

WHO
Country Cooperation Strategy
2002-2005
Sri Lanka
and
Its Application in the Development of
WHO RB 2004-2005 Strategic Plan

WHO Country Office
Colombo, Sri Lanka

FOREWORD

The process of developing the WHO Country Cooperation Strategy in Sri Lanka (CCS) is a long one. From its initiation in the early part of 2000 to the completion of this document, it has taken almost two years. The current document represents a major revision of the first draft Strategy document, which was completed in May 2000.

The CCS of Sri Lanka is built on the principles of equity, fairness and good governance. It focuses on improving the health status of the poor and the marginalized people who are hitherto underserved under the existing health system. It pays particular attention to the restoration of the health system in the North-East of the country which has been severely affected by almost two decades of internal conflict.

The CCS of Sri Lanka articulates the WHO Country Office's commitment to health development and equity in health. It intends to translate the WHO corporate strategy and the One WHO principle into practice in the country. The CCS also takes into account the commitment of WHO to the UN Millennium Development Goals, the changing context of international health, and the Organization's four strategic directions in the health sector.

A main feature of the CCS of Sri Lanka is its commitment to the Declaration of the Alma-Ata and to making the primary health care work. The document provides a clear orientation on how to implement the primary health care approach in Sri Lanka. It lays out the principles of the primary health care approach by which Sri Lanka will achieve the goal of health for all. The CCS gives particular emphasis on the need to develop and strengthen the district health system in order to bring better health services closer to the community.

While the CCS of Sri Lanka has now been fully developed and given wide recognition, it remains to be seen whether or not the strategy can be successfully implemented over the next few years, which depends on the commitment of the key stakeholders in the health sector to the overall goal of WHO, Sri Lanka and to the implementation of the strategy as a whole.

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SECTION 1: INTRODUCTION

The Country Cooperation Strategy (CCS) of Sri Lanka has been developed as a framework of cooperation between WHO and Sri Lanka. As a medium term strategy, it spells out the principles and values of WHO under which WHO commits itself to the betterment of the health sector as a whole. The CCS defines the priorities of WHO's work with the Government of Sri Lanka from 2002 to 2005 and serves as the fundamental guiding document for the development of all WHO technical programmes in the country.

The CCS is based on the following cooperation principles that guide WHO's work in and with Sri Lanka:

1. more strategic with greater emphasis on WHO's role as policy adviser and broker;
2. more selective focusing on upstream policy development and priority areas of work;
3. strong linkages between health actions and poverty reduction;
4. able to address, in a coherent and responsive manner, country, regional and global needs and priorities, and
5. clearer catalytic and leadership roles of WHO and better measures of WHO performance

The preparation of the CCS was started in the early part of 2000. It involved consultation and preparation at all levels of WHO. Initially, consultations took place at the WHO Headquarters. All parties agreed on a draft framework and the content of CCS. The Regional Office then suggested an outline plan of preparatory work. The process of formulating CCS was discussed in the Programme Development and Management Meeting, March 27-30, 2000, SEARO, New Delhi. Informal discussions took place between the WHO Country Office and the SEARO Team. A retreat was organized in Kandy for three days, April 17-19, 2000. The WHO country staff and the SEARO team worked together in the retreat and prepared a write-up entitled: **Health Challenges and WHO Responses (2002-2005)**. On April 19, 2000, the draft document was presented to a national group headed by the Director General of Health Services. An intensive discussion ensued, on the basis of which the revised document was prepared. The then Secretary of Health and Additional Secretary (Medical Services) of the Ministry of Health and Indigenous Medicine (MOH) were briefed on April 20, 2000 about the revised document.

The first version of the CCS document was an outcome of the above consultation process and comments obtained from SEARO and the MOH. The analytical approach employed in the CCS preparation process included the following steps:

- An analysis of country health situations in terms of overall development, health policy, health care financing, epidemiological profiles and health issues;
- A review of partnerships for health: external aid, UN and donor agencies' contributions, NGO and private sector involvement;

- A review of WHO collaborative programmes: past and present, their emphasis and achievements;
- Identification of implications of the WHO Corporate Strategy and core functions in the context of the country's prevailing health situation and future health scenarios; and
- Consideration of concerns of the MOH regarding health issues and priority interventions.

The draft WHO Cooperation Strategy for Sri Lanka was distributed to the concerned MOH officials in May 2000. It was used extensively to prepare Sri Lanka's RB 2002-2003 Detailed Plans of Action. Subsequent to the distribution of the draft CCS in 2000, several steps were further taken to finalize the draft. A series of consultative meetings were held between WHO and officials of the provincial health authorities to assess the needs of the health sector and in different parts of the country. An NGO profile was commissioned in 2001 to map the strengths, weaknesses and capacities of the national NGOs in the health sector. This was followed by a rapid health system study focusing on improving health care for the poor which was conducted by Drs. Fernando Lavadenz and Amala de Silva. Their analysis and findings were incorporated into this document. The CCS has also taken into consideration the commitments made by WHO to the objectives of United Nations Development Framework (UNDAF) in Sri Lanka and to the UN Millennium Goals (MDG) and the increasing involvement of the World Bank and some other bilateral donors in the health sector.

Two further consultations with MOH officials were held in April 2001 and March 2002. The final shape of the CCS of Sri Lanka was decided after the crucial meeting held between WHO and senior officials of MOH on March 15, 2002. In that meeting, the priorities of WHO's collaborative programme and its mode of operation were decided. It is expected that the final CCS document will be used as the basic document for the preparation of WHO's RB 2004-2005 country work plan.

SECTION 2: HEALTH AND DEVELOPMENT CHALLENGES

2. Country situation

2.1 An Overview of Development

Sri Lanka has achieved relatively high standards in social and health development. Its high level of attainment in the Human Development Index (HDI=0.711) has been a well-celebrated success story of a developing country. The level of achievement in terms of basic health and education indicators approaches the levels reached by the more developed countries. The life expectancy at birth (73 years) is considerably above the world average. The literacy rate is also relatively high (90 percent).

The gender development index for Sri Lanka is well above the average for developing countries. Gender empowerment in Sri Lanka is also much higher than in the rest of

the countries in South Asia. The female participation in the work force is fairly high, particularly in the professional grades and garment industries. There are also more women employed at administrative and technical levels than in the rest of South Asia.

The growth of GDP in Sri Lanka has been around 5 percent. The conflict in the North and East provinces has adversely affected the performance of the economy. The 1999 Annual Report of the Central Bank of Sri Lanka estimates that the conflict has reduced the Sri Lanka's economic growth by about 2.3% points a year. The recent economic downturn and the persistent drought over the last two years have eroded the economy of the country. Many households, particularly those from the rural areas, have become destitute or insolvent.

The sectors with the highest level of poverty are agriculture (51%) and mining and quarrying (59%). The available evidence from recent surveys shows that the bulk of the poor comprise:

- a) Workers and self employed individuals living in remote inaccessible areas which lack basic infrastructure.
- b) Landless workers engaged in temporary work which yield low wage rates such as agriculture, mining and quarrying, construction etc.
- c) Plantation workers.
- d) Significantly low income urban and slum shanty dwellers are also emerging as a major problem.

About 80% of the poor reside in the rural areas compared with 8% in the urban areas and 4% in the estate areas. A shift from a lower to a higher poverty line in some of the surveys carried out indicated a substantial rise in the poverty level in the above mentioned three sectors (i.e., agriculture, mining and quarrying). This suggests that borderline poverty is a significant problem in these sectors, with the estate sector showing the highest level of vulnerability. In terms of social indicators such as access to safe sanitation, safe drinking water, safe cooking fuel and electricity this sector is also the least developed. The 2000 demographic and Health survey (Dept. of Census & Statistics) revealed that in terms of selected indicators, the estate sector is more deprived than the other sectors e.g. Immunization coverage for children under 5 is significantly less than the children in urban and rural sectors and children under 5 in the estate sector are also significantly under-weight when compared with the children in the other 2 sectors. A recent study estimated that out of a total of 4.35 million children surveyed in the age group 5-17, 21% are engaged in some form of employment. 52% of child workers are below 15 years. 62% are male child workers and 95% come from rural areas. 10% of these children have not attended school at all. 20% of children have dropped out of school in order to gain some income generating employment.

Sri Lanka has been immersed in an ethnic conflict in the North and the East for over almost 2 decades. The humanitarian social and economic impact of the war is felt most directly by populations in the North and East and the areas bordering it. Some of the effects of the conflict include loss of lives and psychological trauma, damage to infrastructure and homes, displacement, restricted mobility, disruption of local

economies, disruption of community and institutional networks, disruption of educational facilities and deterioration of the health services. Although the Government is trying to maintain a normal level of health services in the conflict affected area, this could not be achieved due to the destruction of health facilities in a number of areas and the non-availability of qualified medical personnel. Virtually everyone in the Wanni area suffers from inadequate medical and educational services the conflict has caused. The United Nations has estimated that the number of persons internally displaced is around 600,000. A recent survey carried out in the Trincomalee district found that 27% of children under 5 were stunted, 26% were wasted and 50% were under-weight. All three indicators were significantly higher in the uncleared areas.

2.2 Health Policy

The National Health Policy has undergone changes twice in the last decade. Overall, the policy has remained consistent though there have been political changes in the government. The main aim of the health policy is to:

- Reform the organizational structure and management to improve efficiency, effectiveness and accountability.
- Establish mechanisms to provide need-based care, set priorities and allocate resources equitably.
- Focus on vulnerable groups and community needs that required special attention: the elderly, disabled, mental health
- Improve patient care provision and quality by reorganizing the health care delivery system especially at district and provincial level.
- Rationalize human resources development
- Increase the life expectancy by reducing preventable deaths due to both communicable and non-communicable diseases.
- Improve the quality of life by reducing preventable diseases, health problems and disability.
- Intensify health promotion through IEC and the media

2.3 Health Care Financing

Throughout the 1990's, total health expenditures were in the range of 3.1 to 3.5% of GDP with Government and the private sector taking almost an equal share of the total. A very large share of the public expenditure is incurred by the Central Government while provincial revenues and other public sources account for a relatively small part of the total expenditure. Most of the private financing is from the household out of pocket spending. Employer spending, commercial insurance and NGOs account for a minor share of the overall expenditure.

Public expenditures at current market price grew from Rs.5.6 billion in 1990 to 19.2 billion in 1999. Government and private sources accounted for approximately 50% each of total financing throughout the decade, or between 1.5 and 1.7% of GDP each.

Although real incomes rose strongly during the decade, government health expenditures rose much slower than the GDP in the same period.

Total Expenditure on Health at Current Market Prices – 1999

Total Public Sources (Rs. Billion)	- 19.2
Total Private Sources (Rs. Billion)	- 20.0
Total National Expenditures (Rs. Billion)	- 39.2

Health Allocation and Expenditure in 1999

Rs. In Million

Item	Recurrent	Capital	Total
Department of Health Services	8551.2	2705.6	11256.7
Provincial Council	4752.6	43.3	4795.9
Total health expenditure			
In Rs.	13303.8	2748.9	16052.7
In US\$	166.3	34.4	200.7
Ministry of Health and Indigenous Medicine	42.2	2253.4	2295.8
Department of Ayurvedic	98.6	34.4	133
Total Government Allocation in Rs.	200,842.7	138,391.3	339,234.0
Total Government Allocation in US\$	2,510.53	1,729.89	4,240.43
Total health allocation as % of total Government expenditure	6.6	2.0	4.7

Source: Management Development and Planning Unit

It has been stated in the Poverty Reduction Strategy document (PRSP) that:

“The government supports a policy of universal health services for all its citizens. Ensuring the continued financial sustainability of the health sector while protecting equity of access and quality of care poses an important challenge. To enhance the financial sustainability of the health care system the government will, by 2003, adopt a national health sector programmed approach that would introduce measures aimed at overcoming regional disparities in access, rationalizing investments and services, encouraging the adoption of health insurance and strengthening hospital-based management systems. The Government will maintain health care expenditures at 8 to 10 percent of total public outlays.”

In reality, the actual government expenditure on health ranged from 4.1% to 5.6% between 1996 and 1999 which does not support the comments of the PRSP that expenditure will be maintained at 8 to 10 percent of total public outlays. Currently, Sri Lanka spends around US\$10 per capita on health, only about half of which is borne by the Government. This amount is far below the estimation made by the World Bank in 1994 that the basic package for health should be at least US\$14 per person.

An analysis carried out by the Management Development and Planning Unit of the Health Ministry has found that the allocations made to the Provincial Councils should be enhanced and made more accountable. Depending on the health infrastructure,

disease pattern and major health issues, economically backward areas such as Moneragala should receive a more realistic allocation.

The percentage spent on Community Health Services was only 16.1% of the total health budget. This holds true at both national and provincial levels. Sri Lanka has realized that the health budget has a disproportionately larger allocation for the curative health services, whereas the emphasis should be on preventative and public health.

2.4 Health Situation

The successes achieved in the Sri Lanka health sector are well known. The vital health statistical parameters indicate the successes achieved by the country. The infant mortality rates, the maternal mortality rates and the crude death rates have been significantly lowered since the beginning of the last century. Sri Lanka has an excellent health infrastructure and has provided its people with medical institutions within a five-mile radius.

Life expectancy for males and females are 71 and 75 respectively. Sri Lanka, although having a modest GDP, has been hailed as a country that enjoys a good health status, which compares favourably with developed countries. Besides, Sri Lanka enjoys a high literacy rate. Since the early 1950's there was a population boom in Sri Lanka. However, with an effective family health programme, it has been able to reduce its annual population growth rate to a minimum. Sri Lanka has eradicated Smallpox and has now achieved Universal Child Immunization. It is now well on the way to another landmark, i.e., eradication of Polio.

Sri Lanka is in an epidemiological transition whilst still being affected by communicable diseases like malaria, tuberculosis, other vector borne diseases like Dengue Haemorrhagic Fever, Japanese Encephalitis, Diarrhoea and Acute Respiratory Infections, emerging diseases such as Cardiovascular Diseases (Coronary and Ischaemic heart diseases), Cerebro-vascular illnesses, Diabetes and Cancer are now playing a greater role in the morbidity and mortality patterns in Sri Lanka. Other components affecting health are pesticide poisoning. Sri Lanka has one of the highest suicide rates amongst adolescents and young adults. Malnutrition exists amongst disadvantaged populations in Sri Lanka especially in parts of the North-East, North Central and Uva Provinces.

With the increase in the life expectancy of the population and the steady decline in fertility, Sri Lanka is aging rapidly. It is projected that by 2020, 20 percent of Sri Lanka's population will have reached 60 years of age or over. Although the care for the elderly has been, to a large extent, carried out by their children, the extended family system is fast breaking down due to a change in the socio-economic structure and the rapidly growing urban population. The total fertility rate (TFR) in 2000 has reached a new low of 2.3. In a small family where both husband and wife are wage earners they are unable to look after their elderly parents. The successful family programme over the past three decades has substantially brought down the fertility

level of the population. The most recent contraceptive prevalence rate (2001) has been reported to be as high as 70.8%, although there still exists a fairly small but persistent percentage of eligible couple practicing traditional methods. Mortality rate, currently at 5.7 per 1,000 population (CDR in 2000), has been steadily declining since independence. The present trend has clearly indicated that Sri Lanka has entered the final stage of the demographic transition.

With the present conflict, over 600,000 persons have been displaced. The disease burden of malaria and diarrhoea are at a premium among the displaced persons and those living in the uncleared areas in the North-East. Tobacco, substance and alcohol abuse have also increased in magnitude over the past two decades.

Although HIV/AIDS situation in Sri Lanka is not alarming yet a cumulative total of 358 HIV infections has been reported out of an estimated 8,500 persons. The number of new cases detected in 2000 was 54. The male/female ratio is 1.6:1. Since 1992, the HIV infections amongst women have shown an upward trend. The predominant mode of transmission has been sexual (82%).

There are other problems that are related to the development of the health system in the country. The health information system of the MOH, which has only recently received greater attention, is in a weak state with little means to verify the quality of the data it collects and processes. Moreover, information utilization by the decisions makers is very low. The existing laboratory system and network has not been functioning properly which has become a major cause to frequent transfers from the lower level health facilities to the higher level institutions. The pharmaceutical system similarly has several problems. Quality control in pharmaceutical production as well as pricing and prescription of drugs and medicine have been major issues that have not received adequate attention. Human resource development and deployment continues to be a major problem in the state health sector, which has adversely affecting the peripheral health system. There is an acute shortage of nurses and other allied health and medical personnel in the country while concerns of health education continue to be dominated by issues related only to the production of medical doctors. The current health situation is further affected by the unwillingness of medical professionals to work in the peripheral areas and their over-concentration in large urban centers, depriving the rural population from getting a fair share of the health services they deserve. The imbalanced human resource development and deployment in the health sector has now substantially eroded the integrity of the health system at the sub-national level.

Although there have been a series of attempts to reform and to decentralize the health system since 1987, the reform agenda could not be completed due to various reasons. All these have called for a continual reform of the health sector with a substantial improvement over the stewardship of the health system. WHO has a major role to play in assisting the Government as well as other stakeholders in the health sector to put the health system back on the right direction.

SECTION 3: DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

3.1 Overall Trend in Aid

The total foreign aid received during the period 1990-1999 amounted to US\$5,983.3 million. Of the total, 1,629.2 million (27.2%) was grant; the balance \$4,354.1 million (72.8%) was loan. There is an overall downward trend with marked yearly fluctuations. The amount received was highest in 1991: US\$885.5 million and lowest in 1999: 408.6 million. The trend has declined as regards grant aid: US\$ 242.2 million in 1993 and US\$ 71.0 million in 1999.

Foreign aid, in the form of financial assistance, drugs and medicine, supplies and equipment, and technical expertise, is provided to the health sector every year. It is difficult to estimate the amount of aid provided to the private sector through national and international NGOs and the civil society in Sri Lanka due to the large number of such organizations in the health sector. It is known that they play a very important role in providing health services and supporting the health system in many parts of the country, particularly in the North-East Provinces and the remote communities.

It is possible to obtain fairly reliable data on the total amount of foreign aid provided to the state health sector. Most of the aid goes to the Ministry of Health. The total amount received for the health sector during the same period was \$116.5 million: \$62.2 million (53.4%) as grant and \$54.3 million (46.6%) as loan. This was 1.95 percent of the total aid. The trend declined till 1995: US\$5.1 million, compared to 12.9 million in 1992. However, in 1998 the amount increased to \$23.2 million from 8.6 million in 1997 and then dropped down to 15.1million in 1999. The amount of grant aid ranged from \$10.4 million (1990) to \$1.1 million (1996). One of the main reasons for the wide fluctuations in aid, particularly for the health sector is due to inadequate capacity in terms of project development and advocacy for mobilization of foreign assistance. In fact, until recently, foreign assistance was more donor driven than demand driven.

