# Piloting a Primary Health Care Reform in Sri Lanka

A guide to establishing a 'cluster of facilities' for providing shared care

**supported by the**

**ADB financed**
**Sri Lanka : Health System Enhancement Project**

*Management Development Planning Unit of the*
*Ministry of Health, Nutrition & Indigenous Medicine*
*and*
*the Asian Development Bank*
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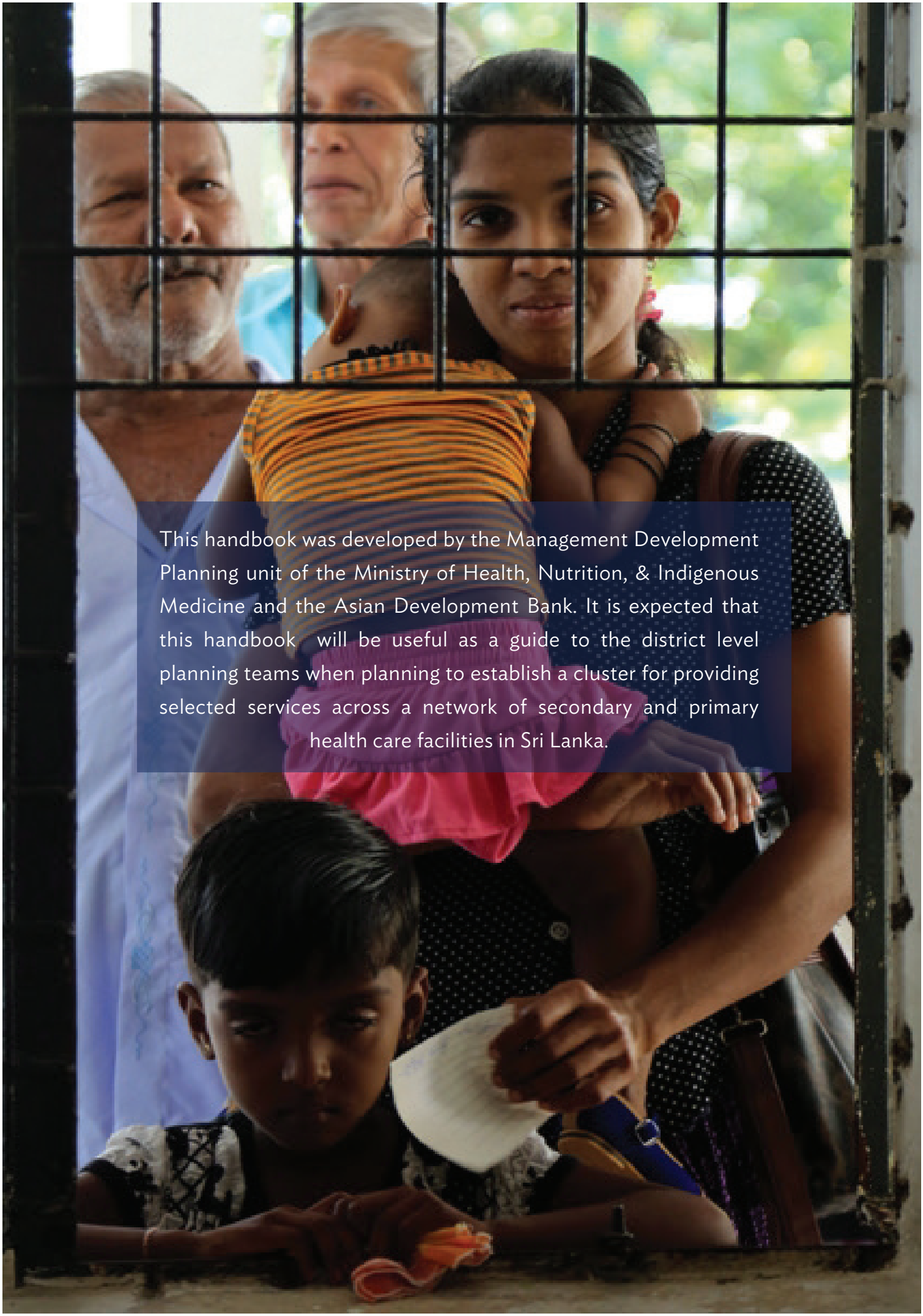
Ministry of Health, Nutrition
& Indigenous Medicine

ADB



This handbook was developed by the Management Development Planning unit of the Ministry of Health, Nutrition, & Indigenous Medicine and the Asian Development Bank. It is expected that this handbook will be useful as a guide to the district level planning teams when planning to establish a cluster for providing selected services across a network of secondary and primary health care facilities in Sri Lanka.

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# 1. BACKGROUND

Sri Lanka has achieved remarkable health outcomes at low cost. The life expectancy is at 74.9 years in 2011–2013 with a reduction in the male–female gap in life expectancy from 8.4 years in 2001 to 6.6 years in 2011, Maternal Mortality is 33.8 per 100,000 live births in 2016 . Immunization Coverage is more than 95% with excellent communicable disease control with near elimination stage reached for vaccine preventable diseases like neonatal tetanus, diptheria, measles and poliomyelitis and Malaria and filaria free since 1994 and 2016 respectively (footnote 2).

Sri Lanka's government health spending as a share of Gross Domestic Product (GDP) is relatively low at approximately 3% and out-of-pocket expenses (OOPE) accounts for about 40 percent of total health expenditures. Of the out of pocket expenses, as much as 50% are spent on doctor fees with differences in the composition of OOPE when compared across income quintiles with the richest spending roughly a third of the OOPE on private practitioners, another third on private hospital care, and 16 percent on drugs. Among the poorest, roughly 70 percent is spent on private practitioners, less than 1 percent on private hospitals, and about 20 percent on drugs.

But due to changing lifestyles, economic development, population health demands and expectations and urbanization; today's health burden has changed from Communicable diseases to more chronic (long term) illnesses like diabetes mellitus, heart diseases, strokes, chronic respiratory illnesses, cancers, mental health illnesses, lifestyle and over nutrition burden, tobacco, air pollution, alcohol usage and low physical activity.

- The age-standardized death rates for the four common NCDs (heart diseases, diabetes, chronic respiratory diseases) are higher for males than females, with cardiovascular death rates at 350 deaths for males compared with 200 deaths for females age-standardized population .
- While 82% of deaths are due to NCDs, 17% of NCD deaths occur prematurely between the ages of 30 and 70.
- At the national level in 2016, in children under 5 years of age, 20.5% are underweight and 17.3% are stunted while even in 2006, 15.1% were underweight and 17.3% were stunted while 15.7% of children were low birth weight (less than 2,500 grams)

1. Government of Sri Lanka, Department of Census and Statistics. Life Tables for Sri Lanka, 2011–2013. http://www.statistics.gov.lk/PopHouSat/CPH2011/Pages/Activities/Reports/FinalReport/LifeTables.pdf.

