system	
2.7.5.	Transport is intuitional based not event based	Establish regional based health transport system	
		Establish tracking system for ambulances	
		Introduce the para medical services for pre hospital care. (need clinical authority for assessment and monitoring)	

Thematic Area 2 . 8

Unregulated Private Health Sector

No.	Identified issues	Proposed Strategies	SDG indicator
2.8.1.	Human resource – lack of full time Doctors, qualified nurses and other categories	Ensure availability of full time Doctors, qualified nurses and other categories	
2.8.2	Inadequate and improper regulatory mechanism	a) Strengthen the regulatory mechanism	
		b) Develop norms the hospital fees for various services	
2.8.3.	Regulates are also in the regulatory body – bias in decision making	Reconstitute the regulatory body	
2.8.4.	Professional and institutional ethics not be maintained	a) Develop and ensure the adherence to code of ethics for the professionals and institutional	
		b) Ensure adherence to the National Recruitment Criteria for the recruitment of professionals	
2.8.5.	Information not available from private sector	Ensure the availability of information to National grid	
2.8.6.	National Guidelines are not implemented in private sectors	Ensure adherence to the National Guidelines n clinical management	
2.8.7.	Specialist time wasted on GP work	a) Improve awareness of the public	
		b) Promote referral system	
		c) GP linked to a designated population	

3 Rehabilitation Services

No	Identified Issues	Proposed Strategies	Major Activities
3.1	Non availability of comprehensive health policy for rehabilitation services	Develop medium and long term physical (and mental) rehabilitation strategic frame work (based on the national disability policy)	1. Establish policy formulation committee 2. Start a dialog with stakeholders (Disability council & WHO) 3. Re visit cabinet approved guidelines
3.2	Insufficient HR for Disability care (eg Physiotherapists , Occupational Therapists)	Develop HRH strategy for rehabilitation services	1. Conduct needs assessment 2. Identification of necessary cadre with norms 3. Recruitment (from GCE A/L results)and training (basic in service) 4. Encourage Private sector to

			train personnel for rehabilitation services with exam standardization
3.3	Limited availability of Rehabilitation services (and infrastructure)	Establish / Expand comprehensive rehabilitation services at national and provincial levels	1. Increase Budgetary provisions to develop health care institutions providing rehabilitation services 2. Develop national centre and nine provincial centres in next five years
3.4	Limited accessibility for rehabilitation services	1. Develop community based rehabilitation services 2. Promote inter disciplinary rehabilitation teams	Establish shared – care rehabilitation intermediate centres in PHC hospitals which are in close proximity to Secondary and Tertiary care hospitals with consultant staff for visiting service
3.5	Affordability of rehabilitative services for general public	Increase budgetary provisions to equipment drugs and devices	Supply assistive devices (Intra Ocular Lenses , Wheel chairs , prosthetic and orthotic devices , hearing aids , etc)
3.6	Un availability of proper social support or insurance scheme	Introduction of a national health insurance plan	Establishment of Social insurance cover / rehabilitation insurance cover
3.7	Non availability of rehabilitation services at PHC level	1. Ensure coverage of a family physician to each citizen 2. Ensure sustainable CBR programme for children with special needs through MOOH 3. Extended services through Community nursing service	Empower the family physician for providing rehabilitation services

3.8	Inadequate coverage of Palliative care for life limiting illnesses	1. Develop national Strategic frame work (protocols & guidelines) for delivery of Palliative care 2. Development of HRH (PG Diploma in Palliative Medicine.)	Establish Palliative care services at homes , hospice and hospital settings
3.9	Limited rehabilitation services for Stroke / Cancer / COPD patients	Establish rehabilitation services Stroke / Cancer / COPD and other life limiting illnesses	Establish Rehabilitation services for Stroke / COPD / Cancer at Secondary and Tertiary care institutions
3.10	Inadequate participation and partnership of non governmental sector in rehabilitation services (Private hospitals , NGOO , CBOO and Un agencies)	1. Develop national plan for rehabilitation , with Non Governmental sector involvement 2. Central approach to be established including non health sectors	Survey and Identify the contribution from non governmental sector
3.11	Deficiency in regulatory mechanism	Establishment of regulatory mechanism for rehabilitation services by developing a national plan (for Govt and Private health Care institutions)	1. Regulate Private sector Rehabilitation services and health care personnel employed within ; through Private Health Development & Regulatory Council to ensure and maintain quality of service 2. Capacity building of private sector personnel confirming