As a proportion to the overall health expenditure by the Government, foreign aid accounts for no more than 10 percent cent, which is not a very significant contribution to the health sector.

Foreign Aid to the Health Sector as a Percentage of the Total State Health Expenditure	
	%
1996	2.6
1997	4.9
1998	4.9
1999	10.0
2000	3.6

Major Development Partners in the Health Sector in Sri Lanka (1998-2000):
IDA/WB
UNICEF
WHO
UNFPA
JICA
Republic of Korea (Economic Development Coop. Fund)
UNDP
Government of France
Government of China

With the change of Government in late 2001 and the signing of an MOU in February 2002 between the new Government and the LTTE leading to a tentative total ceasefire and the possibility of reaching long term peace in the North-East, the demand for foreign aid in the health sector both for the purpose of restoring the health sector in the conflict affected area and for the strengthening of peripheral health services is expected to rise tremendously in the next few years. Many donors and financing institutions are ready to extend their assistance to the health sector of Sri Lanka.

3.2 Partnerships in Health

Partnerships can be differentiated in the following manner:

- Partnership within the health sector including within the government sector and between government and private sector,
- Partnership between the health sector and other sectors,
- Partnership between government sector and other voluntary and international/bilateral agencies, and
- Partnership between the centre and the provinces

Over the last decade, a number of problems in the health sector have been created unwittingly by other elite disciplines and development schemes. The health sector has been fighting a lone war to control diseases like malaria and environmental health problems. It has now been recognized that the health sector cannot be given the sole responsibility in control of such problems and that partnerships must be built at District, Provincial and National levels.

To instill a sense of ownership, the partners must be actively involved in the health project. The activities, which each partner should perform, must be clearly defined. Sectors like Irrigation and Mahaweli and the Dept. of Education have key roles to play.

Most health activities are community based. Media Involvement and Health Education is necessary for Community Awareness and Action. Media Involvement must be at District, Provincial and National levels.

NGOs and Volunteers are needed to make the programme more effective. NGOs, Volunteers and International Agencies, like the Red Cross, MSF, Oxfam, Care and UNHCR will help to augment and supplement the programmes in the conflict areas, where Government human resources and activities are limited.

Private Medical Practitioners and Ayurveda can also help in the treatment of diseases. Their involvement at District and Provincial level is essential.

Service Clubs, like Rotary, Lions and Jaycees can play an important role in health activities at the District and Provincial level. There is also a place for Sarvodaya and Women's Organizations and also in training programmes at these levels.

The Private Sector and the Pharmaceutical Industry can be used, at National, Provincial and District levels to enhance treatment and facilitate the supply of drugs in the Private Sector.

In the case of International Agencies and Bilateral Donor Agencies, the National Authorities should clearly spell out with justification, the additional resources required. To maintain and sustain their interest they should also be made to play a participatory role in periodic reviews of the programme.

3.3 UN Agencies (Other than WHO)

UNDP has been active in helping the war affected by supporting special protective measures. These include: assisting traumatized women and children; creating mine awareness; prosthesis and physiotherapy services; education for conflict resolutions; promoting the concept of children as zones of peace. UNCHR has been pursuing three goals; minimize internal displacement and provide alternatives to flight; stabilize internal displacement and prepare the displaced to help themselves; and facilitate the return of the displaced to their original homes and reintegrate them into the community.

WFP provides emergency food assistance and food for works especially in the conflict areas. FAO support includes: the special programme on Food Security; Disease prevention and health management in coastal shrimp culture; aquaculture development; Home gardening integrated with poultry; Small scale fish culture; and provision of insulated fish containers to small-scale fish folk. ILO is assisting in strengthening industrial relations, human resource development, elimination of child labour and promoting occupational safety and health.

UNICEF works on a five-year programme. The present five year programme (2002-2007) includes a budget of US\$ 3.9 million (Co-budget) and they will mobilise another US\$ 10.00 million for their overall programme activities. The programme includes early childhood development (0-5 years); learning years (5-14 years); adolescence; protection of women and children and a planning section for implementation of these target areas activities. Due to the conflict, UNICEF has a separate programme for the North-East namely; Children Affected by the Arm Conflict (CAAC). It deals with refugees, focusing on women and children, resettlement of refugees and problems faced by the population in the un-cleared areas of the North-East. 11 districts have been demarcated.

The Population and Reproductive Health Policy and a Plan of Action have been developed in collaboration with UNFPA. UNFPA is supporting the government efforts to improve the RH status of people through quality information, education and communication. UNFPA has been supporting the organization of Well Women's Clinics. These clinics screen apparently healthy women aged 35 and above for cervical and breast cancer, diabetes and hypertension. Some NGOs are being supported in providing health care services to vulnerable groups such as internally displaced persons, adolescents and youth, and women particularly in the estate sector

and export processing zones. UNFPA is helping in institutionalising RH education in Sri Lanka's national school system.

3.4 Banks

IDA/WB

The IDA/WB project (1999-2001) involves US\$22.6 million, 83 percent of which is provided by the World Bank as a soft loan. The balance is local taxes and duties funded by the Government. The project components are for: Malaria, STD/AIDS, Nutrition, Health Education, etc.

Asian Development Bank – The second health and Population project of ADB (1993-98) involving a total loan of US\$ 33.26 million was designed to support the national efforts for improving the health care system in three provinces and two districts. The infrastructures of the hospitals were strengthened by upgrading existing buildings and constructing new buildings. Medical equipment and ambulances were produced. Foreign and local training and consultancy services were funded for improving managerial capacities.

3.5 Bilateral Donors

A number of bilateral donor countries/agencies are presently supporting national efforts for health development. JICA has been a major partner with the Ministry of Health in recent years. For example, a nurse training school was constructed in 1999 with JICA's financial support. The development of the Health Sector Master Plan represents the latest endeavour of JICA, which involves the coordination and partnership of other development partners such as the World Bank and WHO. The Republic of Korea has recently funded the development of two district hospitals, Rs. 1.2 billion approximately. China has funded the construction of a new building for Lady Ridgeway Hospital, Rs. 495 million, and France has provided equipment for the cardiology unit of the Kandy Teaching Hospital, Rs.152 million. FINIDA, NORAD and SLIDA have supported some selected initiatives. Overall, with the exception of the Japanese Government, the Group of Seven has not been a very active partner with the MOH.

3.6 Private Sector

The private health sector has been growing steadily. In 1990, there were 1872 beds in private hospitals. The number increased to 2305 in 1997. The number of Ayurvedic Practitioners increased from 13284 to 15076 during the said period. There are approximately 800 full-time, qualified private practitioners in Allopathic medicine. The actual number of full time private practitioners is however not known. Also, a majority of Government doctors do private practice in off-duty hours. However, this should not be seen as a form of partnership between the state and the private sector.

Rather, without proper monitoring and regulation of the private sector, private practice by state employed practitioners could, to say the least, complicate the financing situation in the health sector. In 1997, 204000 admissions were reported from private hospitals, compared to 117000 in 1990. The outpatient visits were 568,000 in 1990 and 1.617 million in 1997. A pattern of health service utilization is beginning to emerge with the private sector providing mostly out-patient care and the public sector dominating the inpatient services.

3.7 NGOs and Community Support

The NGOs and community-based organizations organize important non-governmental activities addressing people's needs increasing the arena of collective development action whether delivering development services or mediating in voicing their needs. Institutionalising their role as inter-mediate organizations, linking government and people in a responsive manner is a challenge in effective governance of development. NGOs can make a significant contribution to sustainable human development as an agent for delivering services and partnering the government services in the management of development.

In the health sector, the Ministry of Health acts as the focal point for NGOs engaged in health related activities. When the applications for registration are received from the NGO secretariat the objectives of the NGOs are scrutinized to ascertain their relevance to programme activities of the Ministry of Health and if suitable, approval is given to the NGO secretariat. The MOH routinely requests the NGO secretariat to instruct the concerned NGO to liaise with the relevant Medical Officer of Health. However, much of the NGO linkage with the state health sector is confined to the use of health personnel in respective activities.

Some of the successes in NGO coordinated activities had been Sarvodaya's role in malaria control and now in the Roll Back Malaria Initiative at district, provincial and national levels. The Rotary Clubs of Sri Lanka have achieved a spectacular success in the polio eradication programmes of Sri Lanka. NGOs have also played a role in effective family planning programmes in Sri Lanka and helped to take these programmes to out-reach areas. In drug addiction and alcohol abuse programmes, NGOs have played a greater role than the government sector in rehabilitative programmes for the abusers. The comparative advantage of NGOs in community services and health promotion is well recognized.

WHO has with the assistance of the Marga Institute developed the profiles on health related NGOs in Sri Lanka. It is hoped that the CCS will foster greater use of these NGOs by the National, Provincial and District health authorities.

3.8 A New Partnership

The formation of the new Global Fund against AIDS, Tuberculosis and Malaria (GFATM) in 2001 has provided yet another opportunity for Sri Lanka to explore a

new approach to form an effective partnership to deal with multiple health issues in a concerted manner. The application for the GFATM required that an inter-sectoral Country Coordination Mechanism (CCM) be established and to formulate one or more proposals together to deal with the three diseases. Under the leadership of WHO and in collaboration with the Ministry of Health, an inter-sectoral Country Coordination Mechanism (CCM) was established comprising the Ministry of Health, UN Agencies, World Bank, Universities, NGOs, Service Clubs and the Private Sector. Three proposals were developed and submitted to the GFATM for funding. Sri Lanka is a successful applicant for all three proposals under the Global Fund against AIDS, TB and Malaria (GFATM). It will be receiving financial assistance from the GFATM from 2002. It is hoped that the success of the GFATM will generate renewed interests in forming larger and wider partnerships among the Government, the private sector, NGOs, civil society and the development partners in dealing with the health

SECTION 4: WHO CORPORATE POLICY FRAMEWORK

4.1 Global And Regional Directions

WHO has re-evaluated the way in which it should work, against a background of improved understanding on the importance of multisectoral responses which are required to achieve better health; the relationship between improved health and poverty reduction; the emergence of the private sector and civil society as an important player to complement the evolving role of the state; the increased involvement of development agencies in the health sector and the heightened importance of safeguarding health in the proliferating occurrence of conflict and disaster.

In response to challenges from this broadened context of international health, WHO globally will:

1. Adopt a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction.
2. Play a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise
3. Trigger more effective action to improve health and to decrease inequities in health outcomes, by carefully negotiating partnerships and catalysing action on the part of others.
4. Create an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

In so doing, it will draw on the respective and complementary strengths of headquarters, regional and country offices under the One WHO policy.

As an integral part of the UN system, WHO also has an obligation to commit itself to the achievement of the global UN Millennium Development Goals (MDG) by the year 2015.

UN Millennium Development Goals

1. Eradicate extreme poverty and hunger;
2. Achieve universal primary education;
3. Promote gender equality and empower women;
4. Reduce child mortality;
5. Improve maternal health;
6. Combat HIV/AIDS, malaria and other diseases;
7. Ensure environmental sustainability; and
8. Develop a global partnership for development.

All of the MDGs are consistent with the overall objective of WHO in attaining the highest level of health by all populations and putting health in the centre of development. They are thus strongly committed to by WHO in all Member States. Based on the MDGs, three UN strategic goals have been developed in Sri Lanka and the WHO Country Office (WCO) has taken a number of initiatives to contribute to these three goals (**ANNEX-I**).

UN STRATEGIC GOALS IN SRI LANKA

1. Provision of emergency and humanitarian assistance to conflict affected areas and people.
2. Assisting in restoring economic livelihood of adversely affected persons and provide support for efforts that contribute to the establishment of peace and social cohesion.
3. Reduction of poverty through promoting improved accessibility to basic services and the creation of economic opportunities for the poor.

To realize the goals of building healthy populations and communities and to combat ill health, WHO has adopted four strategic directions, which provide the broad framework for focusing the technical work of the Secretariat.

WHO's Four Strategic Directions

1. Reducing excess mortality, morbidity and disability especially in poor and marginalized populations.
2. Promoting healthy lifestyles and reducing the risk factors to human health.
3. Developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair.
4. Developing an enabling policy and institutional environment in the health sector and promoting an effective health dimension to social, economic and environmental policy.

The background of WHO's corporate policy framework and CCS, and the UN and WHO goals and strategies are summarized as **Annex I and II**.

For the purpose of identifying the organization-wide priorities, the following selection criteria were adopted by WHO:

1. Potential for significant change in burden of disease with existing cost-effective interventions,
2. Health problems with major impact on socio-economic development and a disproportionate impact on the lives of the poor,
3. Urgent need for new technologies,
4. Opportunities to reduce health inequalities within and between countries,
5. WHO's advantages, particularly in relation to public goods; building of consensus around policies, strategies and standards; initiation and management of partnerships, and
6. Major demand for WHO support from Member States.

In the South-East Asian Region, the Regional Declaration for Health Development in the 21st century has reaffirmed a commitment to the importance of access to health care by all, through strengthening the capacity of the health sector to develop mutual partnerships within the context of strong regional solidarity. Regional Parliamentarians have pledged to take appropriate measures in response to effects of globalisation such as the further marginalization of the poor and the under-served, the need for improved measures for health care financing, decentralization etc. The 1999 Calcutta Declaration has called for the promotion of public health as a discipline and an essential requirement for further health development, through achieving more evidence-based public health policies, reforming public health education and training.

Under the WHO General Programme of Work 2002-2005, the following organization-wide priorities were identified:

RB 2002-2003	RB 2004-2005
1. Malaria	1. Malaria
2. Tuberculosis	2. Tuberculosis
3. HIV/AIDS	3. HIV/AIDS
4. Cancer, cardiovascular disease and diabetes	4. Cancer, cardiovascular disease and diabetes
5. Tobacco	5. Tobacco
6. Maternal health	6. Maternal health
7. Food safety	7. Food safety
8. Mental health	8. Mental health

9. Safe blood	9. Safe blood
10. Health systems	10. Health systems
11. Investing in change in WHO	11. Health and environment

Within WHO's priority areas of work, the South-East Asia Region will focus on Malaria, HIV-AIDS, Tuberculosis, Maternal Health, Tobacco, Major Non-Communicable Diseases, Food Safety, Safe Blood and Health Systems. The region will also focus on diseases for eradication and elimination (Polio and Leprosy), locally epidemic and endemic diseases and environmental health risks.

To uphold the core functions of the WHO, the South-East Asia Region will emphasize articulating and advocating evidence-based policies and strategies; maintaining high level technical expertise for catalysing change and enhancing partnerships. The Region will also sustain national and regional health development capability. Particular attention will be paid to managing information; setting and validating norms and standards and developing and testing new technologies, tools and guidelines.

SECTION 5: WHO'S COUNTRY PROGRAMME

Since the establishment of the Sri Lanka country office in 1952, WHO has been working very closely with the Government and other key stakeholders in the health sector. As an intergovernmental agency, WHO's key partner is the Ministry of Health. The resources provided to the Government are assessed by WHO and utilization of WHO resources is planned bilaterally on a biennium basis. WHO has been playing an important role in Sri Lanka's national health development.

Over the years, as the health sector has become more and more complex and with increasing involvement by the Government in health system development, the scope of collaboration between WHO and MOH has expanded substantially leading to the establishment of a large number of collaborative projects to cover several areas. Although the adoption of the programme approach since the RB1996-1997 biennium has managed to consolidate WHO's inputs into fewer areas, the actual number of components (sub-programme areas) that require WHO support continues to be large. On the other hand, WHO's financial assistance under the regular budget has been progressively curtailed. This situation has led to the spread of WHO resources to a dangerously thin level which threatens the effectiveness of WHO's work in the country.

Quantitatively, WHO's financial contribution to the national health sector is relatively small, compared with the Government's expenditure on health. However, technically, WHO is well placed in the health sector and has been able to play a leading role in exerting a fair amount of influence on the development of the health sector through its collaborative efforts.

Under the WHO RB 2002-2003 Programme, a new planning approach has been introduced. The new approach, which involves the implementation of the One WHO policy and the harmonization of WHO's contributions across all levels, is a result of the realization by WHO that, to overcome its constraints, it has to reform itself so that its inputs will be more focused, more strategic and more innovative and effective in achieving its goals and objectives. A total of twenty-seven Areas of Work (excluding areas that are only relevant to the WHO Secretariat) have been developed. Of which, programmes were developed in twenty-four areas of work under six clusters in Sri Lanka which addressed WHO's eleven organization-wide and sixteen country-wide priority issues identified by the Government.

The sixteen country-wide priority health issues

- Maternal and child health problems
- Malnutrition and nutritional deficiencies
- Problems of the elderly
- Malaria and Dengue hemorrhagic fever
- Diarrhoeal diseases
- Tuberculosis
- Mental health problems

- Suicides
- Accidents
- Cardiovascular diseases
- Diabetes
- Cerebro vascular accidents
- Malignancies
- STD/HIV-AIDS
- Substance abuse
- Rabies

Table 1 presents the programmes that are currently supported under the 2002-2003 biennium regular budget. The table also provides brief information on programmes that are supported by other donors or under WHO's extra-regular budget. It can be seen from the table that in two areas of work, namely, research and programme development in reproductive health and sustainable development, there is no input by either WHO or other development partners.