2. Government of Sri Lanka, MOHNIM, Medical Statistics Unit. 2017. Annual Health Bulletin 2015. Colombo.

3. Govindaraj R., Navartne K., Cavagnero E., Seshadri S.R., Health care in Sri Lanka: What can the private health sector offer? HNP Discussion Series, 2014., World Bank

4. Edireweera D.S., Karunapema P., Pathmeswaran A., Arnold M; Increase in premature mortality due to non-communicable diseases in Sri Lanka during the first decade of the twenty-first century Public Health (2018) 18:584 https://doi.org/10.1186/s12889-018-5503-9

# 2. THE PRIMARY HEALTHCARE SYSTEM IN SRI LANKA

The PHC services for preventive health via Medical Officer of Health areas were first established in 1927. Today, preventive health services are provided to the total population via 342 Medical Officer of Health areas and the population receives preventive health services as home care, clinic care and community care as necessary for immunization, communicable disease surveillance and prevention and control, maternal and child health services, school health services, environment and occupational health services and support to mental health and Non communicable Disease prevention activities.

Primary Health care services for curative care, the Primary Medical Care Units (earlier called Central Dispensary and /or and Maternity Homes); Divisional Hospitals A,B,C (earlier called Peripheral Units, Rural Hospitals and District Hospitals respectively) were established during 1930s And as of 2016, there were approximately 1109 government managed hospitals (Tertiary, Specialized, Secondary and Primary Care facilities) across the country with a total bed strength of 81,580.

Table 1: Distribution of Government managed Hospitals types and Bed strength, Sri Lanka

| Type of Hospital | Number of Institutions | No of Beds |
|---|---|---|
| Teaching Hospitals | 16 | 20,109 |
| Provincial General Hospitals | 3 | 4,790 |
| District General Hospitals | 19 | 11,911 |
| Base Hospitals (A and B) | 71 | 16,660 |
| Divisional Hospitals (A,B,C) | 483 | 22,513 |
| Primary Medical Care Units and Maternity Homes | 12 | 153 |
| Primary Medical Care Units | 480 | 0 |
| Other Hospitals | 25 | 5,444 |
| **TOTAL** | **1109** | **81,580** |

Over the last two decades, clinical service demands at the secondary and tertiary level hospitals increased as a response to address the increasing NCD burden, But this resulted in under investments in the curative PHC system. This led to an increase of underutilization of existing PHCs (curative network) and over utilization of the secondary and tertiary services.

Furthermore, changing patient demands and expectations and the increasing need to provide a continuum of care for the increasing burden of chronic illnesses due to NCDs, there is now a demand and a national policy decision to create functional linkages with the preventive services and the curative services at the PHC level and to also provide an interconnected network of secondary and curative services when providing curative care at the PHC level.

Annual Health Bulletin 2016, Ministry of Health, Nutrition and Indigenous Medicine, Sri Lanka

# 3. UTILIZATION OF PRIMARY HEALTH CARE SERVICES

Patients tend to bypass the local lower level PHC curative services and seek care in secondary and tertiary care hospitals, while PHC preventive services continue to provide a comprehensive package of services.

Majority of the patients with NCDs, mental illnesses, injuries seek care at the secondary and tertiary care levels.

- Only 30% of all clinic users used the 975 PHCs as the rest (70%) attended clinics at the 109 secondary and tertiary care hospitals in Sri Lanka (foot note 2).
- Only 27% of all clinic users are using a PHC as first contact care (first visits) for NCDs (footnote 2)
- Among all inpatients in the public sector, only 22% seek care at PHC level (foot note 2).

The preventive health system (via the Medical Officers of Health) continues to provide extensive coverage with very low bypassing of services.

- Antenatal care (76.2% of pregnant women receive antenatal care from 8 weeks of gestation; more than 90% receive at least three antenatal visits; 54.5% receive as much as eight antenatalvisits; 99.3% of pregnant women receive tetanus toxoid; and 92.5% of mothers receive at least one home visit by the public health midwife within 10 days of delivery);
- Child care (as much as 95% age-appropriate immunization coverage is provided via the MOH offices) (foot note 5);
- Nutrition services are provided with the provision of a nutrition supplement to underweight children below 5 years and all mothers, regular nutrition weighing and regular growth monitoring activities are provided to 87.5% of the children under 1 year and to 80% of the pre-schoolers (2 to 5 years) (foot note 5).
- 88% of all schools have carried out regular School Medical Inspections (foot note 5).
- 67% of eligible families use a contraceptive method while 58% use modern methods (footnote 5).

6 Government of Sri Lanka, MOHNIM, Family Health Bureau. 2018. *National Strategic Plan, Maternal and Newborn Health*, 2017–2025. Colombo.

# 4. WHY REFORM/REORGANIZE THE PHC SYSTEM?

Even though the Sri Lanka health system has been able to achieve good health outcomes, health outcome disparities still exist by sex, age, sector and poverty . PHC system needs to be reformed/ reorganized in order to provide for the local population health needs.

Therefore, the curative sector PHC system needs to be reorganized to achieve the objectives given below.

- To address some of the currently existing health disparities to ensure UHC to all population groups
- To reduce the OOPEs of the poorer quintiles of the population...
- To provide a higher quality of services at the PHC
- To Provide better continuity of care
- To increase health seeker satisfaction
- To increase the accessibility of a well defined service package to ensure better access and reliability.

7 Census and Statistics Department, Demographic and Health Survey 2016, Sri Lanka

# 5. POLICY FRAMEWORK

The supporting Policy Framework for establishing a PHC reform in Sri Lanka include:

- Reorganization of Health care delivery for UHC Policy
- Sri Lanka Essential Service Package

Sri Lanka's key development objective is to provide a 'a people-patient centred health system that provides a high quality package of services to all'.