			to national standards
3.12	No regulatory mechanism for assistive devices (Standardization of devices)	Establishment of regulatory authority for cosmetics (eg artificial breast used after total Mastectomy) Beautician services and related products	Re establish a directorate to regulate specific assistive devices .
3.13	Accessibility problem for disabled	Develop infrastructure to facilitate accessibility for disabled persons at all health institutions	
3.14	Lack of Information on Disability	1. Establish MIS for Rehabilitation services 2. Linkage and networking of available dat	1. Conduct surveillance and feedback to stakeholders 2. Conduct Periodic Disability Survey 3. Maintain a disability register by the each MOH areas
3.15	Inadequate quality care in rehabilitation services	1. Enhance patient safety and quality of rehabilitation services	1. Develop frame work to asses the quality and safety in rehabilitation services 2. Accidents and Incidents (eg Near miss) reporting system in health services
3.16	Lack of inter and intra sectoral coordination for rehabilitation services Eg 1. Community Based Rehabilitation CBR 2. Road Safety Policy	1. Strengthen the excising CBR programe 2. Propagation of other forms/ alternative medicine 3. Integration of all forms of medicine to form a combine service for rehabilitation care	1. Establish a steering committee for coordination 2. Sharing information and mutual understanding of capacity to assist rehabilitation 3. Commission a study on shared care centres
3.17	Non availability of desired environment for the persons with disabilities	Reduce environmental barriers for persons with disabilities	1. Implement existing legal provisions for physical

			accessibility 2. Advocacy for other relevant sectors (transport - universal design , Communication & Information , Education , sign language , Braille
3.18	Unavailability of proper evaluation mechanism of health interventions	Identification of best buy through economic and evidence based evaluation	1. Establishment of health economics and evaluation unit 2. Conduct research on economic evaluation of programs and projects
3.19	Knowledge gap between providers and recipients	Establish comprehensive IEC mechanism (awareness on availability of services , accessibility , training of care-provider in helping the disabled patient	Conduct awareness activities at each level using different strategies
3.20	Disabled patients have to attend different specialties at different clinics	Mulit disciplinary care instead of separate specialties	
3.21	Cardiac Rehabilitation		
3.22	Accidents (Post Trauma rehabilitation)		
3.23	Rehabilitation & Occupational Health Lack of awareness on occupational	 Strengthen awareness creation on	

	rehabilitation among workers Inadequacies in provision of occupational rehabilitation Compensation for occupational injuries is not adequate Inadequacy in availability of prosthesis Workers do not get a fair opportunity to resume work after being injured	occupational rehabilitation among workers Strengthen the provision of occupational rehabilitation including mental health rehabilitation Introduce an insurance system covering occupational injuries Improve the availability of prosthesis Ensure getting back to work concept after being injured	
3.24	Mental Rehabilitation (eg Rehabilitation of Alcohol Addicts)		
3.25	Children with special needs (egAutism)		
3.26	Advancement of Technology to be incorporated		
3.27	Research Gap in Rehabilitation services		

4 Health Administration & HRH

Thematic area 1

General Issues in Health Administration

No	Identified Issues	Proposed Strategies	SDG - indicator
4.1.1.	Some programmes and administrative functions are based on persons (not system based-not resilient)	Health Policy should address the system issues by establishing a high level committee (task force) to stream line issues (creation of new posts , new programmes and new systems)	
4.1.2	Not based on evidence/peoples' expectations/norms/performance i.e. ad-hoc decisions-based on personal preferences	The above committee could handle this effectively by coordination with other stakeholders	