TABLE 1: Programme Areas Supported by WHO and Other Development Partners:

Area of Work	WHO RB Area of Work in Sri Lanka (2002-2003)	WHO EB Area of Work in Sri Lanka (2002-2003)	Area of Work of other development partners
Communicable disease surveillance	Rabies, DF/DHF, Filariasis, Hepatitis B, general epidemiological surveillance and outbreak investigation	Filariasis, multi-disease surveillance	
Communicable disease prevention, eradication and control	Filariasis, rabies, DF/DHF, leprosy	-	-
Research and product development for communicable diseases	Strengthening of MRI	Drug resistance	Malaria drug resistance, alternate drugs in malaria drug resistance cases.
Malaria	Surveillance, prevention and control, logistics	RMB (surveillance, prevention and control, logistics)	Programme funding only. Applied for GFATM, MIS, Combination of drugs, water manipulation, impregnated curtains
Tuberculosis	Prevention and control	-	Applied for funding under GFATM
Surveillance, prevention and management of noncommunicable diseases	NCD (surveillance) Cancer (survey, prevention), cardiovascular disease (prevention), diabetes (prevention) Oral health (education, control of oral diseases) Poisoning (prevention and treatment)	NCD Surveillance	-

Area of Work	WHO RB Area of Work in Sri Lanka (2002-2003)	WHO EB Area of Work in Sri Lanka (2002-2003)	Area of Work of other development partners
Tobacco	Surveillance, prevention, monitoring	Framework Convention on Tobacco Control	-
Health promotion	Training, policy development, IEC, evaluation	-	-
Disability/injury prevention and rehabilitation	Prevention of disability among children, screening and rehabilitative services. Community health care for the elderly (prevention and training)	-	North East area conflict related action only (prevention, treatment and rehabilitation)
Mental health and substance abuse	Disease burden assessment, Community based national mental health programme (training, prevention and control, rehabilitation, IEC), epilepsy (IEC and training)	Health as a Bridge for Peace programme	Drug addicts rehabilitation (UNDCP)
Child and adolescent health	Growth monitoring and promotion programme, low birth weight surveillance, life skills development, child mental health, IEC		Implementation of child health programme, growth monitoring and IEC
Research and programme development in reproductive health	-	-	-
Making pregnancy safer/maternal health	Morbidity and maternal nutrition surveillance, maternal care and postpartum, neonatal infection control/prevention		Reproductive health, family planning, etc (UNFPA).
Women's health	Migrant and female workers' health risks, needs study	Women's health profile	-
HIV/AIDS	Surveillance and BoD study, training in syndromic management and laboratory services, evaluation	-	Programme funding only. Applied for GFATM, all areas with involvement of multiple partners
Sustainable development	-	-	-
Nutrition	District nutrition survey, diet related morbidity, obesity and osteoporosis risk factor surveys, IEC, nutrition promotion among the elderly	-	Comprehensive nutrition programme (UNICEF)
Health and environment	Monitoring of and research on air pollution, IEC, water quality surveillance, training on water treatment, water improvement research, rural sanitation system, training,	-	-

Area of Work	WHO RB Area of Work in Sri Lanka (2002-2003)	WHO EB Area of Work in Sri Lanka (2002-2003)	Area of Work of other development partners
	occupational health training and research.		
Food safety	MIS, HRD (training) and legislation review	-	-
Emergency preparedness and response	-	Health emergency assistance for affected population	Relief, rehabilitation, health services
Essential medicines: access, quality and rational use	GMP and storage training, Ayurvedic medicine quality control and standardization, training in clinical analysis, rational prescription of drugs, introduction of new indigenous medicine	-	-
Immunization and vaccine development	Hepatitis B prevalence study, measles surveillance and lab. training, AEFI monitoring, EPI vaccine quality surveys, monitoring and evaluation of EPI programme	Polio eradication	Polio eradication
Blood safety and clinical technology	Computerized maintenance management system, training, quality control of national laboratories, training and TA to improve blood quality and safety	-	Blood Bank
Evidence for health policy	Analysis/studies of health policies and health systems, NHA, decentralized health monitoring and evaluation system	Conduct of World Health Survey	NHA, sector development master plan
Health information management and dissemination	Provincial and ministerial MIS development, HELLIS	Training on ICD-10.	-
Research policy and promotion	Training on research and evaluation of PHC services	-	-
Organization of health services	NIHS strengthening, HRD, health system development, medical education, strengthening of MoH management and planning	-	-

SECTION 6: STRATEGIC AGENDA FOR SRI LANKA

6.1 The Need to Develop a Strategic Agenda

The significant health achievements made over the last few decades, which give the citizens of Sri Lanka the highest health status in South Asia, need to be consolidated and protected given the rapidly changing demographic and epidemiological scenarios in the country. The demographic and epidemiological transitions resulting from declining fertility and mortality have made it necessary for the Government to assess the effectiveness of past strategies in dealing with its current and future health issues. Moreover, Sri Lanka has yet to be able to tackle the problems of poverty and its health implications such as malnutrition, substance abuse, suicide and mental disorders.

Sri Lanka's past successes were built on the foundation of primary and public health rather than on curative and tertiary care. Its approach to improve the health sector has been based on the principle of incremental change rather than on a sector-wide reform to avoid bringing about rapid but uncertain changes to the sector. This approach has, on the one hand, given steady and stable improvements to the health sector over the long run, and enhanced, to a certain extent, the health status of the poor, it has, on the other hand, failed to close the health gaps between the poor who mostly reside in remote and rural areas and the more well-to-do who mostly settle in large urban or suburban areas. The recently drafted Poverty Reduction Strategy Paper (PRSP) by the National Planning Department of the Ministry of Finance acknowledges the problems of poverty in the country and identifies the role of each sectoral authority in poverty reduction. The health sector has been figured prominently. Five health priority strategies have been identified by the draft PRSP:

1. Expand access to curative health care services through hospitals and other providers at the District level to make these services more accessible in poor rural areas.
2. Expand health care services to meet the needs of specific groups such as the elderly, victims of war and conflict, and promoting specific areas of health care such as occupational health problems, mental health care and estate health services.
3. Develop health promotion programmes with specific emphasis on outreach through the schools.
4. Reform health care funding including a better effort to mobilize and manage resources in both the public and private sector.
5. Rationalize the development of human resources.

The PRSP encourages the partnership of government and private sector to develop secondary and tertiary care. To take into consideration that the population is rapidly ageing, the PRSP suggests expanding training in geriatric medicine and encourages the adoption of health insurance to meet the financial requirements of increasingly sophisticated medical care. While the PRSP has made some positive recommendations to improve certain areas in the health sector for the benefits of the poor, it did not deal with the fundamental issues of how to mainstream the poor into

the health system and how to deal with the root causes of the cycle of poverty. Moreover, its emphasis on curative health care rather than on primary and preventive health care is perhaps, not the most appropriate approach to poverty reduction considering the fact that curative health care is a lot more costly than primary and preventive health care. Further, the PRSP did not discuss the problem of malnutrition among the poor in the country.

The 13th Constitutional amendment of 1987, which gave rise to the decentralization of a number of sectors, including health, to the provincial and lower level represents the last major attempt to reform the health sector with an aim to bring health services closer to the community. While this attempt was well intended, the process of decentralization is, by no means, perfect and well deliberated. Decentralization of the health sector is far from complete after fifteen years. There is increasing evidence that coordination between the central and provincial health authorities is slipping. There are also problems in the areas of resource sharing and division of labour. Questions of who should be held accountable for the delivery of quality health services to the community according to norms and standards have increasingly been raised.

Recent national health account data revealed that, contrary to its long tradition of putting emphasis on primary and public health aiming at providing better access and better services to the community, the Government has been spending only around 16% of its allocations on primary health care. Most of its resources have been invested in tertiary health care whose benefits are not equitably distributed to the have and the have-nots. Moreover, the emphasis on curative health care rather than on preventive care greatly increases the cost to the Government.

In addition to the above sector wide issues, during the WHO-MOH CCS consultation meeting held recently, a number of challenges facing MOH were discussed which need to be addressed:

Key Issues and Challenges for MOH
<p>Policy, Strategies and Priority Setting:</p> <ul style="list-style-type: none"> ▪ Is there a clear vision of future of health sector? ▪ Is there a clear cut health policy and programme and resource development strategy? ▪ Do evidence-based strategies (priority setting) exist? ▪ Are the analyses of NHA and health trends adequate?
<p>Coordination and Organization:</p> <ul style="list-style-type: none"> ▪ Are there clear linkages between central and provincial MOH? ▪ Is the classification of varuiys facilities in different locations appropriate? ▪ What are the roles and responsibilities of staff? Are they documented? Are the staff aware of them? ▪ How efficient and effective is the organization of Ministry of Health and its Department?
<p>Information:</p> <ul style="list-style-type: none"> ▪ Are the overall system development plans, strategies and directions clear to the decision makers? ▪ Is the key information available? ▪ Is key information available only to certain areas? ▪ Is key information routinely collected and verified

<ul style="list-style-type: none"> ▪ Is the difference between IT development and system development clear to the responsible persons? ▪ Is the information network operating satisfactorily? ▪ Is information satisfactorily disseminated? ▪ Are data regularly analyzed and made use of?
<p>Management and Planning:</p> <ul style="list-style-type: none"> ▪ Are the plans strategic? ▪ Is the planning process evidence-based? ▪ Are the management roles and responsibilities at different levels of government clear? ▪ Is there sufficient information for sound planning? ▪ Is there adequate coordination within planning units?
<p>Resource allocation:</p> <ul style="list-style-type: none"> ▪ Are equity and fairness given sufficient consideration? ▪ Is the allocation pro-poor? ▪ Is there sufficient allocation to primary health care? ▪ Is the allocation evidence-based?
<p>Programme Implementation:</p> <ul style="list-style-type: none"> ▪ Is there any accountability? ▪ Do programme activities always experience problems of late commencement and completion? ▪ Are the decision makers clear about who the beneficiaries should be? ▪ Is the programme resource based or result based?
<p>Monitoring and Evaluation:</p> <ul style="list-style-type: none"> ▪ Are there indicators and milestones in all health plans? ▪ Are the roles and responsibilities within the Ministry and Department and between levels of Government clear? ▪ Are the utilities of monitoring and evaluation clear to decision makers and planners?
<p>Funding and Resource Mobilization:</p> <ul style="list-style-type: none"> ▪ Are resources sufficiently and equitably provided in key areas? ▪ Is there any difficulty in getting donors? ▪ Is there good knowledge of resource mobilization techniques? ▪ Are proposals properly prepared and submitted in time? ▪ Is there sufficient knowledge of health sector resource gaps?
<p>Quality Assurance:</p> <ul style="list-style-type: none"> ▪ Are there policies, strategies and guidelines to ensure quality of programme activities and responsiveness of the health system? ▪ Is there too much emphasis on quantity rather than on quality? ▪ Is there any programme on quality assurance?
<p>Support Services:</p> <ul style="list-style-type: none"> ▪ Are inputs adequate and are they well coordinated? ▪ Are there clear cut strategies and policies? ▪ Is adequate attention given to quality assurance issues?
<p>Health System:</p> <ul style="list-style-type: none"> ▪ Is there a full commitment to review the current health system? ▪ What is the future direction of the health system? ▪ Do development priorities exist and is there a process of updating the national health policy? ▪ Are health system issues regularly examined?

A number of the above issues are being addressed by the MOH or with the assistance of other development partners. The WHO is in the opinion that, by refocusing its resources more strategically, the Government, in collaboration with WHO, can resolve many of the above challenges in the health sector. Regarding the need for WHO's intervention or assistance, the following criteria may be used to determine the need for its involvement.

Criteria for WHO's Involvement

1. Areas where WHO has a catalytic and leadership role to play
2. Scope for long term strategic involvement leading to significant outcomes
3. Areas where equity and partnership need to be promoted.
4. Critical support required in areas of decentralization, research, information, and effective and efficient decision making.
5. Innovative approaches to integrate health concern into development.

Further to the criteria for WHO's involvement, the WCO in Sri Lanka will use the following criteria to decide WHO's response to the country challenges.

Criteria for WHO's Response

1. Evidence-based country needs and challenges;
2. Existing inputs from other agencies and development partners;
3. Compliance with WHO corporate objectives and directions;
4. Perspectives of different stakeholders of the role of WHO;
5. WHO's actual and potential comparative advantage; and
6. WHO's actual and potential technical capacity to contribute positively to the issue(s) in question and the opportunity for new and strengthened partnerships.

Annex III summarizes the objective of the key process of the CCS development in Sri Lanka and the criteria used for identifying the challenges and for deciding WHO's involvement in the health sector.

6.2 Overall Goal of WHO, Sri Lanka

Against the backdrop of the above scenario, *the overall goal of the World Health Organization in Sri Lanka is to attain the highest level of health through strengthening of the health system at national, provincial and district levels on principles of equity, fairness and responsiveness with emphasis on the poor and the marginalized.* This will be accomplished by forming partnerships with all stakeholders of the health sector, focusing on the development and adoption of norms and standards, initiate catalytic change through technical and policy support, advocating and articulating evidence based policies and strategies, stimulating research and development and monitoring of trends and performances.

6.3 Key Strategic Directions and Functions

The main objective of WHO's strategy is to develop a pro-poor and decentralized health system that is equitable, fair and responsive through improving the process of

health policy development, planning, implementation, coordination, regulation and financing. WHO is ready to work with any development partner and stakeholder who share similar vision. While acknowledging that improving the health system touches upon all spheres of the health sector and can only be achieved through a long term commitment, WHO is also willing to support other key technical areas that deserve immediate and shorter term assistance.

In summary, WHO's strategic direction in Sri Lanka focuses on six priority areas (clusters) for the period of 2002-2005:

1. Health sector reform and health system development
2. Communicable disease control
3. Promoting healthy life styles and reducing environmental risk factors
4. Integrating health services to enhance efficiency and effectiveness
5. Emergency preparedness and response
6. Partnerships and coordination

Annex IV summarizes the programme areas in Sri Lanka and their appropriate areas of work that have been identified under the UNDAF, the CCS workshops, and the global WHO priorities.

Cluster 1: Health sector reform and health system development

The process of decentralization has already started in Sri Lanka. With the rapidly changing health sector, the roles and functions of the public health system at different levels need to be redefined while the roles of other players such as NGOs, the private sector and other institutions must be taken into account and given proper places in the health sector. WHO will therefore advocate for a major sector reform and facilitate the re-development of the overall health system at all levels based on a sector-wide approach.

Key changes in direction

1. Formulate a new and comprehensive evidence-based national health policy, which will incorporate advances in areas of health financing and health insurance, public/private mix, decentralization, and health system development.
2. Improve district level health system development focusing on improving health services for the poor and the vulnerable.
3. Improve district level service management including management of drugs and their rational use, human resource development and deployment, use of health facilities and referral system.
4. Support information system development, through nation-wide networking; promote information use and quality, and develop multi-disease surveillance systems.
5. Encourage quality assurance and responsiveness in service provision.

6. Consolidate the health decentralization process to improve coordination, resource mobilization, programme planning and implementation and accountability.
7. Promote biomedical sciences as a key component of health care system and development of allied health human resources.
8. Reorient the role of peripheral hospitals in the health care system.

Cluster 2: Communicable disease control

Although Sri Lanka, as a whole, is fast entering the last stage of demographic and epidemiological transition, geographic and socio-economic differentials in a such transition continue to exist. WHO will therefore need to continue to focus its effort on reducing excess mortality, morbidity and disability due to communicable diseases among the disadvantaged populations and to bring equitable services to areas which are lagging behind.

Key changes in direction

1. Build a health laboratory network at the sub-national level to improve health services.
2. Support multi-disease surveillance development and disease outbreak surveillance activities.
3. Support communicable diseases control programmes for the eradication/elimination of polio, measles, leprosy, rabies, filariasis, etc.
4. Focus on strengthening high burden and high potential return disease control programmes, e.g. malaria, tuberculosis, HIV/AIDS.
5. Address geographic and socio-economic differentials in communicable diseases burdens.

Cluster 3: Promoting healthy life styles and reducing environmental risk factors

Recent health statistics has indicated that non-communicable diseases have become the leading causes of mortality, morbidity and disability. Partly, this is due to the ageing of the population which gives rise to degenerative diseases among an expanding ageing population. On the other hand, the fast urban and socio-economic changes over the last two decades have substantially altered the life styles of the general population. Sedentary life styles, which are prevalent in urban living greatly increase the risks of contracting such non-communicable diseases as cardiovascular diseases, certain types of cancer and diabetes. The situation is further aggravated by rapid industrial and urban growth, which leads to increased health damaging environmental pollutions and industrial and traffic accidents.

Key changes in direction

1. Promote healthy living as an effective means of maintaining health and preventing non-communicable diseases (NCDs).

2. Strengthen the health education and family health programmes emphasizing on effective communication to reach the underserved, particularly the poor.
3. Review and strengthen the existing nutrition programmes at all levels.
4. Reduce health risks through advocacy against substance abuse, tobacco consumption, road accidents, and environment pollution.
5. Improve surveillance of NCDs and commission studies on risks and factors associated with NCDs.
6. Promote prevention programmes and rehabilitative activities that are conducive to better mental health.

Cluster 4: Integrating health services to enhance efficiency and effectiveness

Given the limited resources available in the health sector, different ways of delivering services more effectively and efficiently need to be explored and adopted. Integrated approaches to improve comprehensive health services in various programme areas may be considered. A serious health problem that has not made much headway over the past two decades is the issue of malnutrition, which is still quite widespread among the general population, and is definitely a very serious problem among the poor and the marginalized and in the conflict affected area. As a multi-faceted issue, an integrated approach involving interventions from several sectors would be required to tackle the problem of malnutrition more effectively.

Key changes in direction

1. Improve health education and health promotion at all levels, using effective approaches.
2. Consolidate and expand the EPI programme including introduction of new vaccines.
3. Introduction of integrated approach to improve such programmes as child and adolescent health, health for the aged, and vector control.
4. Involve all concerned sectors to provide concerted efforts to deal with the existing nutrition problem and to improve the current nutrition programme.
5. Introduction of a quality assurance programme in health services.
6. Update the essential drugs policy and strategies, support rational use and prescription of drugs and improve the manufacturing and distribution of pharmaceuticals and biologicals with the aim to enhance benefits to the public.
7. Integrate and improve coordination of reproductive and women's health programmes.

Cluster 5: Emergency preparedness and response

The nearly collapsed health system in the North and East resulting from the protracted conflict should be the focus of the next biennium. The recently declared ceasefire in the conflict areas and the real possibility of reaching a long lasting peace this year has offered an excellent window of opportunity to reconstruct the health system there. There is a huge need to rehabilitate the long neglected health facilities in the two

affected provinces and to re-deploy staff to meet the demands of the local population who have so far been unable to receive similar levels of services as in other parts of the country. The immediate strategic direction in this area will be to develop national capacity for health emergency preparedness and response to cope with public health needs.

Key changes in direction

1. Establish and institutionalise emergency preparedness and response units (EPR units) at appropriate levels and promote application of best practices and standards in emergency management.
2. Provide training and other facilities for improving the capacity of the EPR units.
3. Focus on emergency health system development in the conflict affected areas.
4. Provide health emergency services in disaster and conflict affected areas
5. Mobilize resources for health emergencies.

Cluster 6: Partnerships and coordination

The WHO country team will continue to have a major role to play in leading multisectoral partnerships in health and in coordinating donor and government resources in the health sector. Mobilizing resources for the health sector will be one of the key roles WHO is expected to play.