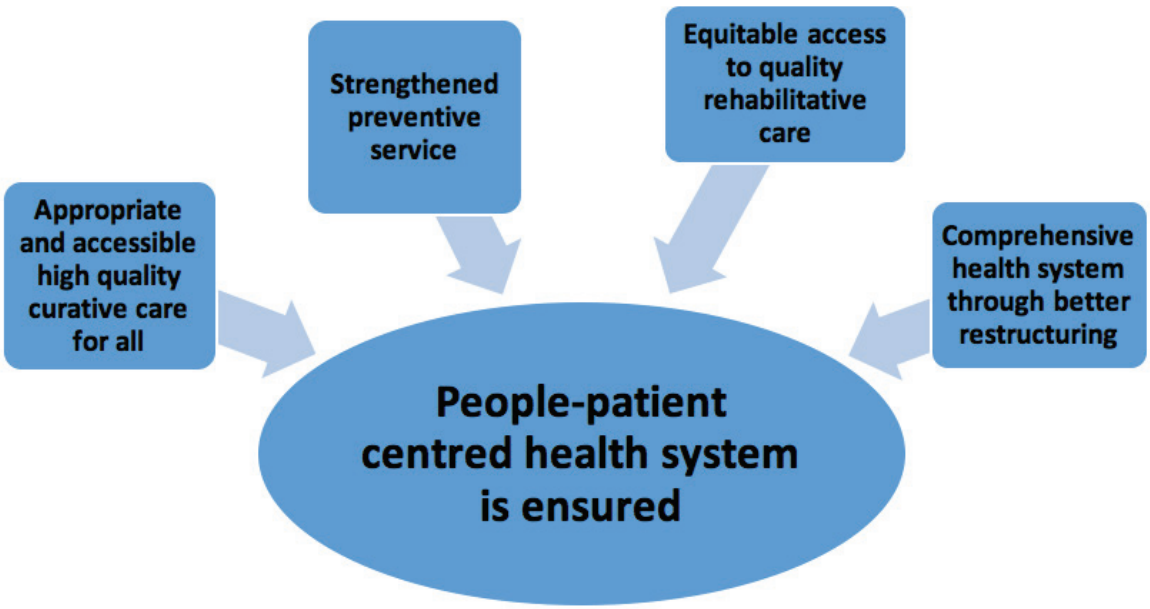



Figure 5.1: Features of the people-patient centered health system

# 6. SRI LANKA: HEALTH SYSTEM ENHANCEMENT PROJECT FUNDING

As recommended in the policy for reorganization of health care delivery for Universal Health Coverage policy, the Sri Lanka: Health System Enhancement Project (HSEP) financed by the ADB is supporting to pilot the implementation, establishment, and evaluation of 9 separate clusters for providing more comprehensive and equitable PHC services with continuity of care.

The overall goal for all clusters will be to come up with an innovative cluster management system for more effective and efficient use of limited resources to improve UHC in the cluster catchment population.

The pilot clusters, identified by the respective RDHS, in consultation with the PDHSs will be in the following areas:

**a.** Karawanella Cluster in Kegalle

**b.** Kahawatte Cluster in Ratnapura

**c.** Teldeniya Cluster in Kandy

**d.** Rikilagaskade Cluster in Nuwera Eliya

**e.** Dambulla Cluster in Matale

**f.** Bibile Cluser in Moneragala

**g.** Welimada Cluster in Badulla

**h.** Thambuthegama Cluster in Anuradhapura

**i.** Medirigiriya Cluster in Polonnaruwa

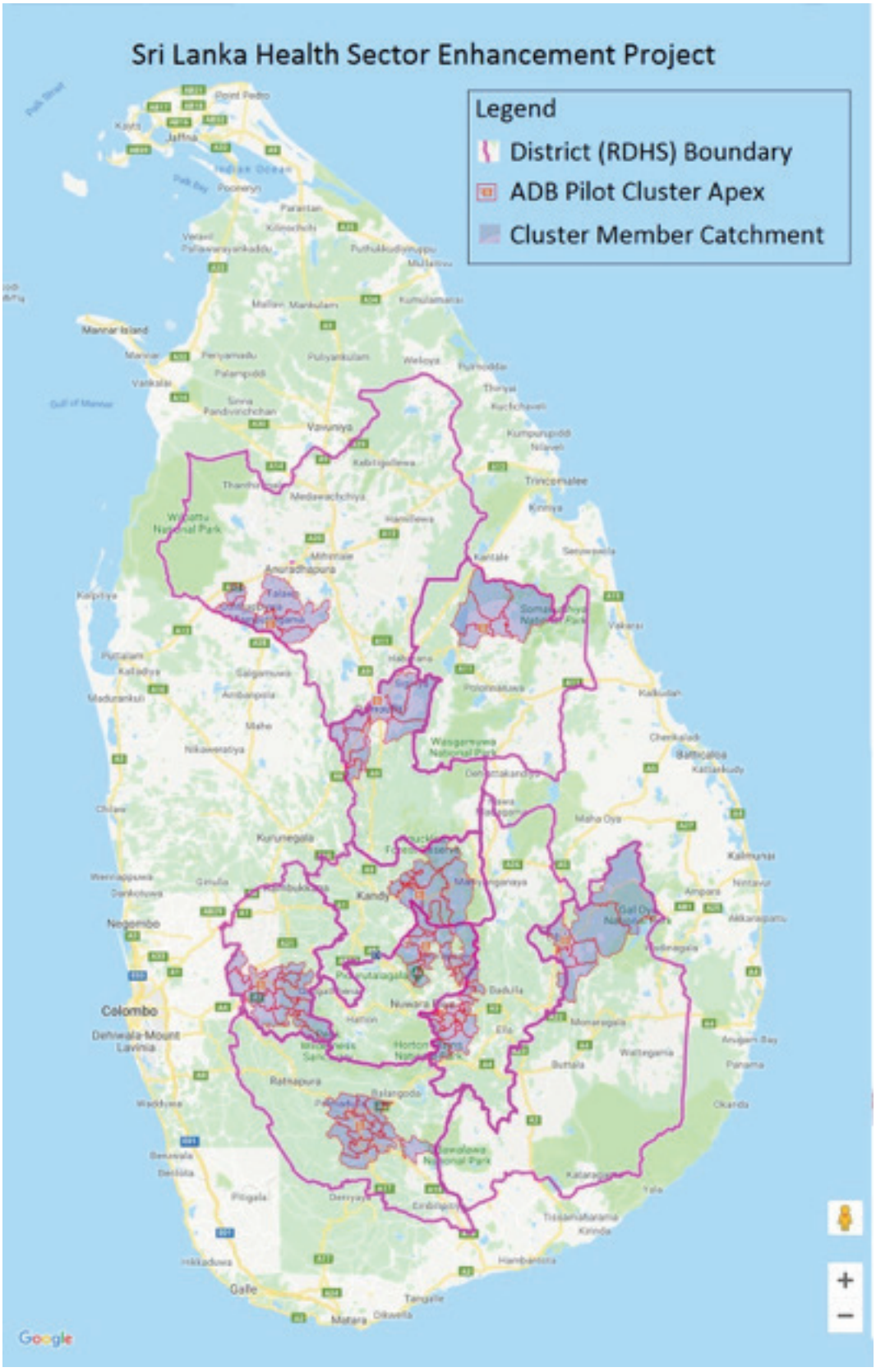
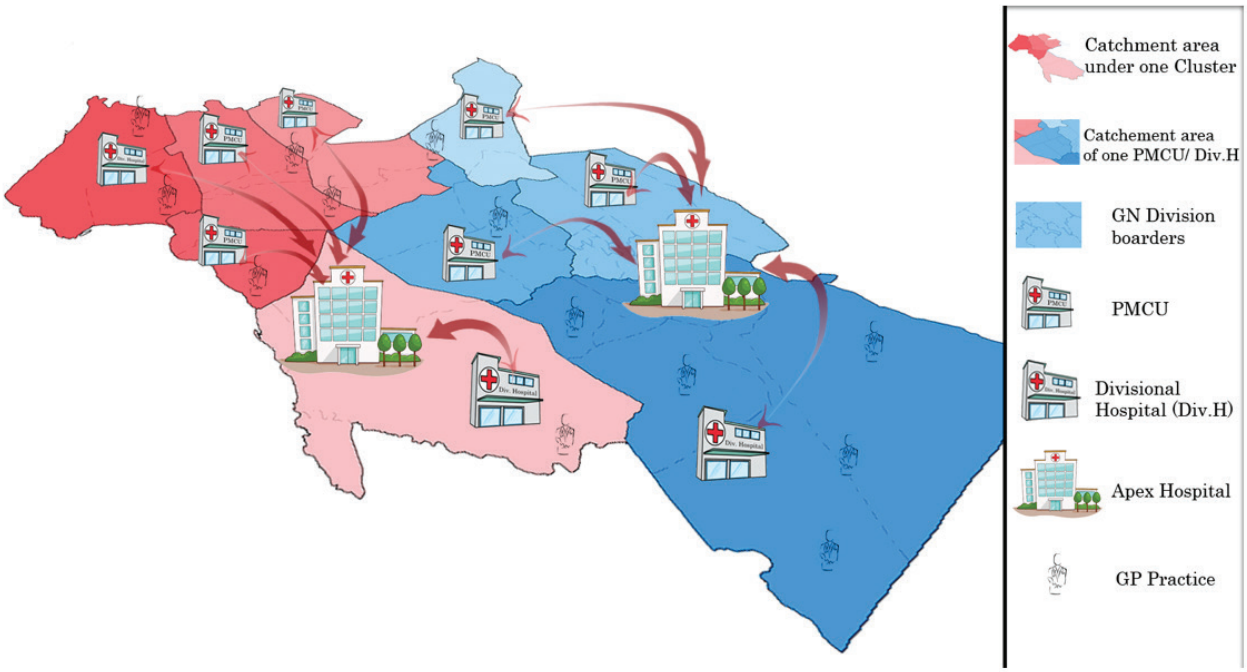