4.1.3	Overlapping of duties of certain directorates	The above committee to solve the issues	
4.1.4	Shifting of some responsibilities of a post with the transfer of the officer to another post	The above committee to solve the issues	
4.1.5	inequity between central and provincial health administrative systems-leading to disparities in health systems and outcomes	Utilizing existing mechanisms such as National & Provincial Health Ministers' forum , Consultative committee on health in the Parliament , National Health Council , NHDC & HDC to address the equity issues (To be an Agenda item) Review the performance of above committees and arrange the agenda outcome oriented to improve the efficiency	
4.1.6	Gaps in the performance appraisal (no target driven appraisal system for the health administrators)	Establish Performance Management System assessing the output and outcome as per health policy	
4.1.7	Gaps in M&E framework	Development of Computer based M&E system in the MOH under the relevant authorities (DDG /P , DDG/ Logistics , DDG / Finance)	
4.1.8	Administrative structure • designing is unscientific/not demand based • Duplication	Development of Human Resource Policy and a HR Management system & Development of a HR unit in the Department	
4.1.9	Ambiguity in chain of command (channel of communication)	Development of a communication system respecting the establishment code but , considering the practicality	

4.1.10	Gaps in obtaining technical inputs for policy decisions taken by the hierarchy	Establishment of technical forums with defined terms of reference at different administrative levels	
4.1.11	Issues of Span of Control in the administrative structure in line with the future health demands	Redesign optimum span of control based on evidence	
4.1.12	Gaps in implementing/operating mechanisms in the centre and the periphery	Development of new web based monitoring system to strengthen the existing implementing / operating mechanisms and to monitor disparities	
4.1.13	Deficiency of stakeholder contribution in policy making	Establishment of a National Health Policy Formulation Committee	
4.1.14	Insufficient provincial and central dialogue- due to conflict of interest/financial issues/ resource mobilization issues	Further ensure central provincial dialogue to make uniform decisions and implementation	
4.1.15	Deficiency in management capacities to respond to organizational changes	• Ensure training of managers to improve capacity with updating knowledge on new challenges • Establishment of a Institute of Health Management	
4.1.16	Managers not geared for the change in global health scenario	Ensure annual exposure to international health scenario (to learn out of best practices)	
4.1.17	Gap in Vision sharing (shared values) from top to down	Establishment of a unit to streamline the planning process of the central and provincial levels and using social marketing for vision sharing	

4.1.18	Non alignment of performance of individual units to the national plans or sectoral plans	Establishment of Organizational Performance management System	
4.1.20	National policies are not adequately patient centered, not based on disease and population dynamics, and economic evaluations	Establishment of market survey system and a online surveillance system to underpin national health policies	
4.1.21	Limitation in authority given to managers to perform their own roles and functions	Revisit authority levels to enhance results based Performance	
4.1.22	Insufficient appraisal/motivation/compensation system for the managers	Establishment of a realistic reward system	
4.1.22	health administrators contribution to the health system under valued/misinterpreted	Social Marketing of success stories , best performing and innovative managers and system	
4.1.23	Gaps in career and professional development opportunities for managers	Capacity building of health managers to respond to organizational and global challenges (specially depending on the special abilities and skills of a particular manager) Human capital management with skill inventory (Balance Score Card)	
4.1.24	Poor coordination between health related other sectors (private sector/education/NGO/ labour department etc) to achieve the common goal	• Re establish the National Health Council and broad basing with other stakeholders (Health in all Policies)	