Key changes in direction

1. Mobilizing One WHO support for the health sector.
2. Reorganize the WHO country office to enhance the Organization's effectiveness and efficiency.
3. Promote inter- and intra- sectoral cooperation for health development.
4. Promote interagency cooperation for health
5. Mobilize internal and external resources for health system development,
6. Place health in the centre of national development and giving health its deserved attention in the development agenda

Strategic Interventions

The WHO country office will play a pivotal role in providing technical assistance and helping to develop partnerships with stakeholders and also mobilize resources for the Ministry of Health so as to:

- Improve the preventative health programmes by
 - 1) reducing the burden of disease in the community
 - 2) early detection of preventable diseases and priority health issues
 - 3) promoting healthy lifestyles

- Ensure accessibility to all sectors of the community targeting the poor and the vulnerable
- Improve the quality of health care to a level acceptable to both the community and the service provider.
- Provide basic health care free of cost to the individual at the point of delivery in state sector institutions.
- Ensure that men and women have access to safe, effective and acceptable methods of family planning of their choice.
- Provide efficient and cost effective health care services to all segments of society.
- Develop and implement a National Drug Policy
- Promote active community involvement in health care at national, provincial and district levels
- Allocate resources between provinces/districts based on their health needs and national priorities.
- Strengthen the sustainable partnerships with government and non-government agencies including the private sector to facilitate better health care for the people.
- Facilitate the development and regulation of the private health care sector
- Encourage health system research
- Equitable human resource development
- Provide more effective and coordinated services for the control of the STD/AIDS problem
- Provide services to emerging health needs of the elderly, disabled and the displaced and also for the management of non-communicable diseases such as cardiovascular diseases, diabetes and malignancies
- Address the emerging problems of tobacco, alcohol and substance abuse with the assistance of NGOs and the private sector.
- Health Promotion

6.4 WHO's Approach and Role

Improving the health of the population of Sri Lanka is a challenge set before the Government and the WHO. While considerable progress has been made resulting in gains in life expectancy and reduction in infant and maternal mortality many problems remain. The majority of problems relate to broader health system issues: impact on the health of women and children; control of communicable diseases; spread of emerging and re-emerging infectious diseases; environmental health; and non-communicable diseases.

The WHO Country Cooperation Strategy defines the broad framework for WHO's work with the Government of Sri Lanka over the next few years. It takes into account the Sri Lanka health needs, its government's policies and expectations, the activities of other development partners and WHO's own principles and priorities.

WHO's overall approach will now have to be more selective and strategic both in the range of functions proposed and in the prioritization of health problems. **Annex V**

presents a brief analysis of the health issues in Sri Lanka and provides a list of recommended strategies and outcomes for each of the issues.

WHO in its new role will be more focused and holistic in its approach. It will help the government in strengthening the provincial and district health administrations, making the health policies more effective, developing a comprehensive MIS system, establishing sustainable partnerships and acting as a catalyst for mobilizing financial resources for health.

SECTION 7: WHO'S COUNTRY COOPERATION STRATEGY

The **overall goal of the World Health Organization** in Sri Lanka is to attain the highest level of health through strengthening of the health system at national, provincial and district levels on principles of equity, fairness and responsiveness. This goal is to be achieved by supporting health sector development; advocating health promoting policies and providing technical leadership in collaboration with the Ministry of Health (MOH) and other concerned government departments; donor partners, NGOs and other actors including the community itself.

The CCS of WHO will use a more holistic approach and will adopt the four strategic directions stated in the WHO Corporate Policy Framework. The main emphasis will be on targeting the poor and marginalized populations in the country and the displaced persons and refugees as well as the underserved groups in the un-cleared areas of the North-East Provinces. The marginalized groups both in the North-East conflict area and those in the rest of the country have already been identified in various country reports. When considering the priority health problems, WHO will focus its financial and technical aid and its key role as a catalytic agency on these groups.

The CCS represents a reinforcement of what the Organization preaches and practices globally, i.e., a) investing in primary and preventive health care is the most cost-effective approach to better health, b) developing a fair, equitable and responsive district health system is essential to community health and an important means to address the health needs of the poor and c) participation by the community in the health sector is important in bringing better health care to the society as a whole.

The WHO over the next five years intends to take a more selective and strategic approach to its work in the country and support the MOH in relation both to areas of its activity and to the functions it performs. To achieve a greater impact it will focus intensively on a limited number of high priority areas. In the specific context of country cooperation strategies, the following strategic options have been decided between WHO and MOH:

Strategies for country cooperation:

Strategy Options	Decision
Partnership: <ol style="list-style-type: none"> 1. MoH only 2. MoH and other selected Ministries with MoH as nodal Ministry 3. GoSL as deemed appropriate by WHO 4. GoSL, NGOs and Private Sector as deemed appropriate by WHO 5. GoSL, NGOs and Private Sector in liaison with the MoH 	GOSL, NGOs and Private sector in liaison with the MOH
Location: <ol style="list-style-type: none"> 1. Regional (selected provinces or districts) 2. Nation-wide 	Nation wide with emphasis on under served areas

Strategy Options	Decision
Socio-economic: 1. Focus on the Poor 2. All socioeconomic groups	Focus on the poor
Life cycle and demographics: 1. All age groups and both sexes 2. Focus on selected age groups and sex	Focus on appropriate target groups
Level of health care: 1. Mostly primary 2. Mostly tertiary	Mostly primary
Within Sector: 1. Entire health sector 2. Sub-sectors	Selected sub-sectors
Planning: 1. Sector -wide 2. Programme based 3. Project based	Programme based
Budgeting: 1. Resource based 2. Result based	Result based programme budget
Cooperation with other development partners (DP) on resource sharing: 1. WHO to provide expertise and DP to provide funds 2. Independent 3. WHO to provide funds and DP to provide expertise	WHO to provide expertise and DP to provide funds
Mode of work: 1. WHO to work upstream (policy, strategies and guidelines) only 2. WHO to work equally up and downstream 3. WHO to work mostly upstream 4. WHO to work downstream (implementation of projects or programmes) only	WHO to work mostly upstream – facilitate policy strategies and national strategies and guidelines.
Focus of inputs: 1. Community oriented 2. MoH at central level only 3. MoH and Provincial level 4. Provincial health authorities only 5. More MoH and less Provincial 6. MOH and provincial level with emphasis on the community	MOH & provincial level with emphasis on the community
Priority setting: 1. Evidence and policy based 2. Politically driven 3. Tradition based 4. Mostly evidence and policy based with small percentage of other factors	Evidence and policy based
Utilization of WHO resources: 1. Mainly catalytic and technical 2. Mainly programme subsidies	Mainly catalytic and technical

As part of the One WHO Policy to utilize WHO's resources more effectively in a more focused manner, six criteria for identifying organization-wide priorities have been developed. These are:

1. Potential for significant change in burden of disease with existing cost-effective interventions;
2. Health problems with major impact on socio-economic development and a disproportionate impact on the lives of the poor;
3. Urgent need for new technologies;
4. Opportunities to reduce health inequalities within and between countries;
5. WHO's advantages, particularly in relation to public goods; building of consensus around policies, strategies and standards; initiation and management of partnerships; and
6. Major demand for WHO support from Member States.

Any programmes that do not fulfil the above criteria will be accorded lower priority in the WHO-GoSL collaborative programmes. Within the six priority criteria, there could be, in general, three types of health interventions, namely, damage reduction, risk reduction, and health promotion and family health. To define WHO's strategies, the following criteria for WHO-Government cooperation will be adopted:

Criteria for WHO-Government Cooperation

Nature of intervention	Damage reduction	Risk reduction	Health promotion and family health
Health priorities identified through the following criteria			
Disease burden	X	XXX	XXX
Potential to become major public health menace	X	XXX	XXX
Urgent need for new technologies	X	XXX	XXX
Health problems with major impact on socioeconomic development and a disproportionate impact on the poor	XXX	XXX	XXX
Addresses health inequalities and governance	XX	XXX	XXX
Public demand	XX	XXX	XXX

XXX high priority XX medium priority X low priority

It can be seen that, regardless of what criterion will be used to determine the health priorities that require WHO's contribution in the country, its main investment will focus on risk reduction and health promotion. This strategy is in line with WHO's assertion that investing in primary and preventive health care is the most cost-effective approach to better health.

UNDAF Priority Programme Areas

As an integral part of the UN System, WHO has a responsibility to ensure that the UN Development Assistance Framework (UNDAF) goals, objectives and procedures are fully reflected in its country programmes and in the activities to be carried out during the 2002-2005 period. Through a process of dialogue and consultation with government and civil society stakeholders, four broad goals and operational objectives were identified for UN assistance in Sri Lanka.

The four strategic goals for UN agency assistance are:

1. Provision of emergency and humanitarian assistance to conflict affected areas and people;
2. Assisting in restoring the economic livelihood of adversely affected persons and provide support for efforts that contribute to the establishment of peace and social cohesion; and
3. Reduction of poverty through promoting improved accessibility to basic service and the creation of economic opportunities for the poor.
4. Governance reform aimed towards promoting people-centred development.

The detailed goals, strategic directions and initiatives of both UN and WHO can be found in **Annex-I**. The initiatives of WHO were developed under the principle that WHO's involvement in those areas are comparatively more advantageous than other UN agencies. Moreover, these initiatives will complement the work of other UN agencies in achieving the UN millennium goals.

If WHO's UNDAF initiatives are translated into actionable programmes, a total of thirteen areas can be identified:

- Malaria
- Tuberculosis
- HIV/AIDS
- Tobacco
- Food safety
- Substance abuse
- Health systems/policy reforms
- Environmental health
- Nutrition
- Quality assurance
- Human resource development

- Violence against women/women's health
- Epidemiological information services

WHO RB 2004-2005 Organization-wide Priority Programme Areas:

For the RB 2004-2005 biennium, thirteen WHO organization-wide areas have been identified to be given collaborative priorities at the country level. These areas are:

- Malaria
- Tuberculosis
- HIV/AIDS
- Cancer, cardiovascular disease and diabetes
- Tobacco
- Maternal health
- Food safety
- Mental health and substance dependency
- Blood safety
- Health systems/policy reforms
- Environmental health
- Major communicable diseases (WHO SEA regional priority)

Many of the organization-wide priority areas are in common with WHO's UNDAF priority programme areas in Sri Lanka. The commonalities and differences of the WHO organization-wide priority areas, the WHO (Sri Lanka) UNDAF priority programmes and the priority programme areas identified during the CCS consultation, along with the comparable WHO Areas of Work are presented as **Annex-IV**. It can be seen from the Annex that Sri Lanka's priority collaborative programmes would encompass 20 WHO Areas of Work. To add to these 20 areas is the 'health information management and dissemination' which is a core function of WHO. The total number of Areas of Work that WHO will give priority in Sri Lanka is therefore 21.

SECTION 8: SUPPORTING AND IMPLEMENTING THE CCS

As a technical agency, WHO's role as a funding agency is at best insignificant compared with many international development agencies that are present in Sri Lanka. The financial resources available with WHO for funding health projects are very limited. This is because WHO does not have a mandate to fund any programmes other than providing seed money to small projects for the purpose of demonstrating or researching on the utilities of new technologies, or establishment of new standards and norms in a country. However, WHO is capable of providing technical support to large scale programmes. WHO's role in a country is to provide technical support to the stakeholders of the health sector in the form of advice, guidance, demonstration and advocacy. Unfortunately, the work of WHO is not always well understood by the stakeholders in the sector as witnessed in the way the WHO resources are distributed and utilized.

Over the past few biennia, only slightly over 30% of the WHO regular budget allocated for Sri Lanka is used for technical assistance and support for international standard setting while the remaining allocations are generally used for supplies and equipment, fellowship and study tour, contractual work (e.g. printing, software development, data entry, etc.), in-service training, workshops and meetings; most of which are for supporting implementation of relatively small and vertical projects. This can hardly be said to be an efficient way of using WHO's resources, considering the fact that there are quite a number of large bilateral donors in the health sector who, along with the Government, have comparative advantages over WHO in the provision of supplies and equipment and contractual services (such as printing and software development) to individual projects. The current mode of utilization of WHO resources is therefore not fully consistent with the CCS outlined in this document.

Sections 6 and 7 have outlined the roles, functions, priorities and the operational strategies, which, together, form the CCS of WHO in Sri Lanka. All of these expectations however, have implications on the financial and technical resources of the Organization. As an international agency whose main asset is its technical resources and an ability to mobilize them, WHO's country allocation should best be used to procure and mobilize technical expertise for supporting key and new areas of the country's health sector. This means that future WHO support should be more focused on provision of technical expertise to areas where they are judged to be of importance to WHO, according to the criteria stated in Sections 6 and 7. The priority is to use WHO's resources for the attainment of the overall goal of WHO, Sri Lanka which is to attain the highest level of health through strengthening of the health system at national, provincial and district levels on principles of equity, fairness and responsiveness with emphasis on the poor and the marginalized. Less resource should be allocated to supplies and equipment, printing, study tour, routine training and other areas defined as non-essential.

A number of programmes have been supported by WHO for many years. Although some of them have shifted their focus and are therefore continuing to require WHO technical support, many other programmes are receiving WHO assistance on the basis of

convention. There is little justice to why WHO should continue to support so many small projects for so long. The full implementation of the CCS would make it mandatory to assess WHO's contributions in each of its supported programmes on a biennium basis. Any component under a larger programme, once determined to be no longer requiring WHO's support, will be terminated. This will give room to WHO to support new and emerging areas of work, as they are mutually identified, in the country.

Providing adequate technical assistance to large number of programmes by WHO has been a major problem in Sri Lanka, considering the fact that most of its resources have been diverted to non-essential areas. Moreover, opinions have been expressed that (a) WHO's long term technical assistance (long term staff) is too expensive, and (b) technical expertise for many areas are locally available. There are, on the other hand, counterarguments that (a) the long term staff could not only bring in the much needed technical expertise to the country, they could also help mobilize large quantities of resources as in the case of the GFATM, and (b) if the country already possesses the needed technical expertise, WHO's involvement should only be limited to making the expertise available rather than paying for it on a long term basis. Obviously, both sides have their valid points and therefore compromises need to be sought. Regardless, for WHO to be able to carry out its functions efficiently and to implement the CCS effectively, a team of competent WHO technical and support staff, both national and international, will be needed to meet the needs of the identified areas of work.

A better solution is to use a mixture of WHO long term international (professional) staff, staff and advisors from the regional office and headquarters, and short term local and international experts (STP, STC, SSA and APW) to provide a variety of needed services to the health sector. In addition, associated professional officers (APO) may also be recruited to assist individual programmes on a medium term basis (2-4 years). This mixture will greatly reduce the cost of using a large number of long term international staff for an extended period in Sri Lanka. The extra cost for meeting the demand for expertise can be met through savings from other non-essential areas or from extra-budgetary funds mobilized jointly by WHO and the Ministry.

The CCS will adopt an evidence-based approach to determine the requirements on technical assistance by a particular programme. The requirement of technical assistance will be linked to the performance and situation of the WHO supported programmes. Each programme will be objectively assessed periodically using a set of mutually agreed indicators. These may include the trends of programme performance or disease pattern (e.g. morbidity and mortality rates), coverage of the programme in question, demand for technical assistance by the Government, the burden of the diseases in question, global actions required for the programme (e.g. eradication of polio) and the potential threat of the issue in question to the health of the public. It is recognized in this document that the final decision on whether technical assistance will finally be solicited lies with the Government.

Section 9: Application of the CCS

To ensure that the completed CCS can be used as an effective tool for development of sector plans, the WCO made an attempt earlier this year to apply the CCS in the formulation of the WHO RB 2004-2005 Strategic Plan of Sri Lanka. This was achieved through the following process:

1. As per the WHO guideline, the RB 2004-2005 country programme should be developed using the logical framework approach (LFA). This was done through the participation of senior MOH decision makers and programme managers in a series of LFA training conducted by the WCO, in conjunction with the MOH planning unit. The LFA training course was designed to be short (1-3 days depending on the target group) and practical and its structure was based on the DANIDA's LFA manual.
2. To ensure that all those responsible for planning the WHO RB 2004-2005 programmes are thoroughly familiar with the CCS development process and its contents, they were invited to participate in two CCS development workshops in which they were presented with the detailed development process of the CCS. They were then requested to participate in making decisions on a number of critical issues related to the CCS.
3. A separate workshop on the WHO RB 2004-2005 programme development involving the same participants was subsequently held. In the workshop, pre-developed LFA formats along with the key information (e.g. the strategic goals and operational objectives) derived from the earlier CCS workshops were distributed to the participants. Six groups were formed according to the operational objectives of the LFA and participants were asked to join the groups on a voluntary basis.
4. Each working group was then asked to complete two LFA formats based on the agreed strategies spelled out in the CCS document. The working groups also considered the activities and programmes that have been sponsored or supported by agencies other than WHO and areas that WHO should give additional support according to the criteria set out in the CCS. The information was later compiled and presented in two tables (**Table 1** and **Table 2**).

At this stage, the outputs and products developed from the LFA still require further refinement. Moreover, as a first stage of the planning process, the inputs needed for the completion of the standard LFA format have not been discussed. This, however, can be done, at the second planning stage. What is learned from this important exercise is that the CCS can be effectively applied for sector or programme planning purpose if a) the decision makers and programme planners are familiar with the CCS and committed to putting it into practice, b) adequate information about the health sector, as a whole, is available, c) information on the performance of the previous interventions is in hand, and c) that the participants are adequately trained in the use of the LFA.