*Figure 6.1: Pilot Cluster Areas of SLHSEP*

# 7. DEFINITION OF A HEALTH CLUSTER

- A cluster is defined as a group of hospitals (secondary and primary) linked together to serve a demarcated population.
  - An Apex Hospital – Base Hospital or above
  - The Divisional Hospitals (DHs) that can be linked to the Apex
    The Primary Medical Care Units (PMCUs) that can be linked to the Apex
- Based on the local level knowledge and expertise of the health team at the District and Province level, the Regional Director Health Services in each of the 9 districts identified the Apex hospital that will be used for the cluster pilots.
- Thereafter, based on local knowledge, and current health seeking behaviour, the PMCUs and the DHs that are geographically linked and are approachable by bus routes were used a to identify the PMCUs and the DHs that are planned to be linked to the cluster.

*Figure 7.1: The diagrammatic conceptualization of the shared care cluster model [8]*




[8]*The Sri Lanka Essential Services Package, Ministry of Health, Nutrition and Indigenous Medicine, Draft version 4.2; January 2019.*

# 8. HOW CAN THE CATCHMENT POPULATION BE IDENTIFIED?

- The Grama Niladhari (GN) divisions are used to demarcate the catchment populations in each of the clusters.
- GN population data is calculated from the Census 2012 data.
- A GIS tool was developed and is hosted in the cloud on http://52.163.248.76/himapnew/ http://52.163.248.76/HIMAPSL/HOME
- Using the GIS technology, the GN areas that feed into each of the cluster linked hospitals using the travel distance was generated.
- The generated GN lists were validated at the local level in discussion with the Regional Directors of Health Services (RDHSs) and their respective health teams.
- Using the GIS tool, the catchment population for each cluster-linked facility can be generated and the total of all will be the catchment population of the cluster.
- Using the GIS tool, the health teams can identify vulnerable populations using parameters like housing conditions, access to road network, access to sanitation etc.
- Existing spatial health survey data can be uploaded to the maps and thereafter, health related vulnerable populations could be identified and used for planning, monitoring and evaluation of health interventions.

# 9. STAKEHOLDER IDENTIFICATION AND PLANNING COMMUNICATION NEEDS

Stakeholder identification and planning the communications needs to address the stakeholders includes:

- Identify all stakeholders who will be positively and negatively affected, key influencers and beneficiaries of the established Clusters.
- Plan out the activities that will need to be carried out to update/inform all identified stakeholders
- Carry out the interventions to address all stakeholders prior to establishing a cluster while taking account of the concerns and issues raised by the stakeholders.

# 10. DEFINING THE SERVICES TO BE PROVIDED VIA A CLUSTER

Based on the Essential Services Package (ESP), following services (clinical, support) should be provided via a cluster.

In the pilot, each of the cluster teams' options are to either:

- Ensure that all clinical and support services are provided via the cluster network as defined in the ESP

Or

- Ensure that a selected few clinical / and /or support services are provided via the cluster while other services are continued to be provided as individual hospitals.

- For each clinical and support services that are selected to be implemented in the cluster, relevant guidelines, clinical pathways, back and up referral pathways, will need to be developed or adapted from existing guideline and pathways.

**Each of the 9 cluster teams will select a package of services that would be unique to the respective pilot cluster.**

# 11. ADDRESSING CLUSTER GOVERNANCE ISSUES

- Based on the Policy on Reorganization of Health Care Delivery for UHC, HCD-UHC, the Provincial Director, via the respective Provincial Health Secretary and Chief Secretary will need to issue a circular / authorization to pilot a cluster in each of the respective provinces.

- The Provincial Director of Health Services (PDHS), the Regional Director of Health Services (RDHS) and the respective Cluster Team in consultation with the Health Secretary and the Chief Secretary, will determine the management model for each of the pilot clusters based on the guidelines and the Policy on Healthcare Delivery for Universal health Coverage issued by the Ministry of Health, Nutrition and Indigenous Medicine .

- The Cluster Head will be the Deputy RDHS in each of the cluster pilot districts based on the guideline issued by the Ministry of Health, Nutrition and Indigenous Medicine. The Cluster head will be appointed by the respective RDHS.