		• Establishment of a new health committee co-chaired by the Governor and Chief Minister with the participation of District Secretary of Districts		
4.1.25	compartmentalization of the service – e.g. NCD, nutrition	Develop a new Administrative structure of the department of health to coordinate the subject of Nutrition		
4.1.26	Gaps in the legal framework to maintain good governance of administration in health eg acts not up dated	Establishment of a standing committee to adopt , monitor good governance principles and to re visit and to formulate new acts		
4.1.27	Strengthening of middle level management to monitor HR (subordinate supervision)	System development to enhance supervisory capacity of middle level managers (updating protocols duty lists guidelines)		
4.1.28	Inadequate attention to Cost effectiveness of interventions	• Economic evaluations to be a part of health management • Establish a Health Economics cell		

No	Identified Issues	Proposed Strategies	indicators
4.2.1.	Cadre and norms need to be revised according to standard criteria (service demand / work load, demographic , geographical and territorial factors, international standards etc)	Develop HRH Policy (to improve planning , recruitment ,training , deployment , Career Development , Professional Development , Remuneration & rewarding , Retention and succession planning) And The said HRH policy includes the development of cadre norms (including new cadres/positions) in compliance with health care delivery needs and revise cadres at five year intervals	
4.2.2	Mal-distribution of health staff (Curative & Preventive) leading to disparities and inequalities among districts	Central Provincial Dialog to improve the dynamic staff distribution in compliance with health services delivery needs in the districts	
4.2.3	Organizational behavior and individual competencies (team work, empathy, attitudes, values, soft skills) are	Strengthening of Training and capacity building of HRH	

Thematic area 2 - General **HRH** issues

	to be developed to assure a responsive service		
4.2.4	Gaps in continuous updating of knowledge and skills	Introduce / support programs that aims continuous professional development (CPD) and training of all categories of health staff	
4.2.5	Inadequacies in Assessment system of performance (performance assessment)	Revisit current performance appraisal system and make recommendations for improvements	
4.2.6	Lack of job descriptions/duty lists to all categories based on service delivery	Update the description of tasks and responsibilities of different categories of staff (Preparation / updating of job descriptions and duty lists for all categories of health staff)	
4.2.7	Gap between expansion in Infra structure Vs inadequate development of Human resources = Often the expanded / new facilities remained closed due to non availability of Technical staff	Establish HRH unit in Department of Health and develop HRH plans in par with expansion of , or establishment of new facilities And Develop cadre norms (including new cadres/ positions) in compliance with health care delivery needs and revise cadres every five years	
4.2.8	Gaps in IT solutions/utilization to improve HRH	Develop and deploy enterprise level HRH management information system	
4.2.9	Gaps in skill mix	Maintain appropriate skill mix in HR production and distribution	

4.2.10	Gaps in HR development capacity –quantity and quality	Establish close corporation with Ministry of Higher Education and other relevant authorities (PGIM for Specialists and other universities for para medical degree holders) Improve the capacities of training institutions under the MoH Support , mentor and monitor health professional development programs in Private sector Introduce simulation and virtual reality technologies in trainings of HRH	
4.2.11	Gaps in facilities affecting equitable distribution of HR (Retention of Health)	Improve facilities for health staff at all levels Set minimum standards of facilities for all categories of health staff Survey the Availability of Quarters and Construct quarters on priority basis at institutions which have no quarters	
4.2.12	Limitations in the authority of the managers over selection, deployment, utilization, promotion and control over human resources	As described in the section on Health Administration , A high Level Committee (task force) should revisit the issue	
4.2.13	Lack of central mechanism for monitoring of HR at each (central/provincial/district/divisional) level	As described in section 8 above an enterprise level HRH management	