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Table 1 – Logical Framework for WHO RB 2004-2005 Country Strategic Plan

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
<p>Strategic Goal To attain the highest level of health through strengthening of the health system at national, provincial and district levels on principles of equity, fairness and responsiveness with emphasis on the poor and the marginalized.</p>	<ol style="list-style-type: none"> 1. Healthy Life Expectancy or similar measures such as Disability adjusted life expectancy 2. Crude Death Rate 3. Crude Birth Rate 4. Overall health system performance score 	<ol style="list-style-type: none"> 1. Official life tables and BoD study 2. Official vital registration report 3. Official vital registration report 4. Official reports/statistics and national health accounts using WHO formula and approach. 	<ol style="list-style-type: none"> 1. Investment in the health sector by the Government has increased. 2. An equitable, fair and well managed health system is in place 3. Health services at all levels have been substantially improved. 4. Social network to protect the poor and the vulnerable is in place. 5. Required human resources for health are adequately produced and appropriately deployed.
<p>Operational Objectives</p>			
<ol style="list-style-type: none"> 1. To strengthen the health sector and to further develop the health system on the principles of equity, fairness and responsiveness 	<ol style="list-style-type: none"> 1. Measure* of equity 2. Measure* of fairness in financing 3. Measure* of responsiveness <p>*WHO recommended measurements</p>	<ol style="list-style-type: none"> 1,2,3. For all three measures, official reports/statistics, national health accounts and special survey using WHO recommended formula, approach and questionnaire. 	<ol style="list-style-type: none"> 1. National health policy incorporated these three principles. 2. The coordination between MoH and the provincial health authorities improved.
<p>Outputs</p>			
<ol style="list-style-type: none"> i. A new and comprehensive evidence-based national health policy, which will incorporate advances in areas of health financing and health insurance, public/private mix, decentralization, and health system development formulated. 	<ol style="list-style-type: none"> 1. Updated health policy document approved by the cabinet. 2. No. of provinces that ratify the adoption of the new policy. 3. Percentage of the new health policy that conform to the guidelines of WHO. 	<ol style="list-style-type: none"> 1. Official gazette 2. Official gazette. 3. Special study to evaluate the health policy. 	<ol style="list-style-type: none"> 1. Political commitment to the development of a new health policy is strong.
<ol style="list-style-type: none"> ii. District level health system developed development focusing on 	<ol style="list-style-type: none"> 1. No. of Samurdhi recipients, war victims, female headed 	<ol style="list-style-type: none"> 1. National and sub-national MIS 	<ol style="list-style-type: none"> 1. MIS has expanded its function to include these data.

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
improving the conditions of the poor and the vulnerable.	households, disabled and displaced persons registered in each division. 2. % of malnourished women and children treated and assisted by division 3. % of poor households having access to safe water 4. % of registered vulnerable people suffering from selected diseases. 5. % of the above registered persons and suffering from diseases treated by doctors/paramedical personnel.	2. Hospital and routine outpatient records 3. Survey and Water Board records 4. Hospital and outpatient records 5. Hospital and outpatient records	2. Reliable records and information 3. Funds available for conducting the survey 4. MIS at lower level established. 5. MIS at lower level established.
iii. Improved district level service management including management of drugs and their rational use, human resource development and deployment, use of health facilities and development of referral system.	1. No. of districts having regular programme review meetings. 2. % of recommendations for improvement of services implemented at the district level. 3. % of patients referred to higher level facilities 4. % of district and lower level facilities having full deployment of essential staff. 5. Health facility utilization statistics issued periodically. 6. % of hospitals having adopted the logistics management information system.	1. Official records 2. Official records 3. Hospital records and summary statistics (to be incorporated into MIS) 4. Provincial planning unit records 5. Health facility records (to be incorporated into MIS) 6. Special study and/or routine reports	1. Commitment by MOH and provincial health authorities of resources and efforts to strengthen the district health system. 2. Availability of manuals and guidelines for district health management.
iv. Information system development supported through nation-wide networking; promote information use and quality, and develop multi-	1. No. of national information sub-systems fully developed. 2. No. of provinces having their own health MIS	1. Official records and tests carried out. 2. Official records and tests carried out.	1. Availability of a team of MIS experts in the health sector 2. Awareness and commitment of health professionals to report and

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
disease surveillance system.	<ol style="list-style-type: none"> 3. No. of provinces brought into the national MIS network. 4. No. of provinces regularly published their own health bulletins. 	<ol style="list-style-type: none"> 3. Official publications 4. Official records and tests carried out. 	make use of health information.
v. Quality assurance and responsiveness in service provision achieved.	<ol style="list-style-type: none"> 1. % of users who are satisfied with the services they received 2. No. of post operation infections cases 3. No. of hospitals which practice safe procedures to dispose of hospital wastes. 4. Average time being served by a medical professional in health facilities. 5. No. of hospitals having carried out medical audits. 	<ol style="list-style-type: none"> 1. Responsiveness survey 2. Hospital records summary statistics 3. Hospital surveys 4. Special survey (to be carried out with the responsiveness survey) 5. Official records 	<ol style="list-style-type: none"> 1. Quality assurance programme established. 2. Commitment of health professionals to quality service to the people.
vi. Consolidated health decentralization process to improve coordination, resource mobilization, programme planning and implementation, and accountability.	<ol style="list-style-type: none"> 1. Availability of policy paper on health decentralization. 2. No. of programmes monitored regularly by the Planning Unit of MOH 3. No. of programme implementation progress reports submitted to MOH regularly. 4. No. of programmes audited annually. 	<ol style="list-style-type: none"> 1. Official Gazette 2. Records of Planning Unit 3. MPDU records 4. Official records 	<ol style="list-style-type: none"> 1. A comprehensive decentralization policy and process made available by the Government. 2. Formal linkages (role and authority) between central and provincial health authorities clearly spelled out.
vii. Health human resource development supported focusing on promoting biomedical sciences as a key component of health care system and development of allied health human resources	<ol style="list-style-type: none"> 1. No. of medical school curricula that encompass relevant areas in behavioural, biomedical, integrated disease control and health promotion. 2. No. of provincial training centers networked with NIHS. 3. No. of curriculum for various 	<ol style="list-style-type: none"> 1. Review by experts 2. NIHS records 3. NIHS records/review by 	<ol style="list-style-type: none"> 1. A consensus on a human resource development master plan by all stakeholders. 2. Commitment by MOH/Gov't to honour and fulfill the plan.

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
	biomedical and health science training courses modified and upgraded 4. No. of trainers by category available nationally.	experts 4. NIHS and provincial training centers records	
viii. Role of peripheral hospitals reoriented in the health care system.	1. Availability of hospital reorganization plan 2. No. of peripheral hospitals reorganized by district according to plan 3. No. of hospitals at peripheral level that are equipped to provide adequate primary health services to the needy and whose services are community based with emphasis on preventive health care.	1. MOH Planning Unit 2. MOH/Provincial health authority records 3. Special survey	1. Political commitment to reform the hospital network and services at all levels.

Table 1 – Logical Framework for WHO RB 2004-2005 Country Strategic Plan

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
<p>Strategic Goal To attain the highest level of health through strengthening of the health system at national, provincial and district levels on principles of equity, fairness and responsiveness with emphasis on the poor and the marginalized.</p>	<ol style="list-style-type: none"> 1. Healthy Life Expectancy or similar measures such as Disability adjusted life expectancy 2. Crude Death Rate 3. Crude Birth Rate 4. Overall health system performance score 	<ol style="list-style-type: none"> 1. Official life tables and BoD study 2. Official vital registration report 3. Official vital registration report 4. Official reports/statistics and national health accounts using WHO formula and approach. 	<ol style="list-style-type: none"> 1. Investment in the health sector by the Government has increased. 2. An equitable, fair and well managed health system is in place 3. Health services at all levels have been substantially improved. 4. Social network to protect the poor and the vulnerable is in place. 5. Required human resources for health are adequately produced and appropriately deployed.
<p>Operational Objectives/Strategies</p>			
<ol style="list-style-type: none"> 2. To prevent and control communicable diseases that cause high burden to the population including emerging diseases that have high potentials to become public health menaces. 	<ol style="list-style-type: none"> 1. Prevalence and incidence of selected important communicable diseases in Sri Lanka 2. Case fatality rates of selected important communicable diseases 3. Burden of communicable diseases by age, sex and socio-economic status of patients 	<ol style="list-style-type: none"> 1. Multi-disease surveillance 2. Hospital records and cause specific death reports from MIS 3. BoD study, hospital records and morbidity survey (Demographic and Health Survey) 	<ol style="list-style-type: none"> 1. Collaboration between MOH, city councils and provincial health authorities on diseases control and prevention has been enhanced. 2. Adequate drugs, insecticides and other logistics adequately supplied to the health facilities. 3. All disease control and prevention programme activities can be carried out nation-wide (anywhere in the country including the North and East).
<p>Outputs</p>			
<ol style="list-style-type: none"> i. A health laboratory network built at sub-national level to improve health services 	<ol style="list-style-type: none"> 1. No. of provincial public health laboratories linked to the central public health laboratory. 	<ol style="list-style-type: none"> 1.1 Records available from the provinces. 1.2 No. of reviews conducted together annually 1.3 No. of tests sent to the central public health laboratory from 	<ol style="list-style-type: none"> 1.1 Cooperation from the referring institutions. 1.2 Availability of the essential human resources 1.3 Necessary infrastructure and facilities available

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
		the provincial laboratories and % of such tests conducted.	
ii. Multi-disease surveillance developed and disease outbreak surveillance activities supported.	<ol style="list-style-type: none"> 1. No. of surveillance reports issued according to planned schedule 2. No. (type) of diseases reported under the surveillance 3. Coverage of the surveillance 	<ol style="list-style-type: none"> 1. Issued dates of each report 2. Multi-disease surveillance report 3. Surveillance report 	1,2,3 National and sub-national health authorities have strengthened their disease management and reporting mechanisms.
iii. Communicable disease control programmes for the eradication/elimination of polio, measles, leprosy, rabies, filariasis, dengue, etc., supported.	<ol style="list-style-type: none"> 1. No. of training programmes conducted for peripheral level staff by each of the disease programmes. 2. No. of laboratory tests conducted at peripheral laboratories by type. 3. No. of patients suffering from preventable communicable diseases admitted to hospitals by type, age and gender 4. No. of out-patients by type of disease, age, gender and area. 5. No. of health facilities reporting of shortage or stock out of drugs for treatment of communicable diseases 	<ol style="list-style-type: none"> 1. Official records 2. Laboratory/hospital records 3. MPDU-MIS Unit or provincial health planning units 4. MPDU-MIS Unit or provincial health planning units 5. Provincial health authorities and or MIS Unit of MPDU 	<ol style="list-style-type: none"> 2. Records are properly kept at the facilities 3,4,5 MIS of MPDU/MOH strengthened to incorporate the additional information required.
iv. Focused support of high burden and high return potential disease control programmes, e.g. malaria, tuberculosis, HIV/AIDS.	<p>HIV/AIDS</p> <ol style="list-style-type: none"> 1. HIV/AIDS prevalence rate 2. No. of VCT centers established 3. STI management integrated into primary health care level (including GP) <p>Malaria</p> <ol style="list-style-type: none"> 1. Annual parasite incidence 	<p>HIV/AIDS</p> <ol style="list-style-type: none"> 1. Routine reports (sero surveillance and behavioural surveillance surveys) 2,3 Report from GP and PHC Reports from VCT centers <p>Malaria</p> <ol style="list-style-type: none"> 1. Blood smear examination results report from medical 	<p>HIV/AIDS</p> <p>Multisectoral collaboration, Sustained political commitment, Adequate donor funding, Enabling legal environment.</p> <p>Malaria</p> <p>No significant climate change, Herd immunity in the population,</p>

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
	<ol style="list-style-type: none"> 2. Annual malaria mortality rate 3. Slide falciparum rate 4. Percentage of severe and complicated malaria patients <p>Tuberculosis</p> <ol style="list-style-type: none"> 1. Tuberculosis cure rate 2. Defaulter rate and no. 3. No. of newly detected cases per month 4. No. of drug resistant cases per year. 	<p>institutions, mobile clinics and filed surveys</p> <ol style="list-style-type: none"> 2. Hospital records 3. Laboratory records 4. Hospital records <p>Tuberculosis</p> <ol style="list-style-type: none"> 1. Quarterly review reports 2. TB registry 3. Laboratory records and TB registry 4. TB registry and hospital records 	<p>Time lag between occurrence of severe and complicated malaria and availability of proper medical treatment. Quickness of malaria patients seeking proper treatment</p> <p>Tuberculosis Referral of symptomatic cases to the chest institutions.</p>
v. Geographic and socio-economic differentials in communicable diseases burdens addressed.	<ol style="list-style-type: none"> 1. Disease burden by age, sex, geographical area and socioeconomic status 2. Measures of equity, fairness in financing and responsiveness by geographical area and economic status 	<ol style="list-style-type: none"> 1. DoB study at subnational level 2. Subnational level World Health Survey, National Health Accounts, and special studies. 	<ol style="list-style-type: none"> 1. Commitment by Gov't to reduce poverty. 2. Recognition of the central role of health in national development.

Table 1 – Logical Framework for WHO RB 2004-2005 Country Strategic Plan

Strategic Goals and Objectives	Objectively verifiable indicators	Means of Verification	External Factors/Assumptions
<p>Strategic Goal To attain the highest level of health through strengthening of the health system at national, provincial and district levels on principles of equity, fairness and responsiveness with emphasis on the poor</p>	<ol style="list-style-type: none"> 1. Healthy Life Expectancy or similar measures such as Disability adjusted life expectancy 2. Crude Death Rate 3. Crude Birth Rate 4. Overall health system performance score 	<ol style="list-style-type: none"> 1. Official life tables and BoD study 2. Official vital registration report 3. Official vital registration report 4. Official reports/statistics and national health accounts using WHO formula and approach. 	<ol style="list-style-type: none"> 1. Investment in the health sector by the Government has increased. 2. An equitable, fair and well managed health system is in place 3. Health services at all levels have been substantially improved. 4. Social network to protect the poor and the vulnerable is in place. 5. Required human resources for health are adequately produced and appropriately deployed.
<p>Operational Objectives</p>			
<ol style="list-style-type: none"> 3. To promote healthy life styles and reduce environmental risk factors. 	<ol style="list-style-type: none"> 1. Prevalence and incidence of major NCDs in Sri Lanka 2. Burden of traffic accidents and other types of injuries 3. Suicide rate by age and sex 4. Smoking rate by age and sex 5. Rates of substance abuse (alcohol, drugs, etc.) by age and sex 	<ol style="list-style-type: none"> 1. NCD surveillance system 2. Police and hospital records and special surveys 3. Police records 4. Special survey 5. Special survey and police and NDDCB reports 	<ol style="list-style-type: none"> 1. Environment protection laws and policies available. 2. Enforcement of appropriate legislation by the law-enforcing agencies.
<p>Outputs</p>			
<ol style="list-style-type: none"> i. Healthy living as an effective means of maintaining health and preventing non-communicable diseases promoted. 	<ol style="list-style-type: none"> 1. No. of local authorities adopting the health district concept. 2. % households that are smoke (cigarette consumption) free. 3. Alcohol consumption pattern 	<ol style="list-style-type: none"> 1. Official local records 2. Special survey 3. Special survey 	<ol style="list-style-type: none"> 1. Political commitment is there. 2. Health education/promotion programme on cigarette consumption carried out. 3. Health education/promotion

Strategic Goals and Objectives	Objectively verifiable indicators	Means of Verification	External Factors/Assumptions
	of adults 4. Level of physical activity by age group	4. Special survey	programme on alcohol consumption carried out. 4. Health education/promotion programme on physical activity carried out
ii. Strengthened health education and family health programmes emphasizing on effective communication to reach the underserved, particularly the poor.	1. % of target population exposed to the health programmes. 2. % of target population made aware of the messages conveyed. 3. % of target population using health facilities by purpose	1,2,3. Special survey	1,2,3 Target population could be properly identified and located.
iii. Existing nutrition programme at all levels reviewed and overhauled.	1. Existing nutrition programme reviewed and report disseminated. 2. Basic nutrition indicators (weight for height, weight for age, height for age).	1. Official records and report 2. Published nutrition report	1. The review will be acceptable to the MOH. 2. Resources allocated to conduct the nutrition survey annually.
iv. Health risks reduced through advocacy against substance abuse, tobacco consumption, road accidents, and environment pollution.	1. Prevalence of smoking in Sri Lanka 2. Monthly no. of traffic accidents 3. Weekly air pollution index	1. Special survey 2. Police records and official statistics 3. Official records from CEA	1. The survey will be conducted periodically. 2. The records are accurate 3. Air pollution is being monitored in at least, the large urban cities.
v. NCD surveillance conducted and improved and studies on risks and factors associated with NCDs commissioned.	1. NCD surveillance system established. 2. Trends in NCD risk factors	1. Official record 2. Register General Dept., Special studies.	1. Resources available for such establishment. 2. Timely and reliable records and data available
vi. Prevention programmes and rehabilitative activities that are conducive to better mental health promoted and supported.	1. No. of prevention programmes conducted. 2. No. of communities/ population exposed to the programme interventions 3. Number of patients treated	1. Programme records 2. Programme coverage statistics	1. Positive social reactions to the programme interventions.

Strategic Goals and Objectives	Objectively verifiable indicators	Means of Verification	External Factors/Assumptions
	for mental illnesses	3. Hospital/clinic summary records/ statistics	
vii. Food safety measures introduced and enforced with an aim to protect public health.	1. No. of food (for public consumption) samples tested by state laboratories. 2. No. of prosecutions made annually as per the Food Act. 3. No. of food poisoning cases reported.	1. MIS-laboratory service records 2. MOH legal register 3. MIS-laboratory records	1. The MIS-laboratory services would have been established. 2. Public health inspectors trained to take food samples and laboratory technologists conduct tests regularly. 3. Chemical reagents and equipment are available to the laboratories.

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<p>Strategic Goal To attain the highest level of health through strengthening of the health system at national, provincial and district levels on principles of equity, fairness and responsiveness with emphasis on the poor and the marginalized.</p>	<ol style="list-style-type: none"> 1. Healthy Life Expectancy or similar measures such as Disability adjusted life expectancy 2. Crude Death Rate 3. Crude Birth Rate 4. Overall health system performance score 	<ol style="list-style-type: none"> 1. Official life tables and BoD study 2. Official vital registration report 3. Official vital registration report 4. Official reports/statistics and national health accounts using WHO formula and approach. 	<ol style="list-style-type: none"> 1. Investment in the health sector by the Government has increased. 2. An equitable, fair and well managed health system is in place 3. Health services at all levels have been substantially improved. 4. Social network to protect the poor and the vulnerable is in place. 5. Required human resources for health are adequately produced and appropriately deployed.
<p>Operational Objectives/Strategies</p>			
<p>4. To integrate and consolidate closely related health activities and strategies to enhance programme efficiency and effectiveness.</p>	<ol style="list-style-type: none"> 1. Cost per treatment of selected vector borne diseases. 2. Cost per prevented and treated case of childhood diseases using IMCI strategy 3. Prevalence of selected diseases in areas where health education is carried out compared with prevalence of the same diseases in areas where health education is not carried out. 4. Cost for care of the elderly using different approaches 5. Efficiency of different approaches for care of the elderly. 6. Availability of an updated drug policy. 7. Overall cost benefits of the implementation of the updated 	<ol style="list-style-type: none"> 1. Special cost study 2. Special cost study 3. Multi-disease surveillance system 4. Special programme cost study 5. Programme evaluation mission reports 6. Official report 7. Market survey and special cost 	<ol style="list-style-type: none"> 1. Various approaches are tried in different areas. 2. IMCI has been officially accepted. 3. Cost information is made available. 4. The drug policy and essential drugs strategy have been reviewed, revised and updated.