- The Cluster management team will be appointed by the Deputy RDHS (Cluster Head) and will include a combination of the following officials.

    - Medical Superintendent of the Apex Hospital
    - A few selected District level Health Officers (based on the clinical services that would be linked in the cluster; e.g. Medical Officer NCD, Regional Epidemiologist, Medical Officer Mental Health etc. )
    - Representatives from the RDHS Office, especially from the Planning Unit of the RDHS
    - Representatives from each of the cluster participating hospitals (PMCUs and the DHs that are networked in the cluster)
    - Representatives from the Medical Officer of Health areas served by the cluster
    - Representatives from the Health users
    - Representative from the hospital committee/s

[9] http://www.health.gov.lk/moh_final/english/public/elfinder/files/publications/2018/phduhc-2018.pdf

- The Cluster Head, in consultation with the Cluster team, may determine to

    - Reactivate the respective hospital development committees and define the engagement mechanisms with the Communities served by the cluster.

    - Work with the Quality Management Units with the participation of all cluster linked hospitals to review progress of cluster performance, patient satisfaction, and improve quality.

    - Establish a Cluster Drugs and Supplies Team with the participation of relevant representatives (pharmacists, dispensers, Hospital Medical Superintendent or Director from all the cluster linked hospitals for managing the drugs and supplies. oEstablish a Laboratory and Imaging Services Management Team with the participation of all relevant staff (Laboratory consultants, Medical Laboratory Technologists, Public Health Laboratory Technicians and Hospital Medical Superintendent or Director).

    - Establish a Geographical Information Systems (GIS) Cell for strengthening GIS based health planning and management with the participation of the District GIS cell representative (Development Officer or a Planning Officer), a Hospital based Development Officer/ Planning Officer, Public Health Medical Officer (if available), Matron or a senior Nurse and HospitalMedical Superintendent or Director.

- All tasks and activities of the committees, individual officers will be defined as job descriptions, guidelines, flow charts, prior to functioning of clusters.

**It is likely that the cluster management sub teams and the role of the Hospital Development Committee and the mechanisms used for community engagement may be innovatively defined by the respective clusters and therefore unique for each of the 9 pilot clusters.**

# 12. ADDRESSING DATA ISSUES IN THE CLUSTER

The cluster team will need to define the structure and the reporting mechanism to review cluster data via the Quality Management Unit in the clusters.

- Review services (clinical/ support) that would be made available for the catchment population via the clusters.
- Review existing data at the hospital level and develop a cluster level hospital monitoring framework, including GIS based data for spatial monitoring and catchment population data, disease surveillance data and existing data from the electronic- indoor morbidity and mortality Register (e-IMMR) and identify the data needs based on the draft cluster performance monitoring framework.
- Train the cluster hospital staff on improving data quality in the e-IMMR, in using GIS for health planning and in monitoring disease surveillance (notification) data etc.
- Review the cluster level hospital performance on a biannual basis, based on the cluster hospital monitoring framework.

The processes and steps that need to be followed to make available data to review the above will need to be defined prior to functioning of clusters.

The job descriptions of the teams / staff who will carry out these tasks, data flow, data cleaning processes, data collecting formats, appropriate software, tools etc. will need to be developed prior to functioning of clusters.

# 13. ADDRESSING HUMAN RESOURCES ISSUES IN A CLUSTER

- Assess Human Resource (HR) availability in the cluster of hospitals that are to be networked.
- Decide on the HR management structure
    - If HR will be shared across the cluster, HR will be managed directly by the Cluster Head

    or

    - If the existing HR will continue to be mapped to the PHC or to the Apex but with some arrangement for HR sharing when needed / where necessary.
- Identify the HR availability, HR gaps for providing the services (clinical and support services) that will be provided via the cluster.
- Develop mechanisms / solutions to address HR issues when providing the services identified as cluster linked services.
- Develop necessary job descriptions, work flow and reporting arrangements for providing the identified services via the cluster.
- Develop a plan to share HR for the selected tasks / activities/ services.
  E.g. of such sharing:
    - Prior identifying a group of MOs who may be able to carry out covering- up services when a particular cluster linked PMCU Medical Officer is on leave;
    - Working out the HR arrangements for providing additional services (e.g. outreach services) for selected illnesses / follow up care/ screening.
- With the successful implementation of clusters, review existing HR cadres, identify the HR gaps, define the job descriptions and initiate the steps related to seeking cadre clearance for addressing HR needs of a cluster of health facilities.

# 14. MANAGING HUMAN RESOURCES DEVELOPMENT

- Review ongoing / recently received capacity building/ human resource development (HRD) programs.
- Identify the new HRD training that needs to be given to service providers of clusters to also include the following:
    - A course on Family Health / Family Medicine for all PHC service providers in the clusters
    - A training on counselling to improve service provider / patient relationship
    - A training on use of guidelines for the management of defined diseases / services that will be provided via the cluster network: e.g. Non-Communicable Diseases at PHC, Mental Health at PHC, Long term care for elderly etc.
    - Training related to Gender sensitivity, Health Care Waste Management (HCWM), Infection Prevention and Control (IPC), Use of Information Technology and GIS etc.
- Develop an HRD training plan to address the HRD gaps, identifying the training needs that are essential prior to functioning of cluster and the training that needs to continue following the establishment of clusters for all  levels of HR.

# 15. MANAGING DRUGS AND SUPPLIES IN A CLUSTER

- Cluster Head, in consultation with the relevant RDHS and PDHS, needs to make a decision if the cluster **can be considered as one entity or as separate hospitals but functionally linked.**
    - The cluster Drugs and Supplies team needs to assess the drugs and supplies needs for the total cluster catchment population, taking into account the past experience of disease burden, utilization patterns of drugs, availability and accessibility restrictions of the Government for various levels of care of each of the cluster linked hospitals.
    - In the clusters, the Medical Supplies Division of the MOHNIM managed drug distribution and management IT system, which is linked only up to the level of Apex hospitals currently, should be expanded to connect to all DHs and PMCUs and to the respective Medical Officer of Health Offices (if possible) in the cluster.
    - IT related gaps for managing this system at all cluster hospitals should be assessed.
    - Identify the changes in guidelines, standard operating procedures, training that may be needed to have an interconnected drug distribution IT system to manage drugs and supplies within the cluster
    - Develop standard operating procedures, drug availability monitoring systems (preferably IT based) to ensure that all authorized drugs and supplies are available at each of the cluster-linked facilities.