		information system should be established	
4.2.14	Production of HRH by different institutions is not appropriate/compatible for service delivery	Ensure adherence to the National Recruitment Criteria and National Training Curricula for the recruitment and training of professionals	
4.2.15	Lack of Transformative education (scaling up of education of all health staff based on current priority / important health needs- Elderly care, Palliative care, Human genetics, Mental health -child and adolescent psychology, Sub fertility, STD, Occupational Health & Safety)	Develop and adopt curricula for transformative health education	
4.2.16	HR needs to be identified to cater the future disease burden (projections)	HR unit to prepare cadre projections Promotion of Research and development in HRH Periodic Reviewing of HRH issues	
4.2.17	Non availability of organized system for handling of Occupational adverse events (Accidents , injuries , disease)	Improve Occupational health and safety	
4.2.18	Complains regarding Recruitment Vs Qualifications	Introduction of a digitalized selection and recruitment system for health staff to ensure good	

		governance	

Thematic area 3 - HR Issues in **Preventive** sector

No.	Identified Issues	Proposed Strategies/ Activities	Indicaors
4.3.1	Mal distribution, lack of commitment, shortages, inadequate capacity building, lack of attractiveness to preventive health services , lack of incentives, lack of a system for frequent updating of knowledge, lack of a coordinated approach in conflict resolution	Establish a Human resource unit in MoH and study the issues identified with a view to design sub strategies to address the said issues	
4.3.2	Lack of supervision	Establish an intensive system of supervision at all levels (with standard formats to report the findings at inspections) and monitor the degree of rectification of identified deficiencies at all levels	
4.3.3	Non availability of Continuous professional development system	Develop a continuous professional development system for preventive health staff	
4.3.4	Need to revise public health cadre norms eg one PHM per 1500 population	Review of cadre norms for public health staff and introduce new norms considering the expanded scope of work	
4.3.5	Non - Retention of Health workforce in rural areas Lack of Deployment Policy to address rural retention (HRH Policy)	Establishment of rural retention programme - eg. Incentive schemes for those in	

		rural/ difficult areas *Proposed by College of Consultant Community Physicians of Sri Lanka* *To develop a deployment mechanism based on vulnerability map (for all categories)* *To establish a mechanism for rational transfer prior to deployment of new recruits* *To re visit the deployment mechanism of M.OO trained in Community Medicine* *To re visit deploy criteria / mechanism of CCP* *To re visit deployment criteria of end posts at Public health institutions* *Advertize all CCP posts of Districts*	*Proposed by College of Consultant Community Physicians of Sri Lanka* *Deployment criteria based on Risk / Vulnerability index* *Each national level Preventive health institution should have at least one CCP* *Each District should have at least one CCP* *Technical units with (end and transferable posts) in which more than 50 percent of cadre positions are vacant , should be filled to meet the requirement* *CCP posts for Districts and Provinces should be responsible technically for Family Health , Epidemiology , Environmental & Occupational Health (E & OH) and Health Promotion*
4.3.6	Family practitioner who will provide holistic care which will include preventive and curative care is lacking - Family medicine model	Establish family medicine model through the proposed GP system	
4.3.7	Anomalies in benefits and allowances given to staff - inter provincial and between centre and province	Analyze the anomalies and rectify through the national & provincial Health Ministers Forum	

4.3.8	Creation of new cadres eg - Community Nurse for preventive & rehabilitation care	Establish Home based programme with the introduction of community Nurse for preventive & rehabilitation care of the needy members of family	
4.3.9	Job functions of all public health staff to be revisited considering their expanded scope of work , Population norm (cadre) to be revised	Establish the Human Resource unit and revisit job functions and cadre norms considering their expanded scope of work and increased population density	