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
	drug policy	study	
Outputs			
i. Improved health education and health promotion at all levels, using effective approaches.	<ol style="list-style-type: none"> 1. % health workers trained at each level by category 2. % service programmes having health promotion component developed. 3. % of health promotion settings established at each level of facility. 4. No. of research studies conducted out of the priority areas identified. 	<ol style="list-style-type: none"> 1. Returns and records 2. Returns and records 3. Returns and records 4. No. of research papers published/completed. 	<ol style="list-style-type: none"> 1. Capacity of the provincial health authority to conduct training programmes remains unchanged or strengthened. 2. Capacity of the Health Education Bureau to provide support to train and develop health promotion components remain unchanged or strengthened. 3. Policy acceptance to establish health promotion settings. 4. Resources made available to conduct research studies.
ii. EPI programme consolidated and expanded to include new initiatives such as introduction and testing of new vaccines.	<ol style="list-style-type: none"> 1. No. of outbreaks of vaccine preventable diseases (covered under EPI programme) 2. EPI coverage rate 3. No. of reported adverse events following immunization (AEFI) 4. No. of events with reported specific indications. 	<ol style="list-style-type: none"> 1. Surveillance records 2. Vaccine coverage returns 3. Review meetings and survey records 4. Review meetings and records 	Health authorities in the center, regions and districts implement activities correctly and according to schedule.
iii. Integrated approach introduced to improve such programmes as child and adolescent health, health for the aged, health education and promotion, and vector control.	<ol style="list-style-type: none"> 1. No. of MOH areas introduced with IMCI. 2. No. of reported child/infant deaths associated with diarrhoea, respiratory tract infections, and other diseases in the programme areas. 	<ol style="list-style-type: none"> 1. Office and programme records 2. Hospital and death records 	1. Policy makers will accept IMCI.

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
iv. Quality assurance programme in health services at the peripheral level introduced.	<ol style="list-style-type: none"> 1. A quality assurance (QA) programme established. 2. No. of districts having established the QA programme 	<ol style="list-style-type: none"> 1. Official announcement of such establishment. 2. Records and returns 	<ol style="list-style-type: none"> 1. Establishment of the QA programme acceptable to MOH. 2. Cooperation from provincial health authorities.
v. Essential drugs policy and strategies updated, rational use and prescription of drugs strengthened, manufacturing, procurement and distribution of pharmaceuticals and biologicals improved with the aim to enhance benefits to the public.	<ol style="list-style-type: none"> 1. Availability of a revised national essential drugs policy and strategy 2. % of doctors aware of and comply with the rational use and prescription of drugs guideline 3. Price of essential drugs 4. Published standards for drugs described in Ayurvedic pharmacopoeia. 	<ol style="list-style-type: none"> 1. Official gazette 2. Surveys, special studies and medical audits. 3. Marketing survey 4. Publications of Ayurvedic Dept. 	<ol style="list-style-type: none"> 1. New policy approved by the Parliament 2. The guidelines are widely available to the doctors. 3. New procurement policy introduced. 4. The practice is approved by the concerned authority.
vi. Coordination of reproductive, family and women's health programmes improved.	<ol style="list-style-type: none"> 1. Availability of a common MIS for these programmes 2. No. of coordination meetings held among directors/officials of the concerned programmes. 	<ol style="list-style-type: none"> 1. Regularly published information 2. Returns and records. 	<ol style="list-style-type: none"> 1. Resources available to establish the MIS. 2. Existence of a coordination committee

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<p>Operational Objectives</p>			
<p>5. To institutionalize health emergency preparedness and response, and humanitarian action as part of MOH's activities; to assist in restoring the health system in the conflict affected area, while contributing to the establishment of peace using health as a bridge.</p>	<ol style="list-style-type: none"> 1. Number of internally displaced persons and returning refugees provided with health services. 2. Number and % of health facilities fully operational in the North and East (conflict affected area). 3. Difference between the health status (measured by a selected number of key indicators such as nutrition, mortality and morbidity rates, some diseases) of people living in the North and East and the rest of the country 4. Responsiveness difference between North and East and the rest of the country 5. Difference in price of essential drugs between North and East and 	<ol style="list-style-type: none"> 1. Special survey 2. MOH and provincial health authorities reports 3. Epidemiological reports and hospital/clinic patient records 4. Responsiveness survey 5. Marketing survey 	<ol style="list-style-type: none"> 1. The conflict in the North and East will end through current peace negotiation. 2. Additional health resources mobilized and allocated to the conflict affected area for restoring the health systems there. 3. Adequate human resources allocated to the North and East provinces. 4. Freedom to transport drugs and medical supplies to the conflict affected area.

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
	the rest of the country.		
Outputs			
i. Emergency health and humanitarian action (EHA) units at appropriate levels established and institutionalized and application of best practices and standards in emergency management promoted.	<ol style="list-style-type: none"> 1. No. of provinces with EHA units established. 2. No. and % of EHA unit staff trained 	<ol style="list-style-type: none"> 1. Provincial health authorities records and reports 2. Provincial health reports 	<ol style="list-style-type: none"> 1. Commitment by MOH and provincial health authorities to establish the units.
ii. Emergency health system developed and properly managed in the conflict affected areas.	<ol style="list-style-type: none"> 1. Availability of EHA MIS sub-system in operation 2. No. of EHA surveillance reports issued per year. 3. No. of provinces with emergency contingency plan prepared. 	<ol style="list-style-type: none"> 1. Official records from provincial health authorities 2. Published surveillance reports 3. Plans submitted to MOH. 	<ol style="list-style-type: none"> 1. Availability of trained personnel to manage the health system in the conflict affected area. 2. Health resources available for the conflict affected area.
iii. Health emergency and humanitarian actions in conflict affected area operationalized.	<ol style="list-style-type: none"> 1. No. of products and activities achieved as per PoA. 2. No. of implementation reports submitted 3. No. of coordination meetings on conflict areas held. 4. Amount of funds for conflict area liquidated 	<ol style="list-style-type: none"> 1. Periodic monitoring report. 2. Official records 3. Official records and minutes 4. Official reports 	<ol style="list-style-type: none"> 1. The implementing agency is able to deliver the services and supplies to the conflict affected area.
iv. Resources for health emergencies and humanitarian actions mobilized.	<ol style="list-style-type: none"> 1. Amount of EHA assistance mobilized annually. 2. No. of EHA taken up by the EHA units. 	<ol style="list-style-type: none"> 1. WR Office records 2. Periodic monitoring reports 	<ol style="list-style-type: none"> 1. Donors and development partners have interest to provide support for this type of programme
v. Health as a bridge for peace (HBP) advocated.	<ol style="list-style-type: none"> 1. No. of HBP workshops held and number of participants. 2. No. of persons who sustained injury as a result of the conflict or landmine rehabilitated 	<ol style="list-style-type: none"> 1. WHO records 2. Hospital and police records plus special studies. 	<ol style="list-style-type: none"> 1. The commitment from MOH to hold such workshops for all stakeholders.

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Operational Objectives/Strategies			
<ol style="list-style-type: none"> 6. To foster partnerships among stakeholders in the health sector and enhance coordination among them. 	<ol style="list-style-type: none"> 1. Availability of a health sector development plan 2. No. of notifiable diseases reported by the private sector and NGOs. 3. No. of collaborative health programmes involving more than 3 stakeholders 4. Availability of a health sector donor coordination mechanism. 	<ol style="list-style-type: none"> 1. Official Gazette 2. Reports submitted to MOH 3. Official records 4. Official records 	<ol style="list-style-type: none"> 1. A coordination mechanism has been worked out. 2. MIS has designed a format for reporting by the NGOs and private sector.
Outputs			
<ol style="list-style-type: none"> i. One WHO support for the health sector mobilized. 	<ol style="list-style-type: none"> 1. No. of SEARO and HQ missions to Sri Lanka annually 2. Amount of ER funding for Sri Lanka 3. Total no. of man months of technical assistance provided to Sri Lanka from SEARO/HQ. 	<ol style="list-style-type: none"> 1. WHO records 2. WHO records 3. WHO records 	<ol style="list-style-type: none"> 1. Both SEARO and HQ are committed. 2. Cooperation from MOH is ensured.

Strategic Goals and Objectives	Objectively Verifiable Indicators	Means of Verification	External Factors/Assumptions
ii. WHO country office reorganized to enhance the Organization's effectiveness and efficiency.	<ol style="list-style-type: none"> 1. Availability of staff deployment and development plan. 2. % of WHO RB funds obligated and liquidated in 1st year of biennium 	<ol style="list-style-type: none"> 1. WHO organogram and No. of WHO staff by function 2. WHO records 	1. Support by SEARO to reorganize the WHO Country Office.
iii. Inter- and intra- sectoral cooperation for health development promoted.	<ol style="list-style-type: none"> 1. No. of planning and review meetings organized between MOH and provincial health authorities annually. 2. No. of intra-sectoral planning and review meetings involving civil society, NGOs, MOH and the private sector organized by WHO. 3. No. of intersectoral planning and review meetings organized by WHO involving various Ministries. 	<ol style="list-style-type: none"> 1. MOH official records 2. WHO records 3. WHO records 	1. Support by MOH for such promotion is provided.
iv. Interagency cooperation for health promoted.	1. No. of inter-agency meetings organized or initiated by WHO.	1. WHO records	1. All concerned parties are interested to work together.
v. Internal and external resources for health system development mobilized.	<ol style="list-style-type: none"> 1. Amount of internal (WHO) resources mobilized by the WR office. 2. Amount of external resources mobilized by the WR office. 	<ol style="list-style-type: none"> 1. WHO records 2. WHO records 	<ol style="list-style-type: none"> 1. MOH committed to district level health system development 2. Essential assistance to mobilize funds provided by SEARO and HQ
vi. Health placed in the center of national development and given its deserved attention in the development agenda.	<ol style="list-style-type: none"> 1. Government to formally recognize health as the center of national development through mass media. 2. No. of health programmes giving emphasis to the poor and the marginalized areas/people. 	<ol style="list-style-type: none"> 1. Official announcement by MOH and Parliament 2. National health plans 	1. Endorsement by the highest level of the Government is given.

WHO RB 2004-2005 Country Strategic Plan
Table 2 – Outputs and Products

Operational Objective: 1. To strengthen the health sector and to further develop the health system on the principles of equity, fairness, and responsiveness	
Outputs:	Products:
A new and comprehensive evidence-based national health policy, which will incorporate advances in areas of health financing and health insurance, public/private mix, decentralization, and health system development formulated.	1. Health policy review committee established and functioning.
	2. Health policy review subcommittees formed.
	3. Health policy review report submitted
	4. Health policy drafting committee formed.
	5. Health policy working group formed
	6. New health policy drafted and submitted for consideration and approval.
District level health system developed which will focus on improving the conditions of the poor and the vulnerable.	1. Formation of district health system development teams in every district of 2-3 piloted provinces.
	2. Health situation analysis conducted in the selected districts and health facilities mapped.
	3. The poor and the vulnerable groups in communities identified.
	4. Strategies to provide quality health care, to improve access to health services, and to equip the target groups developed.
	5. Plans of action to implement the strategies developed.
	6. Implementation of the plans of action monitored.
	7. Pilot areas evaluated.
	8. A system to monitor the trends and existing health conditions of the vulnerable groups at community level established.
Improved district level service management including management of drugs and their rational use, human resource development and deployment, use of health facilities, and development of referral systems.	1. Improved rational use of blood and blood products and monitoring.
	2. Human resource deployment plan prepared.
	3. Process of developing a national referral system started.
	4. Improved laboratory services in peripheral hospitals to make the services commensurate with their size.
	5. LMIS for monitoring inventories of drugs and medical supplies at hospitals developed.
	6. Pilot test of LMIS in 1 district
	7. Health promotion activities at all levels of hospitals introduced.
	8. Social service units established in selected hospitals

<p>Information system development supported through nation-wide networking, promotion of information use and quality, and development of multi-disease surveillance system.</p>	1. Establishment of an information network among major blood banks
	2. Training of staff to make use of the blood bank information network
	3. Training imparted to concerned staff for conducting the multi-disease surveillance and establishing the surveillance system.
	4. Linkage established between the surveillance system and the national MIS.
	5. Health Bulletin regularly published and lead-time shortened.
<p>Quality assurance and responsiveness in service provision achieved.</p>	1. Establishment of the Quality Assurance programme to monitor and implement various quality assurance programmes
	2. Training of staff to sustain the quality assurance system.
	3. Establishment of a quality assurance system among blood banks
	4. Medical audits of various levels of hospitals carried out regularly.
	5. Hospital exit responsiveness surveys carried out.
<p>Consolidated health decentralization process to improve coordination, resource mobilization, programme planning and implementation, and accountability.</p>	1. Strategies to decentralize the health system developed.
	2. Strategies to ensure conformity of all provinces to national health policies and strategies developed and agreed to by all concerned parties.
	3. Formal mechanism to improve coordination between levels of Government on health planning, programme implementation and monitoring developed.
	4. System of health financing and health accounts developed and formalized by Government.
	5. Roles of stakeholders in the health sector clearly defined.
<p>Health human resource development supported focusing on promoting biomedical sciences as a key component of health care system and development of allied health human resources.</p>	1. Level and skills of laboratory personnel improved, sustained and monitored.
	2. Trained staff on infection control and surveillance, waste management, and monitoring of antibiotic resistance monitoring,
	3. Diagnostic services improved through enhancement of laboratory facilities and application of standard methodologies and guidelines, and implementation of quality assurance principles.
	4. Programme planning and monitoring skills improved at all levels.
	5. Skills and knowledge of paramedical staff and health technologists updated.

	6. Facilities for Training/educating paramedical personnel and technologists upgraded and expanded according to HRD plan.
i. Role of peripheral hospitals reoriented in the health care system.	1. Hospital reorganization committee formed.
	2. Role peripheral hospitals in community health reviewed and recommendations made
	3. Peripheral hospitals reorganized/reoriented in selected pilot areas
	4. Awareness of hospital reorganization raised in concerned communities.
	5. Performance of pilot area hospitals reviewed.

WHO RB 2004-2005 Country Strategic Plan
Table 2 – Outputs and Products

Operational Objective: 2. To prevent and control communicable diseases that cause high burden to the population including emerging diseases that have high potentials to become public health menaces.	
Outputs:	Products:
A health laboratory network built at sub-national level to improve health services.	1. Central and regional public laboratory established and strengthened.
	2. Trained staff on laboratory system development and networking with regional laboratories.
	3. Essential and strategic laboratory reagents and equipment provided.
	4. External technical support provided to establish and strength the networking of the laboratory system.
Multi-disease surveillance developed and disease outbreak surveillance activities supported.	1. Strengthened disease surveillance activities including feedback mechanism in order to take rapid action to control communicable diseases.
	2. Trained central and regional health staff on epidemiological surveillance and outbreak investigation and control of communicable diseases.
	3. Established emergency action committees and rapid response teams.
Communicable disease control programmes for the eradication/ elimination of polio, measles, leprosy, rabies, filariasis, etc. supported.	Leprosy:
	1. Regional epidemiologists gained skills to identify the areas for interventions, analyzing the epidemiological data.
	2. Provincial and deputy provincial directors were informed of the leprosy situation in the area and helped district team in finding solutions to the logistic problems.
	3. Newly recruited Medical Officers of curative and preventive sectors gained skills in diagnosis and management of leprosy and managing the elimination programme at local level.
	Dengue:
	1. Reduced mortality due to DHF by proper case management and community mobilization through inter-sectoral collaboration.
	2. Established focal point at the Ministry to monitor, plan and implement dengue control and prevention programmes
	3. Dengue elimination programme plan developed.

	<p>Filaria:</p> <ol style="list-style-type: none"> 1. Filaria elimination programme intensified. 2. Filaria programme reviewed and evaluated 3. Sub-national level training and refresher training on Filaria control and prevention conducted. <p>Rabies:</p> <ol style="list-style-type: none"> 1. Rabies eradication achieved with no rabies death case reported 2. Public education and awareness programme on rabies prevention intensified.
<p>Focused support of high burden and high return potential disease control programmes, e.g., malaria, tuberculosis, HIV/AIDS.</p>	<p>Malaria:</p> <ol style="list-style-type: none"> 1. Preparation of manual on management of severe and complicated malaria, to be used by clinicians managing malaria patients (public and private sector). 2. Improved knowledge and skills of different categories of health staff (on malaria and its control). 3. Supported provided to community based organizations 4. Vector surveillance activities for malaria and dengue prevention and control reviewed at district and national level and district level intersectoral coordination meetings held. 5. Provision of critical supplies and equipment necessary for the malaria control programme. 6. Operational research conducted with the objective of developing more cost-effective malaria control strategies. <p>Tuberculosis:</p> <ol style="list-style-type: none"> 1. Successful advocacy for increased political commitment to NTP. 2. Trained personnel for DOTS implementation at all levels. 3. Trained NTP infrastructure established. 4. TB laboratory services strengthened. 5. National TB database strengthened and quality of data improved. <p>HIV/AIDS:</p> <ol style="list-style-type: none"> 1. Sustainable and effective behavioural surveillance system established. 2. Trained public and private sector staff in voluntary counseling and testing (VCT). 3. Provision of antiretroviral drugs to prevent mother-to-child transmission.

	4. Laboratory quality assurance programmes for HIV established in public and private sectors.
v. Geographic and socio-economic differentials in communicable disease burdens addressed.	1. Targeted intervention in high prevalence areas
	2. Enhanced health services and health education for the poor and the vulnerable
	3. Strengthened surveillance in high risk areas and populations

WHO RB 2004-2005 Country Strategic Plan
Table 2 – Outputs and Products

Operational Objective:	
3. To promote healthy life styles and reduce environmental risk factors	
Outputs:	Products:
i. Healthy living as an effective means of maintaining health and preventing non-communicable diseases promoted.	1. Knowledge with regard to prevention of NCDs through practicing healthy life style disseminated with the participation of school teachers and community leaders.
	2. Capacity of primary health care workers with regard to development of skills in early diagnosis of NCDs strengthened.
	3. Raised public awareness of the risks and prevention of NCDs.
	4. Capacity of the PHII enhanced in improving the life style to maintain a healthy environment through education.
	5. An environment with less pollutants achieved and indoor air pollution improved.
ii. Strengthened health education and family health programmes emphasizing on effective communication to reach the underserved, particularly the poor.	1. Capacity of health volunteers from underserved areas on prevention of NCDs developed.
	2. Occupational health promoted through awareness and advocacy.
	3. Capacity of medical officers of health in occupational medicine developed.
iii. Existing nutrition programme at all levels reviewed and overhauled.	1. Operational research on existing and innovative nutrition programmes conducted.
	2. National nutrition survey conducted
	3. National nutrition strategies developed and implemented
	4. Revised national nutrition programme introduced.
	5. National nutrition programme implementation monitored.
iv. Health risks reduced through advocacy against substance abuse, tobacco consumption, road accidents, and environmental pollution.	1. Advocacy to obtain commitment of policy makers of various sectors to control tobacco.
	2. Quantified consequences of tobacco use especially the economic aspect through operational research.
	3. Community educational and empowerment initiatives towards passive smoking by mobilizing youth and professional groups.
	4. Raised awareness of the general public on prevention of road traffic injuries (RTI) emphasizing the consequences and preventable nature of RTI.