# 16. MANAGING LABORATORY AND IMAGING SERVICES

- Cluster Head, in consultation with the relevant RDHS and PDHS, needs to make a decision if thecluster **can be considered as one entity or as separate hospitals but functionally linked,when managing the Laboratory and Imaging services.**

    - The cluster Laboratory and Imaging Services Management Team needs to assess the laboratory tests and imaging service needs for the total cluster catchment population, taking into account the past experience of laboratory test demand, disease burden, laboratory and imaging service utilization patterns.
    - In the clusters, either an existing laboratory and radiology management information system or a new IT based system will need to connect to all DHs and PMCUs.
    - IT related gaps for managing this system at all cluster hospitals should be assessed.
    - Identify the changes in guidelines, standard operating procedures, training that may be needed to have an interconnected laboratory and imaging system to manage the laboratory and radiology services within the cluster.
    - Develop standard operating procedures, laboratory and radiology availability monitoring systems (preferably IT based) to ensure that all authorized laboratory tests and radiology services are available at each of the cluster-linked facilities.

# 17. MANAGING FINANCIAL RESOURCES IN A CLUSTER PILOT

The Cluster Head, in consultation with the relevant RDHS and PDHS, needs to make a decision if the cluster **can be considered as one entity or as separate hospitals but functionally linked for managing financial resources (use of recurrent and capital allocations) within the cluster.**

- Create / reactivate the existing practices of managing a fund, for addressing within hospital or within cluster, urgent financial issues that are essential for improving and maintaining services in the clusters.
- Also, for capital allocations, a decision is needed if the cluster linked facilities will be developed as a cluster or as separate hospitals.
- If development is planned for the cluster, a cluster development master plan will need to be developed.

# 18. MANAGING THE IT SYSTEM IN THE CLUSTER FOR CONTINUITY OF CARE

- Carry out an IT assessment of all the cluster-linked hospitals on what is currently available.
- Engage in discussions to establish the proposed IT system to interconnect the cluster facilities (ADB HSEP funded) to be able to issue a Personal Health Number (PHN) based on the MOHNIM guidelines, share patient health information including lab services, imaging services so that patient has better continuity of care within the cluster linked facilities.
- Establish an IT system to inform the Medical Officer of Health areas of all notifiable disease patients managed in the cluster-linked hospitals.
- Identify the training that is required to establish a cluster linked IT system to provide the above services.
- Develop necessary flow charts, guidelines for information sharing with authorizations, job descriptions prior to functioning the interconnected IT system within the clusters.

# 19. WORKING WITH PREVENTIVE HEALTH TEAMS, OTHER HEALTH PROVIDERS AND WITH THE COMMUNITY

- Define the functional linkages for providing preventive and promotive services with the Medical Officer of Health areas that are within the catchment population.

- Define the linkages with the Medical Officer of Health areas for improved disease surveillance; especially electronic transfer of information related to notifiable disease notification from the hospital to the Medical Officer of Health areas (funded via the HSEP).

- Monitor the proportion of notifiable disease patients managed in all the cluster linked facilities reported to the relevant Medical Officer of Health areas within the stipulated time.

- Cluster team should also explore avenues of working together with the Hospital Development Committees, the Medical Officer of Health areas, Non Governmental Organizations (NGOs) and Community Based Organizations (CBOs) for providing better community care for disability and rehabilitation, providing care giver support, follow up of patients in the community when providing palliative care, mental health illnesses etc. to help ensure patient and community satisfaction.

- Establish a Grievance Redressal Mechanism for users to report their grievances on the service provided in to the cluster catchment population.

# 20. CARRYING OUT SUPERVISION AND EVALUATION OF CLUSTER PILOTS

## Supervision

- Cluster Head in consultation with the RDHS and he PDHS should define the supervisory structure, workout the roles and responsibilities of each category of staff.
- Review and adapt the PHC supervision circular (General Circular No 02 166/2015 of November 30, 2015) and develop a mechanism for supervision in the Cluster linked facilities for the identified services (clinical and support)
- Develop a baseline to report on the existing status
- Define the responsibilities, job descriptions and authorizations of all categories of staff within the cluster, for carrying out supervision.

## Evaluation

- For evaluation of the ADB Financed HSEP and the establishment of the clusters as a pilot, the HSEP is financing an evaluation study.
- A consulting firm with expertise in Monitoring and Evaluation will be contracted to carry out this task.
- A Cluster Performance Results Framework is developed for evaluation of clusters.
- The baseline survey will be carried out in 2019 and the endline survey carried out in 2023.
- The surveys will be across 4 groups.

| | | |
|---|---|---|
| Group 1 | : | GN divisions that are the cluster catchment areas |
| Group 2A | : | GN divisions that are served by the ADB financed PHCs |
| Group 2B | : | GN divisions that are served by ADB renovated Field Health Centres |
| Group 3 | : | GN Divisions that are served by all other Health facilities |

The comparison groups are shown in the map in Figure 19.1.