Thematic area 4 - HR issues in **Curative Health** Care sector

No	Identified Issue	Proposed Strategies	Indicators
4.4.1.	Mal distribution of HRH	a) Establish HRH unit at national level (Health Department) and also at provincial level b) Development of a comprehensive HRH policy c) Policy measures for Retention	
4.4.2.	Comprehensive palliative care / highly specialized services not provided	a) Establish One palliative care hospice in each district	
		b) Establishment of specialized centres at district level (Poison,	

		dialysis)	
4.4.3.	Problem in dual clinical practice – jeopardizing patient care	Establish a system to contain Consultants and M OO in Govt Hospitals	
4.4.4.	No policy on finer specialties	a) Develop fine specialties such as Transplant (Kidney, Liver, and Stem cells), Genetic diagnosis in a phased manner based on the requirements	
		b) National policy on finer specialties such as cardio thoracic, plastic surgery, neuro surgery, cardio thoracic - heart lung trans plant surgery	
		c) Define job description and quantum of work for the finer specialists	
4.4.5.	**The present capacity of Medical Services Administration in the Department of Health Services is inadequate to coordinate the modern and new trends in development of Curative services**	**Establish reforms to the management structure of Curative Services Division (with necessary expansion of directorates to cater the demands)**	
4.4.6.	No CPD programme for technical category	a) Facilitate continuous professional development of staff to empower them with required knowledge, skills and attitudes	
		b) Link CPD points with	

		annual increment / Research allowance	

Thematic area 5 - HR issues in **Rehabilitation Health** care sector

No	Identified Issue	Proposed Strategies	Major Activities
4.5.1.	Insufficient HR for Disability care (eg Physiotherapists , Occupational Therapists)	Develop HRH strategy for rehabilitation services	1. Conduct needs assessment 2. Identification of necessary cadre with norms 3. Recruitment (from GCE A/L results)and training (basic & in service) 4. Encourage Private sector to train personnel for rehabilitation services with exam standardization

5 Health Financing

Thematic Area 1

Healthcare Insurance

No.	Identified issues	Proposed Strategies	SDG indicators
5.1.1.	Inadequate financial security for certain healthcare problems Eg Transplant Surgery (Liver , Kidney , etc) Coronary Artery Disease Congenital Malformations Neuro& Orthopedic Surgery Retinal & ENT surgery pre implantation genetic diagnosis, genetic diagnosis during pregnancy, IVF for subfertility	Introduction of a National Insurance Scheme for general population With Special emphasis to support financially the patients with life threatening clinical problems	*SDG indicator* *-Percentage of population without effective financial protection or health care* *-Waiting time for elective surgery*

Thematic Area 2

Financing issues in Preventive Health sector

No.	Identified Issues	Proposed Strategies/ Activities	
5.2.1	Inadequate funds for provincial councils which bears the key responsibility for community health services -	fund allocation structure to be revised	
5.2.2	Overall insufficient allocation for public health services – in turn leading to lack of provision of incentives	Incentives to public health staff who are responsible for all preventive and promotive health services to the people of the country	
5.2.3	Non availability of Proper logistics and transport facilities for public health sector	A need based allocative system for preventive health should be introduced	

Thematic area 3

Financing Issues in Rehabilitation Health care sector

No	Identified Issue	Proposed Strategies	Major Activities
5.3.1.	Affordability of rehabilitative services for general public	Increase budgetary provisions to equipment drugs and devices	Supply assistive devices (Intra Ocular Lenses , Wheel chairs , prosthetic and orthotic devices , hearing aids , etc)
5.3.2.	Un availability of proper social support or insurance scheme	Introduction of a national health insurance plan	Establishment of Social insurance cover / rehabilitation insurance cover

Thematic area 4

Sustainability of Health financing

No	Identified Issues	Proposed Strategies	SDG indicators
5.4.1.	Hospitals with Specialist care units in the Provincial Health Services (Base Hospitals A & B) are not having adequate financial resources for required standard development (infrastructure and medical equipment) As provincial funds are mostly diverted to develop Base Hospitals , the Primary Level Curative Institutions (DH A , B, C & PMCU) receive no funds at least to attend the repairs and rehabilitation of capital assets		*SDG indicators* *-Public & Private R & D expenditure on health (% of GNP)* *-Indicator on Technology sharing and diffusion* *-Official development assistance and nett private grants as percent of GNI* *-Domestic revenue allocated to sustainable development as percent of GNI , by sector*