	5. Environment friendly hospital concept promoted in one hospital per province.
	6. Case studies on environment pollution conducted.
	7. IEC materials to promote favourable food habits made available.
	Environmental health
	1. Frequency and quality of air quality status developed for the Colombo City and data collection from ambient air quality monitoring stations improved.
	2. Vehicle pollution trends in Colombo City regularly monitored.
	3. Database of polluting industries in Sri Lanka for environmental protection licensing improved and updated periodically.
	Water and Sanitation
	1. Improved coverage of the water quality surveillance system in Sri Lanka.
	2. Promotion and determination of household water quality improvement system and appropriate research conducted.
	3. Training on water treatment methods and low cost rural water supply and sanitation system.
v. NCD surveillance conducted and improved and studies on risks and factors associated with NCDs commissioned.	1. Capacity of the nodal point on programme planning and analysis of NCD database developed.
	2. Trends in risk factors of major NCDs studied.
	3. Conference on practical national measures to prevent NCDs held.
	4. NCD surveillance report published and disseminated.
vi. Prevention programmes and rehabilitative activities conducive to better mental health promoted and supported.	1. Public campaigns for recognition and treatment of common mental disorders launched.
	2. Mass media used to promote mental health and foster positive attitudes.
vii. Food safety measures introduced and enforced with an aim to protect public health.	1. Safe and healthy food made available to the consumer.
	2. Capacity of health personnel in the enforcement of the Food Act enhanced.
	3. Food analytical capacity strengthened.
	4. Public health laboratory facilities established.

WHO RB 2004-2005 Country Strategic Plan
Table 2 – Outputs and Products

Operational Objective:	
4. To integrate and consolidate closely related health activities and strategies to enhance programme efficiency and effectiveness.	
Outputs:	Products:
i. Improved health education and health promotion at all levels, using effective approaches.	1. New and innovative health education and promotion approaches developed.
	2. New approaches tested for their effectiveness
	3. Manuals for new approaches prepared.
	4. Training of national and provincial staff on use of effective new approaches.
	5. Conventional health education programmes evaluated for their effectiveness
	6. IEC strategies for promoting integrated health programmes and interventions developed.
	7. New strategies introduced to and implemented by all provinces
	8. Coordination meetings regularly held between health education bureau and programme directors on appropriate IEC programme materials and dissemination strategies
ii. EPI programme consolidated and expanded to include new initiatives such as introduction and testing of new vaccines.	1. Mortality and morbidity due to measles reduced and outbreaks prevented.
	2. Hepatitis B vaccine introduced in 3 areas and high coverage maintained in phase 1 and 2 areas.
	3. Poliomyelitis eradicated and polio free certification obtained by year 2005.
	4. Elimination of maternal and neonatal tetanus sustained and whooping cough and diphtheria prevented and controlled.
	5. Improved and maintained vaccine quality and cold chain facilities and AEFI maintaining system
	6. Effective and safe immunization activities achieved and AEFIs reduced.
iii. Integrated approach introduced to improve such programmes as child and adolescent health, health for the aged, health education and promotion, and vector control.	Child and adolescent health
	1. Morbidity and mortality in childhood illness reduced through integrated management of childhood illness.
	2. Prevention of disability of children promoted at community level.
	3. Improved life competencies (life skills) for prevention of health problems and protection of school and out-of-school adolescents and youth.

	4. A comprehensive national strategy for improving the well-being of adolescents and youth developed.
	Health for the elderly
	1. Improvement of vision and prevention of blindness of elders.
	2. Expanded community health care programme for the elderly in new (50) MOH areas.
iv. Quality assurance programme in health services at the peripheral level introduced.	1. Workshops held to develop the quality assurance programme
	2. Policies and strategies on quality assurance introduced.
	3. Manuals for quality assurance at different levels of health facilities developed.
	4. Pilot test conducted in selected facilities by introducing the quality assurance programme
	5. Pilot project evaluated.
v. Essential drugs policy and strategies updated, rational use and prescription of drugs strengthened, manufacturing, procurement and distribution of pharmaceuticals and biologicals improved with an aim to enhance benefits to the public.	1. Achievement of the outputs through a series of consultative meetings, seminar and workshops with professional health and pharmaceutical organizations and consumers.
	2. Implementation of the updated national drug policy.
	3. Implementation and monitoring rational use of drugs guidelines.
	4. Expansion of GMP in local manufacturing of drugs.
	5. Training of pharmacists and storekeepers on management in pharmaceutical sector.
	6. Development of technical skills of concerned personnel in various fields.
	7. Information system developed to register cosmetic devices and drugs.
vi. Coordination of reproductive, family and women's health programmes improved.	1. Regular coordination meetings held among family and women's health programme officials and supporting agencies
	2. NGOs and other stakeholders participated in development of national reproductive, family health, and women's health programmes.
	3. Common reporting mechanism on above programmes developed and adopted.
	4. Indicators for programme monitoring reviewed and improved.
	5. Innovative pilot projects to further integrate the above programmes supported.
	6. Pilot projects evaluated and results disseminated.

	7. New strategies to improve women's and reproductive health developed
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WHO RB 2004-2005 Country Strategic Plan
Table 2 – Outputs and Products

Operational Objective:	
5. To institutionalize health emergency preparedness and response as part of MOH activities; to assist in restoring the health system in the conflict affected area, while contributing to the establishment of peace using health as a bridge.	
Outputs:	Products:
i. Emergency preparedness and response (EPR) units at appropriate levels established and institutionalized and application of best practices and standards in emergency management promoted.	1. Strengthened emergency action committee and rapid response teams on disease control activities in regions.
	2. Trained EPR unit staff for improving the capacity of the EPR units provided.
	3. Facilities provided to institutionalize the units at provincial and national level.
	4. Emergency management and preparedness manuals and guidelines developed.
ii. Emergency health system developed and properly managed in the conflict affected areas.	1. Survey of the overall health situation and the health system of conflicted areas completed.
	2. Strategies on rehabilitating, reconstructing and long and short term development of the health systems in the conflict areas agreed upon by all concerned.
	3. MIS sub-component for emergency preparedness and response developed.
	4. Surveillance and other disaster alert and monitoring system established.
	5. Emergency contingency plans developed.
iii. Health emergency operations in conflict affected area operationalized.	1. Emergency health assistance in disaster and conflict affected areas organized and provided
	2. Health emergency operations in the conflict areas coordinated.
	3. Health emergency operations monitored and evaluated.
	4. Health needs of the population in the conflict area assessed.
	5. Collaboration with all stakeholders in addressing the needs of the most vulnerable and the poor sustained.
vi. Resources for health emergencies mobilized.	1. WHO and donor resources for the conflict areas mobilized.
	2. Technical assistance for emergency health and for disaster preparedness and response provided.
	3. Resources for supporting the EPR units mobilized.

	4. Coordination and management of resources for EPR activities enhanced at all levels
	5. Donor coordination meetings held regularly.
v. Health as a bridge for peace advocated.	<ol style="list-style-type: none"> 1. Advocacy for peace through organization of Health as a Bridge for Peace workshops. 2. Programme organized for rehabilitation of those injured during conflict. 3. Promotion of health as a human right and programmes to combat violence against women.

WHO RB 2004-2005 Country Strategic Plan
Table 2 – Outputs and Products

Operational Objective:	
6. To foster well coordinated partnerships among stakeholders in the health sector.	
Outputs:	Products:
i. One WHO support for the health sector mobilized.	1. Financial resources from development partners and WHO extra-budgetary resources mobilized for the health sector.
	2. Technical assistance from WHO (at all levels) mobilized to support the health sector.
ii. WHO Country Office reorganized to enhance the Organization's effectiveness and efficiency.	1. WCO assessed and organization plan developed.
	2. Regular technical training organized for WHO staff.
	3. Annual work plans developed for all staff
	4. WHO retreat organized to review performance and to solve issue.
	5. WHO RB biennium work plans produced.
	6. Selected number of WHO supported programmes evaluated to determine WHO's effectiveness.
iii. Inter- and intra-sectoral cooperation for health development promoted.	1. Regular intersectoral meeting between officials of different sectors organized at and national and sub-national level.
	2. District health system development promoted and supported.
	3. Technical assistance of WHO extended to other sectors for health development
	4. Impact of various factors (e.g. environmental risks, pollution, poverty) on health monitored and their awareness raised in the community.
iv. Interagency cooperation for health promoted.	1. Consortium meetings organized on a regular basis between development partners, Government and WHO.
	2. UNDAF health programme activities implemented.
	3. Coordinated planning and implementation of health programmes between agencies supported based on the principle of comparative advantage.
	4. Enhanced monitoring of health programmes and performances in the health sector.
	5. Various health days observed.
v. Internal and external resources for health system development mobilized.	1. Resources committed to conduct the World Health Survey on a periodic basis.
	2. Research studies on health system development supported.

	3. Awareness programme on health system development conducted
	4. Resources from development partners committed for health sector reform, development of district health systems, health financing and reorganization of health services.
	5. Training on health system development conducted.
vi. Health placed in the center of national development and given its deserved attention in the national development agenda.	1. Participation of WHO in the high level policy committees.
	2. Recognition of the highest level of Government of Sri Lanka the importance of health in the overall national development.
	3. Policy and strategy development in promoting and strengthening health as an important means to reduce poverty.
	4. Increased allocation by Government to the health sector
	5. Major national conference held on health and macroeconomics.

ANNEX-I UN and WHO Strategic Goals and Efforts

UN Millennium Development Goals	UN Strategic Goals in Sri Lanka under UNDAF	UN Strategic initiatives in Sri Lanka under UNDAF	WHO's Global Strategic Directions	WCO* Initiatives to contribute to UN Strategic Goals in Sri Lanka
1. Eradicate poverty and hunger 2. Achieve universal primary education 3. Promote gender equality and empower women	1. Provision of emergency and humanitarian assistance to conflict affected areas and people.	a. Mitigation of human suffering and protection of human rights emanating from the armed conflict through effective emergency and humanitarian assistance	Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations.	Advocacy Data collection and epidemiological information services Human resources development
4. Reduce child mortality 5. Improve maternal health 6. Combat HIV/AIDS, malaria and other diseases	2. Assisting in restoring the economic livelihood of adversely affected persons and provide support for efforts that contribute to the establishment of peace and social cohesion.	a. Restoring the economic livelihood of adversely effected people through process-oriented, innovative approaches, b. Support for a dialogue and information-exchange process that will promote social cohesion c. Provision of assistance in post-conflict preparedness planning	Developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and financially fair. Framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimensions to social, economic, environmental and development policy.	Advocacy Health as a Bridge for Peace Programmes to combat violence against women

UN Millennium Development Goals	UN Strategic Goals in Sri Lanka under UNDAF	UN Strategic initiatives in Sri Lanka under UNDAF	WHO's Global Strategic Directions	WCO* Initiatives to contribute to UN Strategic Goals in Sri Lanka
<p>7. Ensure environmental sustainability</p> <p>8. Develop a global partnership for development</p>	<p>3. Reduction of poverty through promoting improved accessibility to basic services and the creation of economic opportunities for the poor.</p>	<p>a. Innovative approaches to foster equity through access and participation of the poor in the development process.</p> <p>b. Provision of targeted health, education and nutrition assistance to vulnerable groups.</p> <p>c. Improve the management of poverty reduction policies and programmes by fostering equity through access and encouraging use of socio-economic data and information, particularly disaggregated poverty data.</p>	<p>Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations.</p> <p>Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.</p> <p>Developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and financially fair.</p> <p>Framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimensions to social, economic, environmental and development policy.</p>	<p>Targeted health interventions (Malaria, HIV/AIDS, Tuberculosis)</p> <p>Substance abuse reduction (Tobacco, Alcohol, Illicit Drugs)</p> <p>Nutrition interventions (Anemia, Iodine Deficiencies, Food Safety, Low birth weight)</p> <p>Environmental health (healthy cities settings, water quality)</p> <p>Quality assurance (human resource development, under-served areas, vulnerable groups)</p>

UN Millennium Development Goals	UN Strategic Goals in Sri Lanka under UNDAF	UN Strategic initiatives in Sri Lanka under UNDAF	WHO's Global Strategic Directions	WCO* Initiatives to contribute to UN Strategic Goals in Sri Lanka
	4. Governance reform aimed towards promoting people-centered development.	<ul style="list-style-type: none"> a. Promotion of efficient decentralization, devolution and participatory decision making processes. b. Supporting efforts to deepen market reforms and encourage private sector development. c. Strengthening institutional capacity of the public sector for development management. This includes enhancing monitoring and evaluation capacities and other measures to promote greater public transparency, quality implementation, programme impact and accountability. d. Strengthening the advocacy and supportive roles of Civil Society Organizations (CSOs) in the areas of environment, social harmony and monitoring and evaluation of public programmes e. Encouraging governments to implement and monitor implementation of agreements signed at international conventions and UN conferences. f. Promotion and protection of human rights so as to foster greater civic participation and democratic empowerment. 	<p>Developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and financially fair.</p> <p>Framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimensions to social, economic, environmental and development policy.</p>	<p>Health System/Policy Reforms</p> <ul style="list-style-type: none"> ○ Decentralization ○ Improvement for referral system ○ Health care financing ○ Public/Private mix <p>Human Resource Development</p> <ul style="list-style-type: none"> ○ Geographic distribution ○ Productive performance ○ Management skills

*WCO – WHO country office

ANNEX-II

Background of WHO Country Cooperation Strategies

Changing context of international health	WHO's new approaches to respond to the changing context	Strategic Directions	Core Functions of WHO's Secretariat	Criteria for identifying Organization-wide priorities
<p>1. Understanding of the causes and consequences of ill health is changing. It is increasingly evident that achieving better health depends on many social, economic, political and cultural factors, in addition to health services</p> <p>2. Health systems are becoming more complex. The private sector and civil society are emerging as important players. People's expectations of health care services are rising.</p> <p>3. Safeguarding health is gaining prominence as a component of humanitarian action.</p> <p>4. The world is increasingly looking for greater coordination among development organizations. To rise to this challenge will</p>	<p>1. Adopting a broader approach to health within the context of human development, humanitarian action, equity between men and women, and human rights, with a particular focus on the links between health and poverty reduction.</p> <p>2. Assuming a greater role in establishing wider national and international consensus on health policy, strategies and standards – through managing the generation and application of research, knowledge and expertise.</p> <p>3. Triggering more effective action to promote and improve health and to decrease inequities in health outcomes, through carefully negotiated partnerships and by making use of the catalytic action of others.</p>	<p>Strategic Direction 1: Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations.</p> <p>Strategic Direction 2: Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.</p> <p>Strategic Direction 3: Developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and financially fair.</p> <p>Strategic Direction 4: Framing an enabling policy and creating an institutional environment for the health sector, and promoting an effective health dimensions to social, economic, environmental and development policy.</p>	<p>1. Articulating consistent, ethical and evidence-based policy and advocacy positions.</p> <p>2. Managing information by assessing trends and comparing performance; setting the agenda for, and stimulating, research and development.</p> <p>3. Catalyzing change through technical and policy support, in ways that stimulate cooperation and action and help to build sustainable national and intercountry capacity.</p> <p>4. Negotiating and sustaining national and global partnerships</p> <p>5. Setting, validating, monitoring and pursuing the proper implementation of norms and standards.</p> <p>6. Stimulating the development and testing of new technologies,</p>	<p>1. Potential for significant change in burden of disease with existing cost-effective interventions.</p> <p>2. Health problems with major impact on socioeconomic development and a disproportionate impact on the lives of the poor.</p> <p>3. Urgent need for new technologies.</p> <p>4. Opportunities to reduce health inequalities within and between countries.</p> <p>5. WHO's advantages, particularly in relation to public goods; building of consensus around policies, strategies and standards; initiation and management of partnerships.</p> <p>6. Major demand for WHO support from Member States.</p>

Changing context of international health	WHO's new approaches to respond to the changing context	Strategic Directions	Core Functions of WHO's Secretariat	Criteria for identifying Organization-wide priorities
require more emphasis on effectiveness through collective action and partnerships.	4. Creating an organizational culture that encourages strategic thinking, prompt action, creative networking, innovation and accountability, and strengthens global influence.		tools and guidelines for disease control, risk reduction, health care management, and service delivery.	