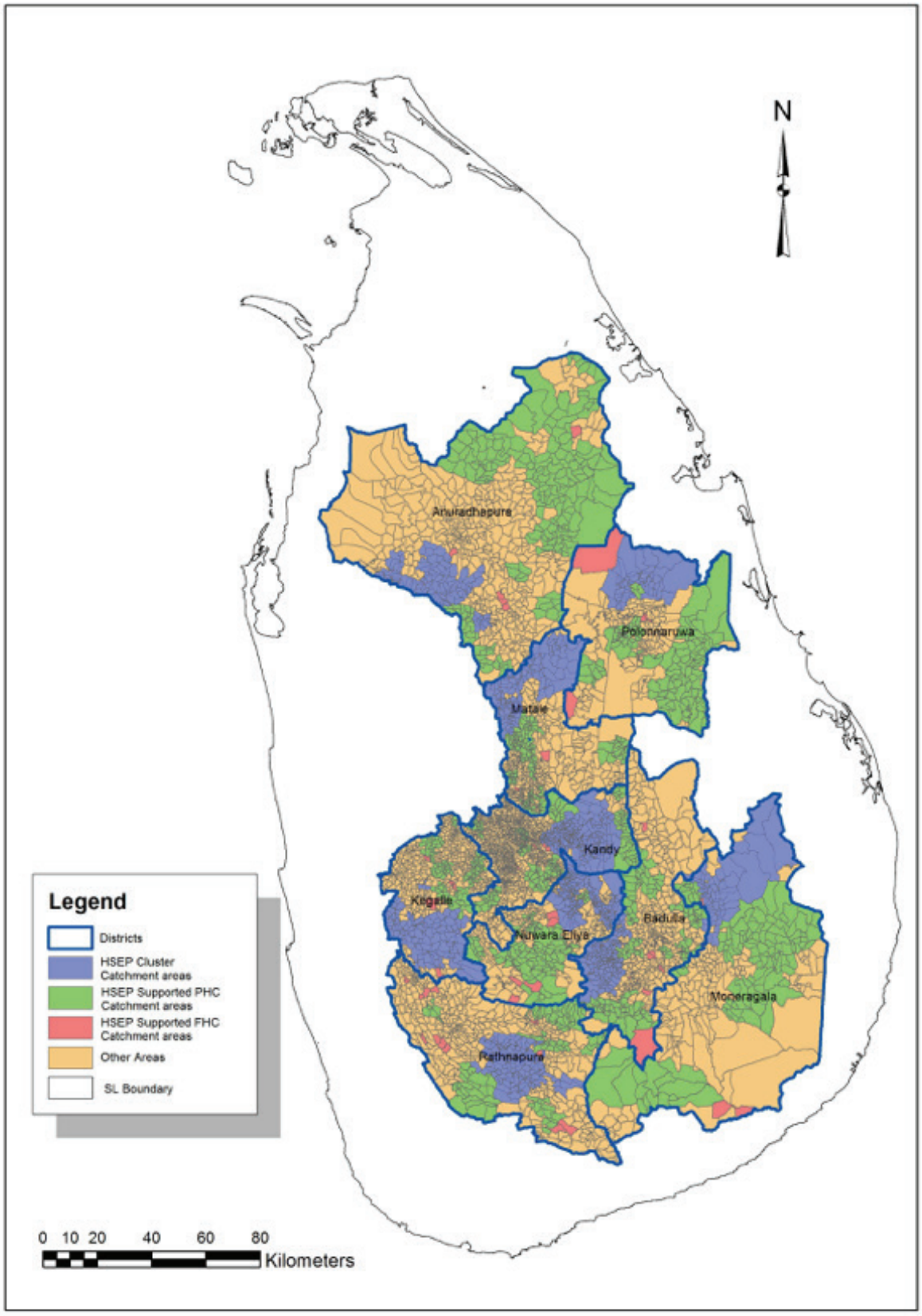



Figure 19.1 Map of GN Divisions for Evaluation of the Pilot Clusters

# 21. PHC INNOVATION FUND: ADB HSEP PROVIDES ADDITIONAL RESOURCES TO HELP ESTABLISH THE PILOT CLUSTERS

The ADB Financed HSEP, in addition to the planned investments for some cluster linked civil works, cluster IT system, medical equipment, training has made available discretionary funds for the 4 provinces via the PHC Innovation Fund.

Objective of the PHC Fund:

- To provide discretionary resources to the provinces to support PHC activities like supporting pilot clusters, innovations, programs in MOH offices, collaboration and coordination.
- Allocation is for US $ 2 million - (Approx. USD 500,000 (- LKR 87.5 million for NCP) (PAM: pages 122-132) during the period 2019 to 2023
    - On average US $ 100,000 (LKR 17.5 million) (LKR per province every year from 2019 to 2023.

The cluster teams, other province and district health staff can seek funds from this fund for the following broad areas:

- **Improving PHC management**, including cluster management, a supervisory system, performance monitoring, gender promotion, and environmental and social safeguards;
- **Human resources development** including training doctors in family medicine, training midwives in field health stations in preventive care, nutrition counseling.
- **IT for better patient management and disease control**, including e-Health cards, linking preventive and curative care, referral systems, medical supplies, geographic information systems, distance learning services, and disease surveillance.
- **Scaling up services** including health and nutrition promotion, diagnostic services, emergency services, family medicine, NCD services, and infection prevention and control;
- **Rehabilitation of facilities** including roofs, electricity, sanitation, water supply, and waste management (no new constructions).

**PHC Funds are eligible to be used for:**

- Salaries of project staff
- Workshops/meetings
- Travel costs and per diem
- IT and other system design
- Facility repairs and waste disposal
- Facility equipment and furniture
- Community based program costs
- Project staff are persons not already paid for services by MOHNIM either as regular or contractual staff. MOHNIM pensioners are eligible as project staff.

Application form for seeking funds from the PHC Innovation Fund is attached as Annex 1.

## Annex 1

**Grant Application Form for the PHC Innovation Fund under the ADB Sri Lanka: Health System Enhancement Project**

# Application Form

| | | |
|---|---|---|
| 1 | Title of the Proposed Grant Project | |
| 2 | Date of Application | |
| 3 | Applicant's Office (details in table 1) | |
| 4 | Oversight's Office | |
| 5 | Short problem Statement (details in table 2) | |
| 6 | Purpose of the Project | |
| 7 | Project Location (details in table 3) | |
| 8 | Link to Government Policy and Targets | |
| 9 | Relevant thematic area (details table 4)<br>monitoring<br>Information technology<br>Scaling up health services<br>Rehabilitating facilities<br>HRH development and training | PHC management and |
| 10 | Targeted beneficiaries or services | |
| 11 | Proposed starting and ending dates<br>Completion date: year/month | Starting date: year/month |
| 12 | Is the project part of ongoing project (see table 5) | |
| 13 | Proposed Project Objectives | |
| 14 | Proposed Project Outputs | |
| 15 | Proposed Key Activities (add details in table 6) | |
| 16 | Implementation schedule (add details in table 7) | |
| 17 | Requested Budget (add cost estimates in table 8) | |
| 18 | Sources of Financing (add details in table 9) | |
| 19 | Management arrangements | |
| 20 | Monitoring arrangements | |
| 21 | Reporting arrangements | |
| 22 | Procurement arrangements | |
| 23 | Disbursement arrangements | |

| | | |
|---|---|---|
| 24 | Proposed project preparation | |
| 25 | Project preparation and seed money required | |
| 26 | Current baseline and expected results | |
| 27 | Proposed monitoring arrangements | |
| 28 | Proposed dissemination | |
| | **Complete with assistance of PIU** | |
| 29 | Link to Project result framework | |
| 30 | Assessment of feasibility and risks | |
| 31 | Gender, safeguards and risks rating (see table 10) | |
| 32 | Ethical clearance (see table 11) | |
| 33 | Need for technical support | |
| 34 | Need for administrative support | |
| 35 | Need for financial management support | |
| 36 | Declaration of the lead officer (see table 12) | |
| 37 | Questions and comments of the lead officer | |

## Table 1: Applicant's Office Details

| Full Names of the Project Team | Designation | ID | Role |
|---|---|---|---|
| | | | Lead Officer |
| | | | |
| | | | |
| | | | |

| | |
|---|---|
| Office Address | |
| Office Phone Number | |
| Office Fax Number | |
| Mobile Phone Number | |
| Home Phone Number | |
| Home Address | |
| Email Address | |

## Table 2: Problem Statement

| |
|---|
| |

## Table 3: Location

| Province | District | Divisions GN/ PHI PHM areas | Towns | Facilities / MOH areas | Villages |
|---|---|---|---|---|---|
| **Central** | Nuwara Eliya | | | | |
| | Matale | | | | |
| | Kandy | | | | |
| **North Central** | Ratnapura | | | | |
| | Kegalle | | | | |
| **Sabaragamua** | Polonnaruwa | | | | |
| | Anuradhapura | | | | |
| **Uva** | Badulla | | | | |
| | Monaragala | | | | |