ANNEX-III

CCS Development Process in Sri Lanka and Criteria for WHO’s Involvement

Objective of the Country Cooperation Strategy (CCS)	Aim of the CCS	CCS Development Process in Sri Lanka	Criteria for Setting priorities and identification of main programme areas and challenges in Sri Lanka	General criteria used to decide WHO’s involvement in Sri Lanka.
<ol style="list-style-type: none"> 1. More influential on health policies, 2. More strategic in working with the Government and stakeholders, 3. More focused in helping to obtain better and more equitable health outcomes, 4. More effective in supporting health sector development, 5. More innovative in forging influential partnerships 	<p>To improve WHO’s performance in its core functions and be a more significant and effective actor in the changing context of international health:</p> <ol style="list-style-type: none"> a. In responding to the needs of the Ministry of health, b. In working with other Ministries whose work directly impacts on the health sector and health, c. In supporting the government in its negotiation with other partners in health and development, d. In finding ways of working beyond the government Ministries. 	<ol style="list-style-type: none"> 1. Involved consultation and preparation at different levels of WHO 2. Consulted extensively with various development partners, the government and other stakeholders 3. Considered and incorporated different development approaches, e.g. UNDAF, WB sector wide approach, etc. 4. Reviewed various documents and analyzed available data, trends, and projections. 5. Analyzed comparative advantages and capacities of WHO and other development partners 	<ol style="list-style-type: none"> 1. Potential for significant change in burden of disease with existing cost-effective interventions. 2. Health problems with major impact on socioeconomic development and a disproportionate impact on the lives of the poor. 3. Urgent need for new technologies. 4. Opportunities to reduce health inequalities within and between countries. 5. WHO’s advantages, particularly in relation to public goods; building of consensus around policies, strategies and standards; initiation and management of partnerships. 6. Major demand for WHO support from Member States. 	<ol style="list-style-type: none"> 1. Areas where WHO has a catalytic and leadership role to play 2. Scope for long term strategic involvement leading to significant outcomes 3. Areas where equity and partnership need to be promoted 4. Critical support required in areas of decentralization, research, information effective and efficient decision making 5. Innovative approaches to integrate health concern into development

ANNEX-IV

WHO Country Cooperation Strategy – Priority programme area identification

WHO Organization-wide Priority Programme Areas	UNDAF Priority Programme Areas	CCS Priority Programme Areas (based on draft)	WHO Area of Work According to Identified Priority Programme Areas
Malaria, tuberculosis and HIV/AIDS	Malaria, tuberculosis and HIV/AIDS	Malaria, tuberculosis and HIV/AIDS	1. Malaria 2. Tuberculosis 3. HIV/AIDS
Cancer, cardiovascular disease and diabetes		Cancer, cardiovascular disease and diabetes, accidents/injuries	4. Surveillance, prevention and management of non-communicable diseases
Tobacco	Tobacco		5. Tobacco
Maternal health			6. Maternal health/Making pregnancy safer 7. Research and programme development in reproductive health
Food safety	Food Safety		8. Food Safety
Mental health and substance dependency	Substance abuse	Substance abuse/poisoning	9. Mental health and substance dependency
Blood safety			10. Blood safety and clinical technology
Health systems/Policy reforms	Health systems/Policy reforms	Health systems/Policy reforms	11. Evidence for health policy 12. Organization of health services
Environmental health	Environmental health	Environmental health	13. Health and environment
Major communicable diseases (Regional priority)			14. Communicable disease prevention, eradication and control
	Nutrition	Nutrition	15. Nutrition
	Quality assurance		Under No. 12
	Human resource development		Under No. 12
	Violence against women/women's health	Violence against women/women's health	16. Women's health
	Epidemiological information services		17. Communicable disease surveillance 18. Health information management and dissemination

WHO Organization-wide Priority Programme Areas	UNDAF Priority Programme Areas	CCS Priority Programme Areas (based on draft)	WHO Area of Work According to Identified Priority Programme Areas
		Introduction of new vaccines	19. Immunization and vaccine development
		Disasters/health emergencies and humanitarian action	20. Emergency preparedness and response

ANNEX V: Analysis of Issues and Recommended Strategies and Outcomes

Communicable Diseases	Strategy	Outcome
<p>Malaria – Still a major public health problem. 50% of malaria is confined to the North-East Provinces (Conflict Areas)</p>	<ol style="list-style-type: none"> 1) Early diagnosis and treatment. 2) Vector control measures such as indoor residual spraying, impregnated bed-net programmes, biological control and environmental manipulation. 3) Establish Partnerships with other Govt. Depts., NGOs and community at district, provincial and national levels. 	<p>Establish realistic targets after considering the baseline data.</p> <p>To eliminate malaria deaths and reduce morbidity by 60% over the 5 years.</p>
<p>Dengue Haemorrhagic Fever – Dengue/DHF increased epidemics and spread of Dengue Haemorrhagic Fever in the country within the last 5 years due to inadequate action by local government authorities and lack of community awareness on the eliminating of breeding places of the vectors of this disease.</p>	<ol style="list-style-type: none"> 1) Training of medical staff in large hospitals for the management of Dengue Fever and Dengue Haemorrhagic Fever. 2) Advocacy for elimination of vector breeding places of DHF by local government authorities and increase community based action to help eliminate vector breeding places. 	<p>Control/eradication of DHF epidemics in 5 years time with prevention of deaths by proper management of acute cases.</p>
<p>Filariasis – Endemics in three of the 8 provinces. Population exposed 9.5 million.</p> <ol style="list-style-type: none"> 1) Lack of community awareness and human resources, impede the targeted coverage of the mass single dose campaign. 2) Inadequate knowledge among health personnel about the causes, prevention, treatment and management of Micro-filaria carriers and patients. 3) Inadequate training of health and local government personnel in vector control. 4) Absence of a proper computerised information system which leads to inadequate monitoring and surveillance. 	<ol style="list-style-type: none"> 1) Increase community awareness amongst the local government and the community for elimination in improving the targeted coverage of the mass single dose campaign. 2) Eliminate the breeding places of the vector mosquitoes. 3) Improve training coverage of health and local government personnel. 4) Introduce an efficient computerised MIS system to assist in diagnosis, monitoring and surveillance. 	<p>Move towards eradication of Filaria by 2010.</p>

Communicable Diseases	Strategy	Outcome
<p>Diarrhoeal Diseases –</p> <p>Still remains a major public health problem in regard to morbidity due to a lack of safe water and latrine usage</p>	<p>1) Improve coverage of safe water and latrine construction in both urban and rural areas.</p> <p>2) Improve quality assurance of coverage of water.</p>	<p>Improve coverage of safe water and latrine construction and usage to 100% in 5 years.</p>
<p>Tuberculosis - Is re-emerging as a major health problem due to inadequate coverage and monitoring of treatment and drug resistance.</p>	<p>1) Improve early diagnosis at both institutions and monitoring of the full treatment in the field.</p>	<p>About 60% reduction in Tuberculosis cases over a period of 5 years from the existing baseline levels.</p>
<p>STD AIDS</p> <p>1) Cumulative increase of cases over the last decade.</p> <p>2) HIV infections among women have increased.</p> <p>3) Sexual transmission is the major mode of infection</p>	<p>1) More effective coordination between the partners including the NGOs.</p> <p>2) Regular monitoring and reviews.</p> <p>3) More effective IEC and social marketing to be carried out throughout the country.</p> <p>4) Promote the use of condoms.</p>	<p>Establish baseline data in regard to the strategies and establish realistic targets to be achieved over a period of 5 years.</p>
<p>Polio Eradication –</p> <p>Sri Lanka has not had a Polio case for a number of years. However, for Polio Eradication vigilance must be maintained throughout the island. Surveillance and IEC for advocacy are essential.</p>	<p>1) Surveillance to be maintained in all MOH areas.</p> <p>2) IEC and advocacy to be strengthened</p> <p>3) Maintain 100% polio immunisation for infants and pre-schoolers.</p>	<p>Achieve polio eradication by 2010 with certification.</p>

Communicable Diseases	Strategy	Outcome
<p>Rabies – Although significant reduction of Human Rabies has been achieved, since the initiation of the Rabies control programme in the mid-1970s it remains a public health hazard.</p> <p>1) Inadequate vaccination coverage especially of stray-dogs. 2) Inadequate management of Rabies vaccine coverage of humans at risk.</p>	<p>1) Advocacy and community awareness on the vaccination programme targeting stray-dogs. 2) Elimination of stray-dogs with community cooperation. 3) Availability of Rabies vaccines for humans at risk in the medical institutions in the country and also a pragmatic economical use of human rabies vaccines. 4) Community awareness – intensify community awareness programmes in reference to the causes of human rabies by stressing the problems of the stray-dog menace.</p>	<p>Reduce the human rabies problem by 60% within the next 5 years.</p>

Non-Communicable Diseases	Strategy	Outcome
<p>Cardiovascular Diseases, Diabetes and Malignancies There has been a substantial increase in all three during the last decade. Although facilities are available in Colombo and few other provincial capitals, a great deal has to be done at district and grass-root levels for prevention such as changing lifestyles and early diagnosis and treatment.</p>	<p>1) Training health care workers at primary care level in early diagnosis and treatment. 2) Intensify community awareness through health education and media advocacy especially at district and out reach areas.</p>	<p>1) Surveys to be carried out at district levels to determine the problem and work out a realistic target for interventions. 2) Review the impact of the health education and media advocacy programmes at the district levels.</p>

Issues Associated with Social Change and Lifestyle	Strategy	Outcome
<p>Problems of the Elderly</p> <p>1) Children unable to look after their parents. 2) Services provided for the elderly are inadequate. 3) Lack of mobile domiciliary services.</p>	<p>1) Develop Geriatric services in Sri Lanka and increase the number of specialists. 2) Major medical institutions to provide a few beds for the elderly. 3) Provide services for a) Psychiatric care b) Coverage of vision and hearing impairments. c) Rehabilitation services for the physically disabled. d) Provide mobile and domiciliary care e.g. meals on wheels by primary health care field staff.</p>	<p>1) Establish baseline data in regard to the number of the aged district wise. 2) Improve coverage of their problems by static and mobile care</p>
<p>Mental Illness –</p> <p>1) Services unable to cope with the mentally ill in Sri Lanka. 2) Mentally ill cases are hidden by families due to the stigma attached to mental illness. 3) Inadequate amenities for group and peer discussions amongst mentally ill patients. 4) Inadequate knowledge by the Primary Health Care workers to identify the mentally ill in the districts and therefore, the inability to refer them for treatment.</p>	<p>1) Increase the number of Psychiatrists in the country. 2) IEC and health education programmes to spread the message that mental illness is another disease and that most mentally ill patients can be cured or their condition improved. 3) Involve NGOs and community groups to initiate group and peer discussions amongst the mentally ill. 4) Establish training for the primary health care workers to identify mentally ill patients and refer them for treatment.</p>	<p>Surveys to establish baseline data and indicators defined to determine the impact of the strategies on the quantum of mental illness.</p>

Issues Associated with Social Change and Lifestyle	Strategy	Outcome
<p>Poisoning/Suicides Poisoning is a major health problem in Sri Lanka with over 80,000 admissions and 3,000 deaths in hospitals. It contributes to a large number of deaths in districts and is the 4th leading cause of death in Sri Lanka. Intentional suicidal poisoning by agrochemicals is the leading cause.</p>	<ol style="list-style-type: none"> 1) Increase community awareness of the communities especially at district levels on this major problem especially in relation to suicides. 2) Farmers and other users of agrochemicals should be made aware to keep these chemicals away from adolescents. 3) Training of health staff on the management of poisoning. 	<p>Baseline data to be collected in the most affected districts and impact surveys to be carried out on the effect the interventions had on the targeted population at the end of a 5 year period.</p>
<p>Traumatic Injuries /Accidents- Accidents are the principle component of traumatic injuries. According to police statistics, accidents are increasing year by year. The causes of accidents may be due to unsafe driving, driving under the influence of liquor and not adhering to traffic regulations.</p>	<ol style="list-style-type: none"> 1) Assist the police in training drivers. 2) advocacy and support for driving not under the influence of liquor. 3) Establishment of accident services/immediate care for victims of accidental injuries. 4) IEC on safe driving and prevention and accidents. 	<ol style="list-style-type: none"> 1) Establish baseline data on the causes of accidents. 2) Surveys on the impact of training and IEC in the prevention of accidents.
<p>Tobacco and Alcohol Use – 1) Has become a major public health problem in the country. 2) Increase in Cancer and Cardiovascular diseases. 3) Enhances child and women abuse</p>	<ol style="list-style-type: none"> 1) Presidential Unit on Tobacco and Alcohol established 2) Primary health care poverty alleviation networks established in districts to reduce tobacco usage and alcohol abuse. 3) NGOs work closely with the government 	<ol style="list-style-type: none"> 1) Surveys to be carried out to determine the extent of the problem in Sri Lanka and whether mechanisms set in motion have had an impact. 2) Aggressive IEC and social marketing to be carried out to counter the propaganda by the tobacco industry.

Issues Associated with Social Change and Lifestyle	Strategy	Outcome
<p>Nutritional Problems in Children – This is a major problem in vulnerable groups in under-served areas like Moneragala, the Wannu etc. Anaemia, protein energy malnutrition, iodine deficiency disorders and Vitamin A deficiencies still remain amongst these marginalized groups.</p>	<ol style="list-style-type: none"> 1) Improve the coverage of these children by the primary health care workers. 2) IEC on correct dietary habits and the use of cheap nutritious food supplements. 3) Correct iron deficiency anaemias with correct iron supplements. 	<p>Improve the nutritional status of these targeted groups by about 60% from the baseline levels.</p>

Issues	Strategies	Outcome
<p>Existing Reproductive Health Issues – 1) Unsafe motherhood 2) Sub-fertility 3) Criminal abortions 4) Reproductive tract infections 5) Gender equality</p>	<ol style="list-style-type: none"> 1) Reduce anaemia and under nutrition in mothers through iron and nutritional supplements 2) Respecting existing human rights, through empowering women to make choices in their reproductive lives with the support of their families and communities. 3) Access to quality maternal health care services. 4) Access to voluntary family planning information and services. 	<ol style="list-style-type: none"> 1) Reduce anaemia and under-nutrition by 60% in identified, vulnerable and disadvantaged areas. 2) Improve access to quality methods in health care services and to voluntary family planning and information services in identified, vulnerable and disadvantaged areas.

Issues	Strategies	Outcome
<p>Planning and Management Issues-</p> <p>Inadequate Managerial Skills – 1) Some of the problems faced by Sri Lanka in the health sector is a lack of good managers. The health sector has not focussed attention on producing skilled managers.</p> <p>2) Inadequacy/Inequity in Human Resources Development - Although there has been an increase in the cadre of Doctors there are still shortages of Nurses, Para-medical and Public Health personnel such as Pharmacists, Radiographers, Public Health Inspectors, Public Health Nurses and Family Health Workers.</p>	<p>1) Management is an important component which should be incorporated in to the undergraduate and postgraduate medical education and also into the in-service training programmes run by the Department and the Ministry of Health.</p> <p>2) Career prospects for paramedical and public health staff should be developed with suitable incentives.</p> <p>3) This disparity should be addressed. Incentives such as housing and schooling for the doctors and their families should be provided.</p> <p>4) The government is addressing the situation in the conflict area through volunteers, NGOs and intensified training programmes for all categories of existing staff.</p>	<p>1) Include management courses in undergraduate and postgraduate medical educations. – In-service training programmes should also cover all managers and future managers at district, provincial and national levels.</p> <p>2) a) Focus on increasing the cadre of nurses, paramedical and public health personnel within a specified time frame.</p> <p>b) Improve their career prospects through promotional avenues and other incentives.</p> <p>3) within five years the vacancies of doctors in remote and inaccessible areas should be filled by providing good housing, schooling for their children and other incentives.</p> <p>4) With the peace initiative, the vacancies could be filled in the various categories of health personnel and intensify training programmes. NGOs and volunteers to help improve the health status for the conflict areas within a five year period.</p>

Issues	Strategies	Outcome
<p>3) The brain-drain of Medical Officers which occurred over a decade ago has been reduced to a large extent. However, as regards distribution of medical officers there still exists a mal-distribution with a predominance of the skilled specialists in urban areas especially Colombo and Kandy. There is still a problem of staffing the rural areas in remote and inaccessible areas.</p> <p>4) Some of the major shortages of human resources is in the North-East province due to the conflict.</p> <p>5) Inadequate information at national level on cadre requirements and vacancies existing at provincial and district level.</p> <p>6) Inadequate mobilisation and Utilisation of Donor Resources - Sri Lanka like most other developing countries has not been systematic in using its donor resources more effectively. Funds available are more donor driven than demanding. Inadequacies in strategic planning have also led to Programme Directors not been able to absorb all the funds available within the stipulated time frame.</p>	<p>5) The Planning Unit of the Ministry and Department of Health Services is developing a computerised Human Resource Management Information System for all categories of staff at National, Provincial and District levels.</p> <p>6) This has now been recognised by the Ministry of Health. With the assistance of the World Health Organization the skills of Programme Directors at national level and mid level Managers (Provincial and District) are being strengthened to identify the gaps in financial resources. Training is being given to these categories of health personnel to identify priority health problems, additional finances required and more importantly the need to develop a good project proposal.</p>	<p>5) Complete human resource MIS for all categories of staff at national, provincial and district level and periodically update it.</p> <p>6) Train all managers at national and provincial level and also the mid-level managers in identifying priority health problems, developing a good strategic plan and project proposal and identify the gaps in financial resource through a series of workshops and processes of monitoring and evaluation.</p>

Issues	Strategies	Outcome
<p>Health Management Information System (HMIS) -</p> <ul style="list-style-type: none"> - Dichotomy in reporting to the national authorities creates confusion. - General Health and Health Services information is compiled annually by the Medical Statistics Unit; Relaying of information on communicable and non-communicable disease surveillance comes under the Epidemiological unit. However, malaria, filaria, tuberculosis, leprosy, STD/AIDS and cancer for which there are special campaigns who receive separate information. - Records in medical institutions inadequately maintained for Institutional morbidity. - Inadequate statistically trained personnel present in institutions. - Diagnosis invariably not given for both OPD and indoor cases. - Basic field health workers overloaded with forms and formats to collect statistics - Feedback mechanisms not timely or not done at all. - Data not analysed at peripheral level where decisions and actions have to be done. - Inadequately computerised at district level. 	<p>Through computerisation and training, the HMIS will be installed and functional in medical institutions and MOH offices at all levels, with a direct link to the national level.</p> <ul style="list-style-type: none"> - Training on data management and utilisation at national, provincial and district levels. - Records to be properly maintained in the medical institutions. - Train a suitable person at medical institutions or MOH offices to maintain statistics. - Medical Officers to be motivated and trained to record diagnosis for OPD and indoor cases. - New MIS system will streamline forms and formats to collect statistics. - Peripheral workers should receive information on time to take action. - Data to be analysed at district level and early remedial action taken. 	<p>Baseline data to be established and indicators established to determine how efficient the MIS system is working at district, provincial and national levels.</p>

Issues	Strategies	Outcome
<p>Monitoring & Evaluation Issues –</p> <p>With decentralisation, inadequate supervision and monitoring exists especially at provincial and district levels.</p> <p>Inadequate authority for the central health authority in regard to supervision, monitoring and evaluation.</p>	<p>Streamline forms and returns. Records of both direct and indirect supervision should be maintained at all levels.</p> <p>Action taken on inspection reports should also be recorded re. - correction of defects.</p> <p>Authority and facilities for central health authority to supervise at provincial and district levels.</p>	<p>Improve the quality and coverage of the inspections at all levels by setting out realistic targets.</p> <p>Appropriate operational research to determine the impact of supervision, monitoring and evaluation on improving the performance of key health activities.</p>

END OF PART I.