## Table 4: Thematic Areas

| **A. PHC management and monitoring** | |
|---|---|
| 1.1 Cluster management | |
| 1.2 Services promotion and performance sharing | |
| 1.3 Cluster facilities supervision | |
| 1.4 Work force planning | |
| 1.5 Participatory planning and team work | |
| 1.6 Performance Monitoring | |

## Table 4: Thematic Areas

| | |
|---|---|
| 1.7 Gender training | |
| 1.8 Environmental examination and monitoring | |
| 1.9 Engagement of vulnerable populations | |
| 1.10 Patient satisfaction monitoring | |
| 1.11 Other | |
| **A. PHC management and monitoring** | |
| 2.1 IT connectivity among health facilities | |
| 2.2 Health management information system | |
| 2.3 Patient e-Health card system | |
| 2.4 Referral system | |
| 2.5 Diagnostic services | |
| 2.6 Medical supplies | |
| 2.7 Geographical information system | |
| 2.8 Distant learning services | |
| 2.9 Disease surveillance | |
| 2.10 Quarantine services | |
| 2.11 Disability and rehabilitation services | |
| 2.12 Other | |
| **C. Scaling up services** | |
| 3.1 Community Nutrition promotion | |
| 3.2 Child nutrition clinics | |
| 3.3 Nutrition interventions | |
| 3.4 School reproductive health promotion | |
| 3.5 Community vector and infection control | |

| | |
|---|---|
| 3.6 Family medicine | |
| 3.7 Community MCH / NCD prevention | |
| 3.8 NCD services (specify) | |
| 3.9 Emergency services | |
| 3.10 Hospital infection prevention and control | |
| 3.11 Laboratory services | |
| 3.12 Ultrasound and other imaging and radiology services | |
| 3.14 Other | |
| **D. Rehabilitation of facilities** | |
| 4.1 Roof repair or replacement | |
| 4.2 Electricity repair or replacement | |
| 4.3 Sanitary facilities repairs | |
| 4.4 Water supply repair | |
| 4.5 Waste management repair | |
| 4.6 Waste management transport | |
| 4.7 Equipping field health stations | |
| 4.8 Replacement of essential equipment | |
| 4.9 Replacement of motorcycle / three-wheeler for outreach | |
| 4.10 Other | |
| **E. HRH Development and training** | |
| 4.1 Roof repai5.1 | |
| PHC training | |
| 5.2 Training needs assessment | |
| 5.3 HRH Review for PHC | |
| 5.4 Addressing HRH vacancies | |

| | |
|---|---|
| 5.5 Advocacy | |
| 5.6 Training on Emergency care | |
| 5.7 Training on Health communications | |
| 5.8 Other | |

### Table 5: Part of another project?

| **Is this project/part of this project ongoing?** | **Yes/No** | **Title and Sponsor** | |
|---|---|---|---|
| **If 'Yes', when did the project commence? *** | **Year** | **Month** | **Day** |

*** Please attach a progress report of the project from the start-up to today**

### Table 6: Key Activities: What, Where, When, by Whom and How

| Nr | Activity | Where | WhenBy | Whom | How |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

### Table 7: Implementation schedule

| Nr | Activity | Year 20.. | | | Year 20.. | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |

### Table 8: Detailed Cost estimates

| | | Cost items | Rate | Amount | 3 monthly Cost Breakdown | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | 20.. | | | | 20.. | | | |
| **1.** | **Personnel** | | | | | | | | | | | |
| | Salary | | | | | | | | | | | |
| | Travel allowance | | | | | | | | | | | |
| | Other | | | | | | | | | | | |
| **2.** | **Civil Works** | | | | | | | | | | | |
| | Salary | | | | | | | | | | | |
| | Travel allowance | | | | | | | | | | | |
| | Other | | | | | | | | | | | |
| **3.** | **Transport** | | | | | | | | | | | |
| | Fuel | | | | | | | | | | | |
| | Motorcycle | | | | | | | | | | | |
| **4.** | **Equipment** | | | | | | | | | | | |
| | Medical | | | | | | | | | | | |
| | Laboratory | | | | | | | | | | | |
| | Other equipment | | | | | | | | | | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **5.** | **Furniture** | | | | | | | | | | | |
| **6.** | **Workshops** | | | | | | | | | | | |
| **7.** | **Training** | | | | | | | | | | | |
| **8.** | **Services** | | | | | | | | | | | |
| **9.** | **Information Technology** | | | | | | | | | | | |
| **10.** | **System development** | | | | | | | | | | | |
| **11.** | **Recurrent expenses** | | | | | | | | | | | |
| **12.** | **Other (specify)** | | | | | | | | | | | |
| | **TOTAL** | | | | | | | | | | | |

**Add rows as required, budget in SLR**

## Table 9: Financing

| | | | | |
|---|---|---|---|---|
| Total project cost (see Table 8) | | | | |
| Total Amount Requested for ADB PHC innovation fund financing including taxes | | | | |
| Total Government contribution excluding in kind | | | | |
| Total Amount from other sources of financing* | | | | |
| Period of funding from other sources | From | Year | Month | Day |
| | To | Year | Month | Day |

*** Attach documentation confirming funding from other sources**

### Table 10: Gender, Safeguards and Risks

| Gender/Safeguard/Risk | Rating | Remarks* |
|---|---|---|
| Gender and Development | GM | |
| Ethnic minorities | B/C | |
| Resettlement | C | |
| Environmental safeguards | B/C | |
| Financial Risks | M | |
| Procurement Risks | M | |

*** Add appendix using ADB guidelines in case of major gender issues, safeguards A/B, and/or substantial or high financial and procurement risks.**

### Table 11: Ethics approval for the project

| | |
|---|---|
| Is ethics approval for this project required, e.g., for research? | Yes/no |
| If 'Yes', state the date of approval of the ethics review committee* | Yes/no |

*** Attached copy of approval of ethics review committee**

### Table 12: Declaration of the Lead Project Officer and Provincial Representative

**Declaration of the Lead Project Officer**

I hereby agree to the terms and conditions laid down by the Ministry of Health in approving and providing funding for the district health innovation projects under the ADB-supported Health System Enhancement Project and that the declared details furnished above by me are true and correct.

Date: .....

.....

Signature of the Lead Project Officer

**Observations and Recommendations of the Province**

I hereby recommend and forward the above Application for the Project Proposal for funding under ADB Health System Enhancement Project

Date: .....

.....

Signature, Stamp, and Designation of the Provincial Representative